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ABSTRACT

The traditional psychoanalytic approach to sexual dysfunctions deemphasizes societal factors as contributing to sexual dysfunctions The new approach to sex therapy, which has developed since 1970, emphasizes a diversity of factors, including societal factors. Sex education—following sex therapy—has now begun to recognize the area of sexual dysfunctions as a valid topic. Knowledge and understanding of the societal factors which directly or indirectly contribute to sexual dysfunctions can help people to change or better react to these factors. The clinical sociologist as a sex educator can and should make a major contribution to the prevention and correction of sexual dysfunctions.

Background: The Psychoanalytic Perspective

Prior to 1970, the prevailing perspective on sexual dysfunctions defined them as manifestations of serious psychopathology, symptoms of deep-rooted personality conflicts that interfered with sexual satisfaction. Their treatment generally was considered to be in the province of psychiatry (Levine, 1976). Pessimism marked the psychiatric approach, with the prevailing belief being that sexual dysfunctions were "amenable, if at all, only to the lengthy and costly treatment procedures that are based on the psychoanalytic model" (Kaplan, 1974:xi). This situation was largely an outgrowth of the traditional psychoanalytic view of

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sexuality, which saw nongenital sexuality as a sickness or as arrested development (Bullough and Bullough, 1977). Some of these psychoanalytic views have changed, but this perspective has generally remained among psychoanalysts and some other therapists.

In line with Wirth's (1931:52) observation that those who get in on the ground floor often determine policies, the psychoanalytic approach has dominated the field of sexual dysfunctions until recently. This psychoanalytic foothold, combined with little attention to sexual functioning and dysfunctioning from other—particularly sociological—perspectives, has led to a situation where until recent years little attention has been given to the diversity of societal factors contributing either directly or indirectly to sexual dysfunctions. There have been a few exceptions. For example, Grinker, with his systems theory, emphasized in his approach to marriage counseling a combination of biological, psychological, and social bases for sexual behavior (Grinker et al., 1961). Gagnon and Simon's (1973) concept of sexual scripting, the idea that we internally rehearse most behavior according to societal rules, also added to the awareness of sociological factors in sexual behavior. They criticized the psychoanalytic emphasis on a biologically based psychosexual drive, and suggested the importance of "sociocultural elements and social structure" in sexual behavior. Gagnon and Simon (1973:19) concluded that the biological emphasis of psychoanalysis has predominated, even among some sociologists, because of "our collective blindness to or ineptitude in locating and defining these scripts." Despite some exceptions, however, the traditional treatment of sexual dysfunctioning is an important example of the type of treatment referred to by Glassner and Freedman (1979:27): Treatment which has been based almost exclusively on psychological and psychiatric assumptions has ignored the sociological context of problems, and has been logically incorrect and "historically inadequate."

The Sociological Contribution

The pioneering work of Masters and Johnson, themselves operating from a medical perspective but taking a larger view than the traditional approach, began to broaden the perspective on sexual functioning and dysfunctioning. Masters and Johnson stated (1970:21) that "sociocultural deprivation and ignorance of sexual physiology, rather than psychiatric or mental illness, constitute the etiological background for most sexual dysfunctions."[1] They estimated that about 10–20% of sexual dysfunctions are caused primarily by organic factors, and that the remainder are caused by psychosocial factors—including psychological, interpersonal, environmental, and cultural factors (Masters et al., 1982:376).[2]

Masters and Johnson's listing of the most common types of sexual dysfunctions indicates the societally related origins of dysfunctions (Figure 1). They note, for example, that most men with premature ejaculation have a common

Figure 1
Primary sexual dysfunctions as listed by Masters and Johnson, with a listing of major causes or associated factors

Dysfunction	N	Major Causes or Associated Factors
Dysfunction (males)		
Premature ejaculation	186	Early heterosexual attempts hurried
Ejaculatory incompetence	17	Religious restrictions, fear of impregnation, lack of physical interest in or active dislike for partner, traumatic event
Primary impotence	32	Seductive mother, religious belief in sex as sin, homosexuality, traumatic initial failure
Secondary impotence	213	Premature ejaculation, alcohol, dominating parent, religious restrictions, homosexuality, physical problems
Dysfunction (females)		
Primary orgasmic dysfunction	193	Religious prohibitions, protective vacuum (lack of experience), inability of woman to identify with partner (most common), sexually inadequate male
Situational orgasmic dysfunction	149	Negative attitude toward partner, homophile orientation, low sex drive
Vaginismus	29	Marriage to an impotent male (may be more a result than a cause, women prone to vaginismus tend to select an impotent partner), family background in which sexuality is considered sinful and dirty, previous physical attack, partner's clumsiness, painful intercourse, homosexual orientiation
Painful intercourse	—	Failure to lubricate, infection, chemical sensitivity

history of their early heterosexual attempts being hurried, with an emphasis on speedy ejaculation because of the situation (e.g., in the back seat of a car, in a lovers' lane, with fear of being caught). In discussing male impotence, they note the psychological burden placed on the male by "the cultural concept that the male partner must accept full responsibility for establishing successful coital connection" and, in discussing female dysfunctions, they note how the female's

being forbidden by her culture "to accept herself honorably as a sexual being" has led to problems (Masters and Johnson, 1970:159, 158).

Kaplan, another pioneer of the new approach, states that the work of Masters and Johnson and other therapists provides compelling reasons for reevaluating the traditional position. Kaplan adds (1974:155) that the sexual system is often highly destructive and dehumanizing, and that "for a person to function sexually in such a system, where there is fear, rejection, misunderstanding, humiliation, demand and alienation between the spouses, would be dysfunctional." Zilbergeld (1980:28), discussing the cultural stereotype that men should be easily aroused by any attractive women anywhere, notes that failure to fulfill this cultural expectation might be viewed as inadequacy in the masculine role, by either males or females.

The importance of societal factors is also noted by others researching specific areas. For example, Jones et al. (1977:325) demonstrated that even the reaction to castration of the male is primarily determined by cultural factors: Castration can easily result in impotence if the male and/or his partner expects it to, but "reassurance and encouragement from the sexual partner, and an informed and healthy attitude on the part of the man" are the most important factors in determining whether intercourse continues after castration. As another example, Foster (1979:26) concludes, "There is little doubt that for many (perhaps most) of the elderly, acceptance of cultural sexual stereotypes seriously impairs the quality of their lives." Particularly in the area of gender stereotyping, which is learned from one's society and varies by cultures and subcultures, the point is made that women develop some dysfunctions because of the disproportionate number of negative signals they receive because of the double standard, while men develop some dysfunctions because they "may never consciously realize that they need warmth, tenderness, and identification with their partners to function effectively" (Belliveau and Richter, 1970:159).

Sex therapy today is much different from what it was prior to 1970. New approaches emphasize a "combination of sex education, attitude reinforcement, specific behavioral exercises, communication between partners, and minimum general psychotherapy" (Luria and Rose, 1979:309). Today, after over a decade of rapid change, sex therapists include practitioners of different backgrounds — sociology, social work, nursing, biology, health, theology, and diverse fields of psychology, as well as the traditional fields of psychiatry and medicine.

Toward a New Definition

Within a society, definitions of sexual functioning and dysfunctioning vary over time. When women were not expected to enjoy sex, and when concern was on "excessive" desire in women rather than on the absence of desire, orgasmic difficulty by the woman or premature ejaculation by the man were not viewed

as dysfunctional (Jones et al., 1977:160). Dysfunctions, or perceived dysfunctions, can also result from new definitions of sexuality emerging from new cultures or subcultures. Fixation on female multiple orgasms, for example, can lead to problems by creating new pressures (Diamond and Karlen, 1980:329). For a while, having simultaneous orgasms was touted as the ideal, and some couples felt that they had a problem if they did not orgasm together (Karlen, 1979). Concern over such issues can take away spontaneity, intellectualize lovemaking, and lead to dysfunctions.

New concepts, taken out of context, and not necessarily accepted by all scholars, can cause unrealistic expectations for both women and men. The concept of the G-spot (a small, very sensitive spot on the anterior wall of the vagina, which leads to strong arousal), for example, has received much media attention, even though it is not accepted by a number of sexologists. The authors of *The G-Spot*, while arguing for its existence, nevertheless recognize the dangers of uncritical acceptance: "We don't want to create new pressure for women or men. Sex is for pleasure, and when it becomes goal-oriented, the pleasure is often diminished. . . . Because we have reached a new synthesis with regard to certain aspects of sexuality, let's not establish another tyranny involving the G-spot, female ejaculation, multiple orgasm, or the male prostate" (Ladas et al., 1982:170, 174). These authors strongly assert, however, that this position does not negate education, that information and support are important to healthy sexual functioning (178).

The influence of society on the definition and frequencies of sexual dysfunctions is also indicated by cross-cultural studies. Not only does the definition of dysfunction vary, but what one learns as "possible" varies. As Glassner and Freedman (1979:227) note, the contrasts in what "sexual advice books" advocate as proper sexuality become clear in cross-cultural comparisons. For example, elderly individuals in Western society often decrease their activity level because "our culture had conditioned aging men and women not to expect sex or to enjoy sex" (Belliveau and Richter, 1970:216). This belief in waning sexuality may lead to depression and loneliness in our culture (Jones et al., 1977:198). On the other hand, the traditional Oriental approach has emphasized and experienced the enjoyment of sexuality at any age (Chang, 1977). According to the anthropologist William Davenport, the mountain people of Abkhasia in Russia also consider sexuality a primary pleasure to be pursued as long as possible, and most couples remain active beyond the age of 70 and some beyond the age of 100 (Beach, 1978:557).

Western society traditionally has deemphasized the importance of female satisfaction, and, despite recent changes, there are still significant numbers of Western women who experience orgasm problems because of this deemphasis. In a sexually repressive society off the coast of Ireland, female orgasm is largely unknown, and is considered deviant when it rarely occurs (Messinger, 1971).

In sharp contrast to this society, and in some contrast to Western society in general, males in the South Pacific Mangaian culture value female sexual satisfaction and regularly help their partners achieve two or three orgasms to the male's one. In this culture, all women apparently have orgasms (Hyde, 1982:19; Marshall, 1971:122).

Male multiple orgasms are rare in the Western world (Hartman and Fithian, 1984; Robbins and Jensen, 1978), but for followers of Taoism in the Orient, a male who does not regularly have multiple orgasms (not multiple ejaculations) could be considered dysfunctional by his partner (Chang, 1977). Similarly, the Western male rarely can have an orgasm without an ejaculation, whereas the follower of Taoism could be considered dysfunctional if he did not separate them (it is this ability that results in the frequency of multiple orgasms).

Sexual Dysfunctions in the United States

How common, and how severe, are sexual dysfunctions in United States society? Because of the recency of the interest in sexual dysfunctions, no large-scale surveys have yet been conducted specifically on this topic (Victor, 1980:86). One small study found that 40% of men and 60% of women experienced sexual dysfunctions, and that 50% of men and 77% of women experienced other kinds of sexual problems (inability to relax, etc.) (Victor, 1980:60). Other estimates of the proportion of married couples with problems have ranged from 14% (Rainwater, 1966) to 77% (Frank et al., 1978).

Pietropinto and Simenauer, in one of the best recent studies of sexuality in the United States (1977:195)—based on findings from 4,066 males randomly selected from throughout the United States—conclude that "about 84% of men today have experienced some sort of potency difficulties." The generally accepted estimate is that of Masters and Johnson (1970): "A conservative estimate would indicate half the marriages [in this country] as either presently sexually dysfunctional or imminently so in the future." Additionally, "Few people go through life without experiencing at least some instances of difficulty in their sexual responses" (Jones et al., 1977:160). While the estimates of therapists may be high because of the people they see, it is also possible that those who seek help are "few in number compared with those who have a dysfunction but suffer quietly and never seek therapy, as a result of either ignorance or embarrassment" (Hyde, 1982:449). The problem may be accentuated because "the distress experienced by one partner directly affects the other" (McCary and McCary, 1982:493), and because when sexuality is a problem people "spend almost all of their time being distressed about it" (Gotwald and Golden, 1981:365).

Change: Education as Prevention

At the same time that the new approach to sex therapy was beginning, sex education was also beginning to make some progress in United States society—a result of the same broad social changes that led to changes in sexual attitudes, sexual practices, sex roles, and to the new therapeutic approach. Included among the goals of sex educators were providing "an appreciation of the positive satisfactions that wholesome human relations can bring in both individual and family living" and providing "the understanding and conditioning that will enable each individual to use his or her sexuality effectively and creatively in the several roles of spouse, parent, community member, and citizen" (Kirkendall, 1965).

Extending this view, sex educators began to argue that some sexual dysfunctions experienced by adults "could have been prevented had they received adequate sex education during childhood" (Jones et al., 1977:15). Blazer, in a study of one thousand women with sexual problems so serious that sexual intercourse had not taken place in the marriage (1964:213-214), concluded even for these women that if they "had been given appropriate sex education at an early age, the sexual problems of at least 80–85% of them very likely would not have existed—or persisted."

Recent sexuality textbooks now routinely include a section on sexual dysfunctions. Nearly all these sources—from psychology, health, biology, medicine, social work, sociology, etc.—note that a small percentage of sexual dysfunctions have physical origins, and that most dysfunctions are a mixture of other causes (Figure 2). Aided by these recent changes, the clinical sociologist in the educational setting, being concerned with diverse factors that affect functioning (Freedman, 1982:37), is now in a good position to advance preventive and corrective knowledge in the area of sexual dysfunctioning.

While some writers still have a tendency to classify all nonphysical origins as "psychological," an examination of these writings indicates that these origins include ignorance and misinformation (often resulting from society's attitudes toward sexuality), problems in communication or interpersonal relations (often caused by society's role-stereotyping of males and females), anxiety, fears of failure, fears of performance (often caused by unrealistic expectations learned from one's society), shame and guilt (often learned from society's attitudes about sexuality), and inaccurate information (e.g., beliefs about aging and sexuality, usually learned from one's society).

The point is made that even when sexual dysfunctions manifest themselves as psychological problems, the origins frequently are based in societal values, expectations, etc. In fact, Masters, Johnson, and Kolodny (1982) use the term

Figure 2
Major causes of sexual dysfunctions as listed in recent human sexuality textbooks.

Author/s	Year	Outline, or listing, or major causes
Crooks, Baur	1980	Cultural, personal, interpersonal, organic
DeLora, Warren, Ellison	1981	Physiological, psychological, cultural, relationship
Diamond, Karlen	1980	Stress, misinformation, unrealistic expectations; nonsexual, intrapsychic, and interpersonal conflict
Godow	1982	Negative sociocultural attitudes (sex as sinful, traditional role-expectations), anxiety, sexual ignorance and poor communication, relationship factors, organic factors
Gotwald, Golden	1981	Negative learning, lack of information, religious orthodoxy
Harmatz, Novak	1983	Physical, psychological (anxiety, performance fear, ignorance, inability to communicate, stress)
Hyde	1982	Organic, drugs, psychological
Jones, Shainberg, Byer	1977	Physical, psychological (taboos, inhibitions, emotional blockage such as fear, anger, anxiety, hostility)
Luria, Rose	1979	Ignorance, shame, fear of failure
Masters, Johnson, Kolodny	1982	Organic, psychosocial (psychological, interpersonal, environmental, cultural)
McCary, McCary	1982	Ignorance about sexual techniques, general misinformation, fear of failure, etc.
Meeks, Heit	1982	Complex (most psychological)
Offir	1982	Organic, psychological, interpersonal, cultural
Reed	1979	Some from physical inability, but most from negative, often faulty and inaccurate learning and conditioning
Sandler, Myerson, Kinder	1980	Ignorance, unrealistic expectations, performance fears, overemphasis on techniques, fears of rejection and intimacy, guilt
Victor	1980	Bodily malfunctions, personal anxieties, cultural expectations, interpersonal conflicts, any combination of these
Wilson, Strong, Robbins, Johns	1980	Psychological (negative feelings about sexuality or destructive personal or sexual interaction), physical factors

"psychosocial" to include all nonorganic causes (psychological, interpersonal, environmental, cultural). One set of authors, in discussing the nonphysical factors that are likely to influence future sexuality, say, "To be totally accurate, we should probably label these factors as being 'socio-politico-economic-psycho-cross-cultural.' Well, you get the picture: Many forces within society affect human sexual behavior" (Harmatz and Novak, 1983:543).

One of the pioneer advocates of scholarly sex education, McCary (1971), stated that the question was not whether sex education would be taught in the schools, but rather where in the school it would be taught—in the schoolroom or in the schoolyard. If intelligent information is not provided, false information will be gained and will exact a cost. For sexual dysfunctions, a similar situation exists: knowledge and understanding of sexual dysfunctions can be provided before dysfunctions occur, and help prevent them, or knowledge and understanding can be gained (if at all) after dysfunctions have occurred and costs have been paid.

Knowledge and understanding can help protect people from sexual dysfunctions. People can be reassured ahead of time that most people have mild or occasional sexual functioning problems and that most of these experiences are normal and predictable. This knowledge is important "because it can prevent the anxiety that can easily lead to more persistent and severe problems" (Jones et al., 1977:160). If people can learn to focus on their sensations—to learn to touch each other in a communicative way (which Masters and Johnson note is the key concept in prevention, as well as in therapy)—even the occasional problem can be diminished.

The Clinical Sociologist as Sex Educator

If sexual dysfunctions can be learned through faulty education or can be unlearned through the new behavioral approach to therapy, then often they can be "not learned" in the first place through preventive education. This is where the clinical sociologist as a sex educator can make a major contribution as a change agent in an area previously neglected by sociologists: to prevent or lessen sexual dysfunctions by providing specific knowledge and understanding of how to react to or change societal factors which are likely to lead to dysfunctions. The clinical sociologist can make this contribution by helping to foster "changes in students' attitudes and/or behavior as a result of classroom experiences" (Fritz, 1979:577). Similar to bibliotherapy (therapy through reading and understanding one's problem), this approach is appropriate for either the classroom, or for informing clients, on an individual or group basis, of new possibilities of attitudes and behavior.

This author began teaching a course on the sociology of human sexuality at the University of Maryland in the mid-1970s, and continued the course at the

University of Miami for five and a half years beginning in 1978.[3] A section on sociological (societal) influences on sexual dysfunctions comprised about 25% of the course, being presented as the last part of the course after the students had been provided information on different cultural and subcultural perspectives about sexuality. The perspectives part of the course, comprising about 30% of the course, covered the sociohistorical development of Jewish and Christian attitudes toward sexuality, and a comparison to other cultures (e.g., Oriental, Indian-Hindu, Arabic-Islamic). The section on dysfunctions discussed the six major sexual dysfunctions shown in Figure 1, and the extent to which societal factors influence the specific sexual dysfunction. Societal factors discussed included gender role expectations, religious influences, parental and peer influences, stereotypes of aging and sexuality, social class differences, and ethnic differences. The book used in this part of the course was Belliveau and Richter's (1970) *Understanding Human Sexual Inadequacy*, a layperson's condensed version of Masters and Johnson's (1970) *Human Sexual Inadequacy*. The book is clearly written, and was very well received by college students. (This book is now out of print; however, a number of textbooks now include sections on dysfunctions, and, with additional information from the instructor, can be as effective as Belliveau and Richter's book). Student reactions to this information were positive, with the desire being expressed for more of this information. This is in line with the observation that because of "cultural changes, many people today are seeking professional assistance in improving their overall sexual functioning and relationships" (Sandler et al., 1980:177).

This author also has used this approach on an individual counseling basis, helping clients to put their situation into perspective relative to society's teachings, intellectually to understand the origins of the problems, and to learn new perspectives and/or techniques to alleviate the problems. On an individual counseling basis, the success has been good for those clients who are able intellectually and emotionally to gain a broader perspective. No "before-after" comparisons are possible in the classroom situation, but, in addition to strong interest in this part of the course, informal comments from many students suggest that the broadened perspective gained in the classroom has helped students prevent problems from arising. The most common situation related by students is the one by the male who is unable to have an erection in a specific incident, but who accepts this as "my turn to have a headache" rather than "making a big deal out of it and worrying about the next time." As in the individual counseling situation, the success of this approach depends on the ability of the student intellectually to understand how his/her situation fits into the overall perspective, and on the ability emotionally to broaden his/her perspective. While this author has not utilized this approach in a group counseling situation, his experience in the classroom and individual counseling situations suggests that it would be effective in this modality also. Opponents of sex education probably would oppose this

information being provided in a high school situation, but it is this author's belief that the approach could be adapted successfully to a high school situation—at least on a briefer and less detailed level. On the college level, the audience is self-selected, and, as noted, the reception has been strongly positive on the part of students.

Psychological, medical, and other approaches are also important for some individuals with sexual dysfunctions, and must be recognized. New research on the effects of drugs on sexual behavior, for example, suggests that the physiological factors might have been underestimated in recent years. As a humanistic and holistic approach, clinical sociology must be multidisciplinary (Glass, 1979:513–514). In the area of sexual functioning/dysfunctioning, clinical sociology can supplement and be supplemented by clinical psychology and clinical psychiatry to lead to a "more valid and complete explanation of human behavior" (Dunham, 1982:27). At this point in time, the clinical sociologist is most likely to appreciate the part that sociological factors play in influencing sexuality, and hence is most apt to be the source of broadening understanding in this area. By no means, however, is this appreciation limited to sociologists. As the study of sexuality increases, hopefully a multidisciplinary approach to the understanding of sexual dysfunctioning will be accepted by all disciplines. While each discipline—for example, sociology, psychology, biology—should emphasize factors within its discipline, any approach which does not recognize the diversity of factors is arbitrarily limited.

By recognizing the diversity of factors influencing sexual functioning and dysfunctioning, while emphasizing the influences which societal teachings can have—either directly or indirectly—upon sexual dysfunctions, the clinical sociologist as sex educator can make a primary contribution to the prevention, and a secondary contribution to the correction, of sexual dysfunctions.

NOTES

1. The work of Masters and Johnson has been criticized by Zilbergeld and Evans (1980) on methodological grounds, and by Szasz (1980 164), who claims that sexual dysfunctions should be viewed as individual solutions to problems rather than as dysfunctions Undoubtedly, the work of Masters and Johnson and other therapists and researchers will be refined as new findings occur. Nevertheless, the nonpsychoanalytic approach already has had a strong effect, largely due to the findings of Masters an Johnson

2. Kaplan (1974:69) estimates that 3–20% of individuals with sexual dysfunctions have some organic component contributing to the dysfunction Despite the small percentage of organic origins, it is not unusual, as noted by Kaplan, to have a physical examination to confirm the lack of a physical problem At the time of her book, Kaplan was Clinical Associate Professor of Psychiatry in charge of Student Teaching of Psychiatry at Cornell University College of Medicine. She also was head of the Sex Therapy and Education Program at the Payne Whitney Clinic of New York Hospital.

3 This author took the Institute for Sex Research (Kinsey Institute) course in 1973, and three courses from the American Association of Sex Educators, Counselors, and Therapists (AASECT):

Clinical Workshop on Sex Therapy and Counseling Skills (1975); Workshop on the New Sex Education (1976); and Workshop on Advanced Studies in Human Sexuality (1978). These courses helped form the final outline of the sexual dysfunctions part of the author's teachings. In 1981, an entire course was taught on "Sociological Aspects of Sexual Dysfunctions." This course, taught as a workshop to upperclass students, emphasized the social factors which contribute to sexual dysfunctions and problems, and how these factors are internalized. Special emphasis was put on gender role expectations, and how problems result from individuals attempting to follow a rigid "masculine" or "feminine" definition of sexual behavior.

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