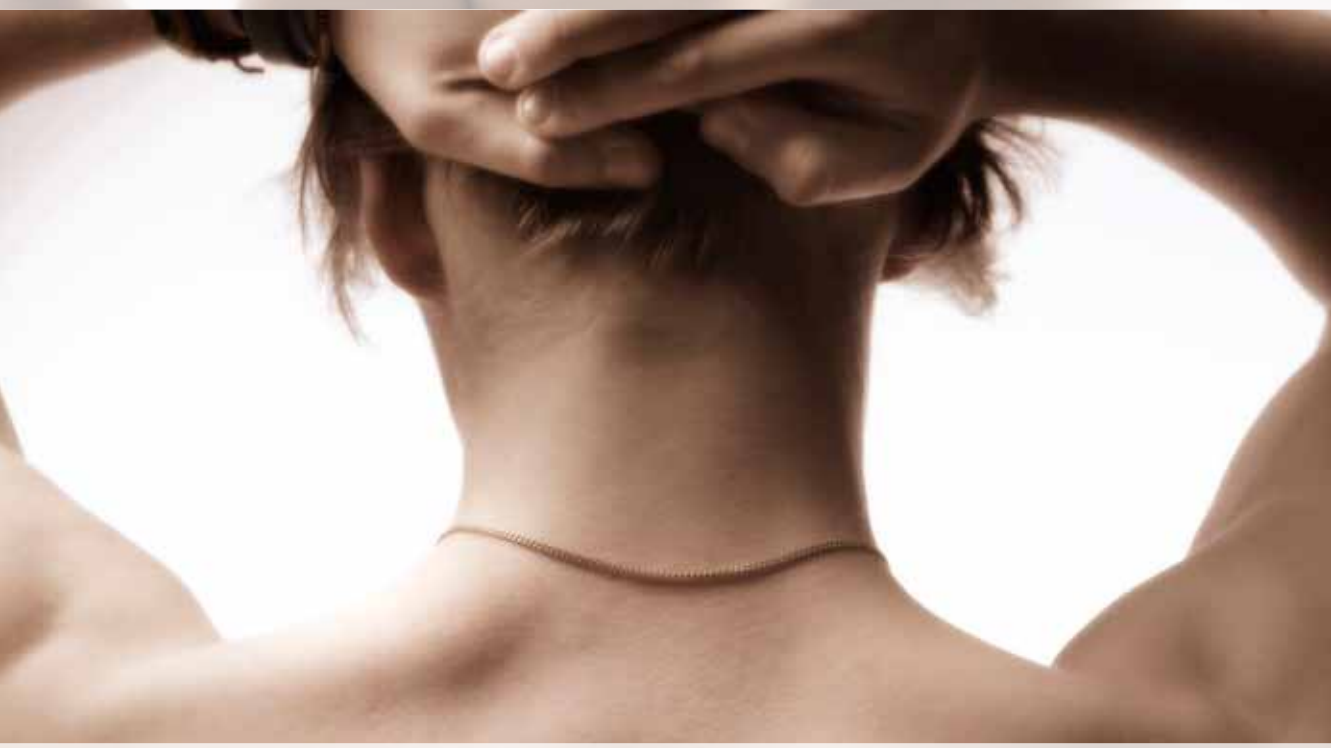
Pleasure and Health

by education, councelling and treatment



Nordic Association for Clinical Sexology NACS 2012

Pleasure and Health
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Preface

This Proceedings book is a publication of the Annual conference of the Nordic Association for Clinical Sexology (NACS) held in Helsinki 4.-7.10.2012. Conference was organized by the Finnish Association for Sexology (FIAS). As far I know this is the first Proceedings book ever published of these NACS conferences. It was also exceptional that this book could be edited and published already before the conference. In some conferences similar books have been edited and published only after the conference was over.

Publication of this book was made possible by the Board of FIAS that decided in June to invest necessary resources for this work. I thank the Board of their support for this book. Even more important were active participants of the conference who were willing to submit their excellent contributions to this book with a very short notice. It was impressive. I'm happy to announce that most participants of the conference, altogether 16 people – many with their other colleagues, sent their manuscripts for this publication. 15 of them provided an oral presentation in the conference. I'm greatly thankful to all authors of their excellent contributions.

Articles have been grouped into the same order as they were presented in the conference. The style of submission was not explicitly predetermined. Some of articles adopted traditional scientific form, others have more informal style. All of them provide readers very interesting and novel information of sexual issues. Many of the articles deal with sexual pleasure and wellbeing but every author has selected the issue that they wanted to share with other participants of the NACS conference. Hopefully you will enjoy as much as I did while readings these scholarly and professionally stimulating sexology texts.

Helsinki 3.9.2012

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Editor

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Cancer and Sexuality

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Introduction

Cancer usually is a major blow to a person's integrity, and the subsequent treatment tends to damage various aspects of sexuality. Over the last decades, the treatment developments caused more people to survive cancer, but they also caused more ´negative consequences´. Many survivors have to face sexual disturbances, diminishing their quality of life. Whereas oncosexology has developed a wide range of adequate interventions for sexual disturbances, unfortunately many disturbances never reach the sexology professionals. Because the patient's shame prevents them to speak out and because many oncology professionals don't address sexuality. That is why it is important to pay attention to this area.

This chapter is compiled in the following manner:

- Some facts and figures of cancer.
- Some general aspects of the sexual damage caused by cancer and treatment
- Some of the most relevant sexual consequences of various cancers.
- An idea on the average common patterns of sexuality after cancer
- Some aspects on cancer and sexuality in gay and lesbian patients
- Oncosexology and some of the treatment elements of their toolbox

It will be clear that this is not a complete reproduction of what is known. More detailed information can be found in a recent book on Cancer and sexual health[1] and on the website of the ISSC (International Society for Sexuality and Cancer www.issc.nu → see under 'books').

Facts & Figures

For several reasons it seems relevant to increase the attention we pay to the sexual aspects of cancer.

- People grow older. The life expectancy (at birth) in the 6 Nordic (NACS) countries is 76,0 yrs for male and 82,2 yrs for female. There is no average age to contract cancer. Leukaemia and testis cancer happen for instance at young age. The fact that the majority of these patients survive, means that the sexual side effects of their treatment can last for decades! The majority of cancers however happen at later ages with ± 63% at age 65 or above.

- Since the treatments are improving, more people will survive cancer. Prostate cancer as well as breast cancer gradually get in the range of 'chronic disease'. At the same time the sexual damage of many treatment interventions is tremendous.
- People are changing. Many of the younger generation seniors (the baby boomers) will not accept a life without sexual expression.

Assuming that the Dutch population and cancer figures will not be very different from the Nordic countries I will use Dutch figures. I tried to calculate the percentage of the three groups of people above 20 yrs of age with cancer.

0,1%	The people recently diagnosed and in the process of (waiting for) treatment and recovery;
4,0%	The survivors; the lucky ones who apparently got cured.
0,2%	The people where cure is no more option and who reached the palliative / terminal stage.

These numbers and the total of 4,3% probably will gradually change in the near future since there is a growing group of people who stay alive for many years after breast cancer and prostate cancer without being cured. Although it is not easy where to place these 'chronic disease cases' (under 'survivors' or under 'palliative'?), it is clear that many of them will suffer in the areas of sexuality and intimacy. This 4,3% can nearly be doubled because in most cases the partner will suffer as well.

These combined numbers and facts seem to be good reasons to pay attention to this area. Whereas the oncology community should be prepared to deal with sexual and intimacy aspects of their caseload, the sexology community should to be prepared to deal with cancer patients.

The Damage Done

With sexual disturbances as the starting point, sexologists use a biopsychosocio(-cultural) approach to explain the various causes and from there they develop a proper treatment strategy. When cancer or other medical conditions and medical interventions are the starting point, we recommend as well another approach. In that situation we should look at the consequences of disease or intervention in three different areas of sexuality: sexual function, sexual identity and sexual relationship.

An example for each:

- Disturbed sexual function: extensive surgery for rectal cancer causing loss of erection.
- Disturbed sexual identity: Androgen Deprivation Treatment (ADT) for prostate cancer causing loss of sexual desire, loss of assertiveness, hot flashes, female appearance (included breast development), and diminished erection ('I am not a man anymore').
- Disturbed relationship: mastectomy (removal of the breast) for breast cancer making the woman very insecure and afraid to enter a sexual encounter with her partner. He then can react too careful and never initiate intimate contact. Subsequently, she probably will feel guilty and both will lack the physical warmth and benefits of intimacy.

Those three areas can be solely affected, but frequently they will interact with each other.

We'll start here addressing some general aspects and then we will highlight several specific forms of cancer with some of the corresponding sexuality related consequences.

Cancer as a disease does far less damage to sexual function than the medical interventions that aim to stop the cancer and cure the patient. On the other hand, the diagnosis of cancer is usually a serious blow to the personal integrity of patient and partner. For most people this is a major life event after which they will never be the same. That is why in psycho-oncology we use the phrase 'the new me'. Several general 'side effects' are seen in many patients with different cancers. Cancer patients typically go through a long period of fear. After the initial fear for death, many have bouts of fear for recurrence, rising before every new medical examination and with every strange sensation in the body. There is a wide range of mood disorders. In a meta-analysis covering 10.000 oncological and haematological patients a total of 38,2% was suffering of one of the mood disorders (depression, anxiety, adjustment disorder or dysthymia).[2] As we know, both the depression and antidepressants can have a negative influence on sexuality. Another disturbing general complaint is fatigue, found in up to 80% of all cancer patients. Fatigue can easily interfere with sexual desire of the patient and also reduce the participation in the normal daily tasks, and as such aggravate the daily life of the partner. The mood changes and fatigue of the patient added up to the own fatigue and fears, can turn the daily life of the partner in a rollercoaster. That is why we tend to use also the phrase 'the new we'.

Some patients and some partners suffer so much psychotraumatic damage that their sexual life is finished. However, some other patients react in a completely different way. They no more accept 'just sex' and go for high-quality sex, sometimes even dropping a lousy partner.

In later stages of the cancer process, physical factors of the disease can get more negative influence on sexual function itself. Cachexia, dizziness, nausea and pain can become too disturbing to allow sexual feelings to develop.

RADIOTHERAPY (RT) & CHEMOTHERAPY (CT)

RT and CT have several side effects in common. Whereas CT usually reaches all body cells, the damage of RT is only in and round the radiated area. Intended to destroy cancer cells both treatments can also damage healthy cells. Usually this damage is temporarily causing dry mouth, feeling sick, loss of appetite, diarrhoea, fatigue, sore skin, or hair loss; all symptoms that can obstruct sexual desire. In very sensitive cells the damage can be permanent. For instance in the gonadal cells, resulting in a decrease in fertility and in hormone levels. RT can also cause permanent skin damage in the form of scars.

HORMONAL THERAPY

The gonadal hormones (especially estrogens and androgens) are very relevant for sexual functioning. In some cancer treatments the level of these hormones is deliberately forced into the very low range to stop the growth of cancer cells. An example is ADT in prostate cancer. Androgen deprivation seriously damages sexual function and sexual identity. In other cancers very low hormonal levels do not develop by intention but as a side effect of treatment. Both in men and in women a minimum amount of androgens is needed for sexual desire and arousability. In the man 95% originates from the

testes and 5% from the adrenal glands; in the woman 50% from the ovaries and 50% from the adrenals. Castration (bilateral removal of the gonads) will strongly cut down the androgen level. With the addition of chemotherapy that level will drop even more. An example is ovarian cancer where bilateral ovariectomy and CT cause absence of desire, no arousability and difficulty to get orgasm.

Sexual Consequences of Specific Cancer

In this chapter we will look at various cancers and pay attention to some of the relevant elements that can influence sexuality. This overview absolutely does not pretend to be complete. It is a way to indicate topics that can be specific for a given type of cancer and patterns exemplary for more types. In the table the incidence percentage is shown for each of those tumours in 2010 in the Netherlands

Incidence new tumors (Netherlands)

2010	male	female
brain	1,4%	1,1%
head & neck	3,8%	2,1%
lung	15,0%	9,9%
blood & lymph	8,6%	7,2%
colorectum	14,0%	12,6%
anus	0,2%	0,2%
bladder	4,5%	1,5%
prostate	20,8%	
testis	1,3%	
penis	0,3%	
breast	0,2%	29,1%
ovaries		3,1%
endometrium		4,2%
cervix		1,6%
vagina / vulva		0,9%
other tumors	29,8%	26,5%
all new cancers	100,0%	100,0%

Data of Dutch Cancer Registry

Brain Tumour

The consequences of brain tumour and its treatment can resemble the symptoms after a cerebrovascular accident (CVA) with loss of muscular function and loss of sensation. Some patients get epileptic fits, that (just as the corresponding medication) can influence sexual desire, with sometimes a decrease in androgen hormone levels. In the majority of patients sexual desire is diminished, but a small amount of patients display an increase in sexual desire, usually a (brain damage related) symptom of disturbed control over sexual impulses. This can be accompanied by a more extended change in personality.

The same problems can also be found when other cancers have caused extensive metastases in the brains.

Head & Neck Cancer

Disease or medical intervention can cause changes in the face. Such 'dysfigurement' is not only disturbing for the sexual identity (especially for women). For the partner it can be also a handicap to engage in a sexual encounter and for a potential partner in the dating dance.In some of these cancers surgery or radiation can arrest the production of saliva, causing a serious handicap in kissing and oral sex.

Lung Cancer

Since the majority of lung cancer cases cannot be cured and since the period till death is rather short, the sexual consequences of lung cancer are hardly investigated. One can guess what sexual disturbances can be expected. A tickling and gurgling cough with much mucus will disturb intimacy. The dyspnoea and fatigue will impair sexual excitement. Then, extra oxygen can be of help in some cases.

Blood & Lymph Cancer

There are two relevant treatment strategies for the wide range of cancers originating in the haematopoietic or lymph system. Chemotherapy (CT) applied to kill the cancer cells, also damages the gonads. This can cause impaired fertility (frequently shown in young women as irregular or no menses) but also diminished desire and fatigue. This triad of symptoms can be a sign of diminished androgen production in gonads and adrenal glands. That is a clear situation for androgen hormone treatment, which (in blood & lymph cancer) carries no hormonal risk.

The other treatment strategy is total body irradiation with transplantation of stem cells. That too can cause the above mentioned triad of reduced fertility, fatigue and absent sexual desire and then hormonal treatment should be considered as well.

When the transplanted stem cells are allogenous (i.e. from another person) there is the risk of transplantation reaction (Graft vs. Host Disease) with in men penile changes, pain and erectile problems and in women vaginal inflammation, narrowing, scars and dyspareunia.

When, during CT or total body RT, the white blood cell count becomes extremely low the resistance to infection has gone. Then every form of penetrative sex (even oral) is dissuaded.

Colorectal and Anal Cancer

Colorectal cancer, for women the second most frequent cancer, has many sexual implications.[3] Two major relevant topics are at stake. One is the ostomy ('stoma'). An artificial bowel outlet damages the intact belly and can disturb sexual identity, especially in the patients with a high sense of external appearance. Bowel movements tend to accompany sexual excitement (especially in the orgasm phase). Whereas in the normal situation the anus prevents such activity becoming visible, a stoma doesn't have such a safety valve. So, bowel contents will appear in the stoma bag, being a reason for shame, fear for leaking and fear for bad smell.

The other topic is the treatment damage to the nerves needed for erection and lubrication. The closer the tumour is to the rectum, the more these sexual functions will be disturbed.[4]

Anal cancer is still a rather rare cancer. Treatment (with radiotherapy) will damage the flexibility of the anus, causing problems for the women and gay men who have receptive anal intercourse in their 'love map'.

Cancer of the Bladder

This is mainly a disease of the aged. In the more advanced stages the bladder is completely removed, and an artificial bladder is created to function as urinary reservoir. During the operation the prostate is usually removed as well, causing erectile problems and the need to start penile rehabilitation (see below). In women the uterus, ovaries and anterior vaginal wall are removed together with the bladder, causing dyspareunia or even complete impossibility of penetration.

Since such radical bladder surgery does not interfere with the neural pathways for orgasm, orgasm usually is still possible.

Prostate Cancer

The number one male cancer in the Western World has many sexuality implications. In the process of decision how to treat, there are two main relevant questions.

One is on life expectancy. When this is below ten years, usually nothing is done, because the patient probably will die before the cancer will kill him. This 'watchful waiting' approach (WW) preserves the patients' quality of life (QoL) including sexual function.

The second relevant question is how widespread the tumour is. As long as limited to the prostate ('localised prostate cancer') the cancer can be treated locally with several surgical and radiotherapy modalities. Whereas the cure rates are the same, the side effects of each modality become very relevant. So, the process of proper and honest explanation to them and then decision by patient or couple is a new aspect of care (and a new professional skill to be learned).

Whereas the damage of radiation develops slowly over up to two years, surgery causes immediate damage. Radiotherapy causes more bowel problems; surgery causes more urinary problems included urinary incontinence during orgasm. Both modalities damage the erectile potency.

The surgical field gets very close to the nerves for erection. When these nerves are completely cut, spontaneous erection is no more possible. However, even without cutting, slight traction of the nerves is followed by damage, after a while causing an extended period of no erection. That tends to happen even when experienced surgeons apply bilateral nerve sparing.

The erectile system in the penis itself regularly needs the circulatory effects of erection (that is why men have nocturnal erections). Without regular erection and its oxygenation those tissues gradually deteriorate. So, 'penile rehabilitation' is becoming the standard after radical prostatectomy. That means regular evoking (or 'forcing') an erection by method of vacuum, injection, intra-urethral or daily oral method. My guess is that maximum stimulation with erotica, vibrator and partner will do as well in some cases. That should be at least recommended as a relevant addition (because sex is more than erection). Adding explanation to the couple on the importance of continuing intimacy and keeping the partner's vagina in proper shape seems wise! If not, two years after prostate surgery, the returned erection can become the cause of female dyspareunia, asking for a next period of 'vaginal rehabilitation'.

When the cancer has grown outside the prostate, it can no more be treated locally. Since prostate cancer cells 'need' testosterone (T), their growth can be stopped by bringing down the T-levels to almost zero. Androgen deprivation therapy (ADT) (reached by surgical or chemical castration) will cause numerous hypogonadal side effects. Sexual function is impaired with loss of sexual desire, loss of arousability (no more horny), erectile problems (in part of the men) and no more semen. Sexual identity is seriously impaired by hot flashes, gynaecomastia (breast development), loss of muscle mass and more 'female fat'. Sexual relationship can be changed by fatigue, impaired assertiveness and loss of memory. Men experience this package far more disturbing then the side effects of surgery or radiotherapy.

In treating this total, extra attention should go to renegotiating sexual roles and scenarios, especially to the partner. This is where psycho-oncology could benefit much from listening to oncosexology.

A rather new approach is alternating ADT and T treatment.

Testis Cancer

Here the age range (20-40 yrs) is relevant, as well as a 99% cure rate when discovered at an early stage. Hormone deficiency, due to removal of (both) testes, will cause low

desire and should be corrected. A testicular prosthesis should be considered for cosmetic and psychological reasons. Damage to ejaculation can happen as a result of retroperitoneal lymph node removal. This will happen far less with proper nerve sparing surgery.

Penile Cancer

This is a rare, but very threatening cancer. Some cases can only be cured by complete penis amputation. Renegotiating sexual interaction without penis in a man with seriously damaged male identity seems the ultimate challenge for the medical sexologist.

Breast Cancer

This is the number one female cancer in the Western World. The various treatment strategies can have numerous and multiform sexual implications. Monolateral or bilateral mastectomy is for most women seriously damaging their female identity. Many women fear that the mutilation means that her partner no more wants to have sex with her. However for the great majority of men (at least in North Western Europe) mastectomy is not a reason to stop sexual contact, although many men have problems dealing with the woman's shame and avoidance behaviour.

With mastectomy an area is removed that for many women is an important erogenous zone. For part of the women breast or nipple stimulation is nearly a necessary condition to reach orgasm. However, for another 7% of women, the reaction will be different, since breast stimulation decreases their sexual pleasure.[5]

When surgery includes removal of the axillary lymph nodes lymphoedema can develop. In contrast to mastectomy, such dysfigurement cannot be concealed. Lymphoedema reduces the sensations of sexual touching with that hand and being touched in that part of the body.

The presence of estrogen and/or progesteron receptors is an important criterion in breast tumours. When they are absent, the tumour cells are less differentiated, which means a poorer prognosis. In approximately 70% they are present, and then various hormone influencing strategies are implemented, which means that sexual function can become impaired: ovarian suppression with low desire, vaginal dryness and dyspareunia at vaginal penetration.

Ovarian Cancer

Freely located in the abdominal cavity, ovarian malignancies quickly are spreaded all over. That is why this cancer is called 'the silent killer'. Treatment is by surgical removal of uterus, lymph glands and both ovaries combined with extensive chemotherapy. The castration causes acute estrogen shortage with hot flashes and reduction in androgen level. Chemotherapy reduces the androgen level even more by damaging the remaining adrenal production. The results of that androgen deficiency are absence of desire, no arousability, difficulty to get orgasm, lost genital sensation and fatigue.

With exception of part of the women with a BRCA mutation (→ an increased risk for breast cancer), there is no contraindication for hormone treatment with estrogen and/or androgen.

Endometrial Cancer

This is a cancer for the older women, with a higher risk for the adipose and the childless. Usually, genital sexuality is already impaired before the diagnosis by irregular

blood loss. Treatment is by radical hysterectomy (afterwards causing deep dyspareunia) or by radiotherapy (causing the same, but also problems with bowels and bladder).

Cancer of the Cervix (uterine mouth)

Both cancer and treatment occur right in the location where vaginal intercourse takes place. The sexual side effects hit extra hard because of the relatively young age of many patients.

The usual treatment is radical hysterectomy with removing of the ovaries and the upper third of the vagina. Among the side effects are decreased lubrication capacity and a shorter vagina, both causing dyspareunia. This is typically the situation where penile length and depth of penetration are important topics to deal with.

The alternative treatment is by local application of radiotherapy. This too can cause dyspareunia, with shortening, but also narrowing of the remaining vagina.

Both treatments lead to infertility, which can be a heavy blow to the female identity. Being caused by HPV infection this cancer will gradually disappear in societies with an HPV-vaccination scheme.

Cancer of Vagina or Vulva

Cancer of the vagina is rare. In the recent past it was the result of exposure to DES and happened in rather young women. Fistulae from vagina to bladder or rectum could develop as side effect of the radiation treatment.

The less rare cancer of the vulva happens to the older generation, for instance following lichen sclerosus. Superficial dyspareunia and orgasm difficulties are common after treatment with surgery or RT. Another side effect of surgery is lymphoedema around the pubic area.

The Average Course of Sexuality in Cancer

In some cases the actual cancer diagnosis is preceded by a period with blood loss, pain, fatigue or fear and then sexual expression already can have been impaired. For others the diagnosis is the moment where sexuality and intimacy get in a free fall. The range of sexual reactions is very wide, representing the great variety in characters and relationships of human beings. Some quit sexuality and intimacy completely, others refrain only from genital contact, but have increased physical intimacy, and some need the release of orgasm and contact 'not to fall in pieces'. That is one of the many reasons why people enter sexual expression. Where Meston & Buss found 237 arguments[6], an oncology population most probably has still other arguments. In the phases of treatment and recovery afterwards most people are mainly occupied with surviving the burden of treatment and with redefining their life. Gradually, part of the patients transition into the survivorship phase and then sexuality can re-enter. New levels of relationship and sexuality develop fitting to the gradual development of the new me or the new we. Part of the patients and couples regain their old intimacy and sexual expression. For others the psychotraumatic damage and (or) the physical damage result in diminished or no more intimacy or sexual expression. Another small percentage of patients finally reaches a far better level of sexuality and intimacy. Having apparently gone through the moment of truth they no more accept insignificant sex.

What about the patients who enter the palliative and terminal phase? The common assumption is that then sexuality has left completely. The reality is far more divers.

Some people stop every erotic encounter. There are couples at the other end of the spectrum with more frequent and sometimes more intense sexual encounters than in many years before. For some this continues up to very close before dying.[7]

The experiences in this last phase of life teach sexology important lessons on the complexity of sexual motivation and on the power of human sexuality.

Minority Groups

Sexology professionals tend to pay more than average attention to minority groups. So, oncosexology wonders whether cancer is the same for gay and lesbian people. It is not! In many countries they don't get as good care as the mainstream patients. Many health care providers will never ask about orientation and assume that every patient is straight. And many patients are scared to disclose their sexual relationships. Then, communication will not be smooth and medical consumption will be lower.[8]

Besides, from a group perspective, the pattern of cancer risk is different.

For lesbians, the bad side is that they are more prone to get cancer. With fewer pregnancies, there is more breast cancer and more endometrial cancer. Less breastfeeding causes more breast cancer. With fewer oral contraceptive use there is more ovarian cancer. A less healthy lifestyle causes more bowel cancer and more lung cancer. More overweight is accompanied by more cancer of breasts and endometrium. And, yes, they have less cancer of the cervix because of less HPV transmission via heterosexual intercourse. However, being lesbian is no guarantee. Being more adventurous than average, many lesbians also slept with men. Besides, HPV is easily transmissible; not only via a dildo, but also via rubbing of two well lubricated vulvas.

The good side for lesbians is when they have got cancer. Decreased sexual desire and dysfigurement will be less of a problem than in heterosexual couples. Cancer in lesbians causes less frequently the end of the relationship, and when single, having had cancer is less a handicap in the dating process.

What about gay men? With their less restricted rules and wider range of sexual contacts they run a higher risk to contract several of the sexual transmissible diseases that can be the precursor of cancer. With HCV and HBV there is more liver cancer; with HIV there is more Kaposi sarcoma and Burkitt lymphoma; with high risk HPV strains there is more anal cancer, more penile cancer and more mouth & throat cancer. In some ways the lifestyle of gay men is healthier with less overweight, so one could guess that some cancers will be found less in the gay community. Apparently, research is not yet ready for such questions.

Appearance and sexual performance are highly valued in the gay community. Properties that can easily be damaged by cancer. So, after cancer, gay relationships more easily come to an end and one-night stands are more difficult to find.

Dealing With Sexuality & Intimacy in Case of Cancer

Oncosexology is the name we give to the slowly developing new field that deals with various aspects of sexuality and intimacy in case of cancer.

It encompasses several areas:

- Treating the patient and the couple with cancer-related sexuality disturbances. Care, cure and rehabilitation aspects apply to all phases, including the palliative phase.

- For the time being much time and energy has to be invested in raising awareness and education. Whereas patients should get space to ask for help, oncology professionals should learn the importance of addressing this area.
- Investigating incidence and prevalence of disturbances in sexual function, identity and relationship in various cancers, the various stadia of disease and treatment, and in the various cancer intervention modalities.
- Further development of treatment modalities for sexual disturbances.
- Developing guidelines on how to incorporate sexuality in the approach and treatment of patients and couples with cancer.
- Teaching the sexology and oncology professionals on how to deal with sexuality in the various stages of cancer (included the palliative stage) and on the *´Who does what, when and how?'*.

Here We Will Concentrate on Treatment Aspects

We mentioned how cancer and oncology interventions can have consequences on three areas: sexual function, sexual identity and sexual relationship. Although there are disciplines that could take care for each of those areas, proper care is frequently hampered in several ways. For instance because the typical sexual aspects remain undiscussed, as recurrently was the case in psycho-oncology. Or because sexual function is addressed without paying attention to relationship and identity as regularly happened in sexual medicine. Or because neurological or hormonal causes are not properly addressed, as repeatedly was seen in the approach of sex(ology) therapists.

Sexuality disturbances deserve a multidisciplinary approach, especially the more complex sexuality problems after cancer. In an oncology centre such multidisciplinarity can be reached by combining the expertise of various professionals in a team with frequent interdisciplinary contact. Another approach is by professionals who are in themselves already multidisciplinary. Physicians or medical psychologists who have gathered in their 'cure & care' toolbox much oncosexological skills and who can combine pieces of expertise of many disciplines. Several of these strategies have been developed in physical rehabilitation sexology, where patients face comparable complex sexual disturbances.

Hereunder we will indicate some of those strategies. Be aware that this list does not pretend to be complete:

- Explaining female-male confusion. In spite of many years together, many couples don't sufficiently understand the differences in sexual desire and sexual identity
  and on how a sexual disturbance affects the other person. Besides, many couples are hurt by the differences on how to deal with disease and medical care.
- Restructuring roles and patterns. Over the years most couples develop rather fixed sexual patterns on 'Who initiates sex?'; 'Who does the job in bed?'; 'One or two orgasms'; 'What is not allowed?', etcetera. Cancer can strongly interfere in those patterns and bring sex to a standstill.
- Dealing with fatigue. There are many solutions available. Timing of the lovemaking; adapting activity to the partner; when muscular movement is desired (for instance to generate own or partner's orgasm) use of a strong vibrator; medication; etcetera. For nearly every couples useful solutions can be found.

- Dealing with pain. Fine-tuning and timing of pain medication (and eventually marihuana) in relation to sexual expression. Restructuring sexual scripts; Positions that do not hurt; Sexual arousal can increase the pain threshold (i.e. cause less pain!) especially vaginal anterior wall stimulation. Helping couples to deal with balancing the benefits of sex against the presence of some pain. Partners are sometimes too gentle and, by being too scared to hurt, they can deny the patient the joy of sex.
- Renegotiating sexual intimacy. How to handle the situation when penetrative sexual intercourse is no longer possible or desirable? Some patients and/or partners are so strongly influenced by 'the coital imperative' that no alternative is possible except 'real sex'.[9]
- Dealing with loss and mourning. Loss of sexual possibilities; loss of penis, limbs or external beauty. Or the reality of the inevitable death of self or partner.
- Adaptations in the palliative phase. Now, there usually are no more restrictions against hormones, too much pain killers, cannabis, etc[7]
- Developing new erogenic zones.
- Use of tools and toys. Toys and all other erotica can be useful to regain sexual arousal. Some tools have another function / benefit. When surgery or radiotherapy have shortened the vagina too much (for a relatively too long penis) a donut of soft material round the penile basis can prevent going too deep and cause dyspareunia. Part of vaginal rehabilitation after radiotherapy for cervix cancer can be reached by regular use of a clitoral vacuum pump.[10] Tools can be used for multisensory integration. An example is the strap-on dildo for the man with lost erection and lost male identity in case of prostate cancer or penile cancer.[11]
- Stoma & continence management. Discussing this can decrease the shame. Diet, timing and taping the stoma can influence the amount of disturbance. When oral sex was needed for orgasm, alternatives have to be learned. For sex-associated urinary incontinence in male a flexible constriction band round the base of the penis is recommended.
- Dealing with sexual side effects of medication (included antidepressants).
- Dealing with hormonal deficiencies when hormones pose no risk (for instance after Hodgkin, leukaemia and most ovarian cancers). Even with a robust explanation for real hormonal shortage after such cancer and even with serious complaints, many women don't get the hormones they deserve. With nearly all her androgens disappeared, a woman also lacks the power and assertiveness to speak up for her sexual rights. Even when forgetting the sexual benefits, androgens are also needed for mood, muscles, bones and physical strength.
- Dealing with hormonal deficiencies when hormones pose a risk (for instance after many breast cancer cases). Then the strategy depends on the balance between needs and fears. Whereas some women will not accept any increased cancer risk, whatever the (sexual) price, other patients experience sexuality so important that they want hormones for a better sexual function, accepting an increased cancer risk as a pay-off. Such diversity among patients asks for fine-tuned cancer care, where the professional gives fair and detailed information on risks and benefits and where nobody else but the patient has the final say on the strategy to be followed.
- Partner relation therapy.
- Medication (PDE5 inhibitors, hormones, lubricants, vaginal moisteners, etc).

- 'Rehabilitation courses'. Strategies to prevent vaginal radiation damage; strategies to prevent endothelial/cavernous damage after radical prostatectomy[12]; strategies to prevent vaginal function loss [13]; etcetera.

In the coming decade we can expect an increase in new cancer patients and in cancer survivors. Many of them will be confronted with the sexual side effects of cancer and treatment. In North-Western Europe gradually the mainstream of cancer patients will consist of the Baby Boom Generation with more sexual experience, more explicit sexual desire and more sexual needs. Both the oncological community and the sexual health professionals should become prepared for that challenge.

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Towards Improved Diagnostic Criteria and Treatment Interventions for Early Ejaculation

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Abstract

Recently, the definition and diagnostic criteria for early, or premature, ejaculation has been a topic of vigorous debate in the scientific community. In preparation of the updated versions of the diagnostic manuals DSM-V and ICD-11, considerable efforts have been undertaken to reach consensus regarding these issues. The general disagreement regarding how rapid ejaculation should be defined is evident in, for example, the vastly different prevalent estimates that appear between studies. Generally, studies that rely on subjective indicators of ejaculatory problem (e.g. subjective perception of poor ejaculatory control) generate substantially higher prevalence rates (around 30%) than studies focusing on objective indicators (e.g. ejaculatory latency times of around a minute or less; prevalence rate around 1.5% in population-based studies). The etiology of early ejaculation is largely unknown. Early ejaculation is commonly treated pharmacologically with selective serotonin reuptake inhibitors, with mixed success. Studies investigating effects of psychotherapeutic interventions are scarce, and their efficacy remains disputed. In this presentation, we focus on definition of early ejaculation on proximate and ultimate levels of explanation, as well as their implications for future treatment interventions.

Key Words
Ejaculation, premature, early, definition, treatment, diagnostics and etiology

Introduction

Early (or premature, rapid) ejaculation (EE)[1] is often quoted as the most common male sexual dysfunction (e.g. Salonia et al., 2009; Montorsi, 2005). However, prevalence estimates vary substantially between studies – estimates have been shown to vary between 1% and as high as 75% between studies (Jern, 2009). There are likely several reasons for these enormous fluctuations in prevalence rates, but a major reason is certainly the different definitions of EE that have been used between studies (other reasons include methodological issues such as small sample sizes, non-random populations, etc.). Ejaculatory function can be measured using several different parameters

[1] Most publications and diagnostic manuals use the term "*premature ejaculation*". The term "*early ejaculation*" will be used throughout this paper in order to comply with the updated definition that will appear in the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5); see http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=174.

(that are correlated to higher or lesser extent; see e.g. Jern et al., 2008). These are, in turn, often categorized as "subjective" (meaning that they rely on a person's self-evaluation of his ejaculatory function and/or its consequences, such as self-perceived ejaculatory problems, self-perceived lack of ejaculatory control, and self-reported negative feelings and consequences of one's ejaculatory function), or "objective" (meaning that they are more or less objectively measurable by an outside observer; objective EE indicators include ejaculation latency time, number of penile thrusts between penetration and ejaculation, and frequency of occurrence of involuntary ejaculation before or during the first penetration). Studies using subjective indicators to operationalize EE commonly report substantially higher prevalence estimates (about 30% in large, population-based studies; see e.g. Jern, 2009; Montorsi, 2005) than studies using objective indicators (such as ejaculatory latency during coitus). Of the objective indicators, the intra-vaginal ejaculation latency time (IELT; Waldinger, 2005a) has emerged as one of the most popular measures of EE in recent years, with a suggested cut-off latency of about one minute commonly used to distinguish the affected from the non-affected (less than two per cent of men express coital IELTs of less than one minute with any regularity in population-based studies). As of 2012, however, the scientific community has yet to agree on a suitable definition for EE.

Definitions and Diagnostic Criteria for Early Ejaculation

Numerous different definitions for EE have been proposed in the literature, however, in this paper, I have chosen to focus on two: that of the American Psychiatric Association (2000), which appears in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), as well as that proposed by the International Society of Sexual Medicine (ISSM), who recently assembled a work group of experts to develop a new, evidence-based definition of EE (Althof et al., 2010). The DSM-IV-TR definition has been widely criticized for its imprecision, and for being based on the opinions of authorities rather than empirical evidence (e.g. Waldinger & Schweitzer, 2006, 2007, 2008a). It reads as follows:

> *"Premature ejaculation is a persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes. It must also cause distress and marked interpersonal difficulty, and may not be due exclusively to the direct effects of a substance."*

As can be observed, this definition emphasizes indicators that are subjective in nature. There is a mention that ejaculation should occur quickly, but it is unspecific with regards to the time frame within ejaculation should occur to be considered dysfunctional: it does not address the question *"how early is too early?"* In order to address the shortcomings of the DSM-IV-TR definition, the group of experts and researchers assembled by the ISSM published the following proposal for a new definition of EE (Althof et al., 2010, p. 2949):

> *"(Lifelong) premature ejaculation is a male sexual dysfunction characterized by ejaculation which occurs prior to or within one minute of vaginal penetration, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy."*

Upon closer inspection, there are two major differences between the two versions. Firstly, the ISSM version lacks a mention that the EE problems should not be attributable to the effects of a substance. Secondly, and perhaps crucially, they differ in that the ISSM version *does* address the question *"how early is too early"*: within one minute of vaginal penetration. The one-minute cut-off has been selected as it is a very good predictor of EE diagnosis (i.e. men with IELTs of one minute or less are more likely to have an EE diagnosis than men with a longer IELT), and because it reduces the slice of the male population that is to be considered pathological from 30% to less than 2% (e.g. Althof et al., 2010). The observant reader may also note a significant flaw in the ISSM definition: it is inappropriately heteronormative in that it states a time frame valid only for *vaginal* intercourse. This awkward wording is due to the fact that most empirical evidence upon which this definition is based stems from studies involving heterosexual men and couples (this flaw is also duly noted by Althof et al. [2010], who insist that the ISSM proposal not applicable to men who have sex with men due to lack of empirical data).

Etiology of Early Ejaculation

Despite recent ambitious attempts to elucidate the causal mechanisms behind EE, very little is known about its exact etiology. Historically, EE has been considered a "psychological", anxiety-related issue, and a correlative positive association between depression, anxiety and EE has been established in studies (so that men who suffer from EE are more likely to suffer from depression and/or anxiety as well; Althof et al., 2010). However, there is no evidence for the direction of causality in this association, and thus it is unknown whether the psychopathology is a result of the ejaculatory problem, or the other way around. It should, however, be mentioned, that relatively few studies have investigated psychological correlates of EE; and very little is known about how contextual factors (such as characteristics of the sexual partner, set and setting of the intercourse, etc.; Althof et al., 2010; Jern, 2009). Perhaps surprisingly, it has repeatedly been demonstrated that age has very little or no contribution to EE etiology (Jern, 2009; Waldinger et al., 2005).

Although the idea of a partial biological etiology was introduced already in the 1940's by Schapiro (1943), who observed intra-familial resemblance among his patients, and subsequently hypothesized that EE may be heritable. Today, there is empirical evidence from twin studies that part of the etiological background of EE is heritable: around 30% of the phenotypic variance of ejaculatory function is attributable to genetic effects (i.e. is heritable; Jern et al., 2007, 2009). A number of subsequently conducted studies have also attempted to chart specific polymorphic regions in genes that may contribute to EE development (e.g. Janssen et al., 2009; Jern, Eriksson, & Westberg, in press; Jern et al., 2012; Ozbek et al., 2009; Santtila et al., 2010), but none of these has been unequivocally replicated, and much controversy remains regarding exactly which genes contribute to EE etiology.

Most of the evidence regarding how ejaculation is regulated stems from studies on rodents. In a landmark paper, Truitt and Coolen (2002) demonstrated that a group of neurons in the lumbar spinal cord play a crucial role in the regulation and evocation of the ejaculatory reflex (if these neurons are removed in male rats, ejaculation is completely disrupted whereas other aspects of their sexual behavior, such as erection, mounting behavior and sexual lust remain unaffected). The mechanisms that trigger these neurons in a natural setting are, however, poorly understood, but at least

the neurotransmitters dopamine, glutamate, and (perhaps particularly) serotonin are thought to be involved. Studies involving both rodents and humans indicate that the serotonergic system is involved in the regulation of the ejaculatory reflex (e.g. Dominguez & Hull, 2010; Waldinger, 2005b). It is known that increased release of serotonin impairs overall sexual function and behavior (e.g. erectile and ejaculatory function in both humans and rodents, in addition to causing decreased libido) in both men and rats (Dominguez & Hull, 2010). It is also widely reported, that selective serotonin reuptake inhibitors (SSRIs; a class of drugs originally designed as antidepressants) impair sexual functioning, including causing ejaculatory delay (Porst, 2011). However, the exact mechanisms of the serotonergic involvement in ejaculatory function remain unclear.

Treatment of Early Ejaculation

In the past two decades, substantial efforts have been undertaken to develop treatment interventions for EE, almost exclusively within the field of pharmacotherapy. EE is commonly treated off-label with various kinds of SSRIs (among the most common are paroxetine and sertraline) and sometimes with tricyclic antidepressants (such as clomipramine) (Porst, 2011). Recently, in 2009, an SSRI-class drug (dapoxetine) was approved as the first pharmacological treatment intended explicitly for EE treatment. Finland and Sweden were the first countries to grant sales permits for dapoxetine, with several other countries in Europe and Oceania having followed suit since. Dapoxetine has, however, been declined marketing permits in several countries, including the United States. Dapoxetine differs from most SSRIs in that it has a short half-life, and can therefore be administered on-demand rather than continuously, which some patients find advantageous (Pryor et al., 2006). Nevertheless, paroxetine (which requires continuous, daily medication) appears to be the most efficient ejaculation-delaying SSRI (Waldinger, Zwinderman, Schweitzer, & Olivier, 2004; Waldinger & Schweitzer, 2008b), although it should be noted that the applicability of SSRIs in PE treatment has been equivocal: Studies have repeatedly shown that treatment with any SSRI is commonly and dose-dependently associated with numerous side effects, including nausea, dizziness, and various sexual dysfunctions (e.g. Montejo-González et al., 1997). Furthermore, their clinical efficacy is highly variable between individuals, while some patients do receive good treatment benefits while remaining virtually unaffected by side effects. The reasons for this are unknown, but genetic susceptibility to both positive treatment outcomes and side effects has been hypothesized (Abdel-Hamid & Andersson, 2009).; Quite surprisingly, very few methodologically solid studies have been conducted to investigate the effects of psychotherapeutic interventions for EE. A recent systematic review compiling the few available studies concluded that "there is weak and inconsistent evidence regarding the effectiveness of psychological interventions for the treatment of premature ejaculation" (Melnik et al., 2011), further noting that most studies have unacceptably small sample sizes, and that there is a lack of consistency regarding the therapeutic approach. Further studies evaluating different psychotherapeutic approaches with larger sample sizes are called for.

Discussion

In order to address the question of how EE should be defined and diagnosed, we need to re-address the crucial question: *how early is too early?* Lawrence Hong attempted to answer this question already in 1984, drawing conclusions from his observations of sexual behavior in chimpanzees. Male chimpanzees, as most primates, will on average ejaculate in just a few seconds during intercourse. Hong noted that chimpanzees live in a strictly hierarchical society, where males high in the pecking order (i.e. alpha males) will react immediately and violently towards any male attempting intercourse with a female unless the high-ranking male has mated with that female first (females are also increasingly likely to aggressively reject a male the lower down the pecking order that male is). As most males will never become alpha males, it would seem conceivable that a mechanism that improves the chance of "lesser" males to conceive their own biological offspring would be a highly valuable trait in terms of natural selection – evolution, Hong argues, would favor quickly ejaculating males over males that need much time to complete copulation, and has indeed done so to the extent that virtually every male chimpanzee alive today ejaculates within a couple of seconds. The ability to ejaculate quickly, Hong continues, is a therefore to be considered evolutionary *adaptation* – the very opposite of a *dysfunction*.

Let us return to our crucial question: how early should ejaculation occur for it to disrupt the *function* of ejaculation (bear in mind that it has been suggested that EE is a neurobiological, or at the very least sexual, *dysfunction*)? This, then, boils down to a question of ultimate and proximate level of explanation. Ultimately, the function of ejaculation (as hopefully most will agree), is to fertilize a female's egg and thereby create offspring. In that sense, can any ejaculatory latency be so short, that this function would be impeded? The answer given available evidence is: no, unless it is so short that it occurs *prior* to penetration (i.e. any IELT shorter than 0 seconds). While this does occur in some men, extremely few individuals experience regular, involuntary anteportal ejaculations (Jern, 2009; Waldinger et al., 2005). However, it is likely that men seek help for EE-related problems not because they have problems with reproduction, but because they want to improve the quality of their recreational sex life. This brings to the proximate meaning of ejaculation (and orgasm, which usually accompanies it): the recreational aspect of intercourse. If the function of ejaculation is considered to be the pleasure it brings to the ejaculate, then an ejaculatory latency can conceivably be short enough to disrupt this function.

In order to do that, we need to take a closer look at how ejaculatory latencies are distributed in the population. A multinational population survey of coital ejaculatory latency involving 491 men revealed that on average, men will ejaculate in just over 8 minutes (Waldinger et al., 2005), although the median value (which is probably a better indicator of the "average" considering that ejaculatory latency is very skewed towards the shorter end) is significantly shorter at about 5.5 minutes. The standard deviation is more than seven minutes (for a mean of about 8). In other words, an ejaculatory latency of exactly one minute (which is to be considered as indicative of *lifelong* EE according to ISSM standards; albeit together with other indicators) is still within one standard deviation from the arithmetic mean.

Another vital thing to consider is what exactly we are looking to treat when we are treating individuals presenting EE-related complaints? Assuming that most agree that we should be aiming to improve the overall satisfaction with these individuals' sex life (the proximate meaning of ejaculation), we should then examine which indicators of EE are best able to predict sexual satisfaction and overall well-being (Table 1).

TABLE 1
NON-PARAMETRIC CORRELATIONS BETWEEN INDICATOR VARIABLES OF EARLY EJACULATION AND OVERALL SATISFACTION WITH SEX LIFE.

Variables	Ejaculation latency time	Feeling of control	Worrying about EE	Satisfaction
Ejaculation latency time		.29***	.25***	.09***
Feeling of control	.63***		.31***	.18***
Worrying about EE	.58***	.68***		.24***
Satisfaction	.40***	.46***	.58***	

Note. Correlations above the diagonal are calculated from a population-based sample of Finnish men (n = 1391); correlations below the diagonal are based on a clinical sample of men with "primary premature ejaculation" diagnoses (n = 148). *** = p < .001

As can be seen in Table 1 (note that these data are preliminary and in part from ongoing data collections, and therefore subject to change in forthcoming publications), ejaculatory latency during penetrative intercourse does not emerge as a particularly good predictor of sex life satisfaction – in both clinical samples of EE patients as well as population-based samples, it appears to have slightly poorer predictive ability than two (in terms of existing and proposed diagnostic criteria) relevant subjective EE indicators. Furthermore, no longitudinal studies have been conducted to investigate the temporal stability of EE, and little empirical data is available about how ejaculatory latency (indeed; ejaculatory function) varies as a function of different partners or contextual factors. It should be borne in mind, that over-reliance on subjective EE indicators does result in unreasonably high prevalence rates (around 30%; e.g. Montorsi, 2005), and that considering ejaculatory latency therefore arguably has its place, but there are other potential caveats to a substantial emphasis on ejaculatory latency as well: as Hong (1984) argued, it may lead to an unnecessary labeling of normal function as pathological; a distorted view of normal variation in a biological function that may have been advantageous in a not too distant past. Perhaps especially so, since any cut-off latency (the most commonly proposed in recent literature is that of 1 minute; e.g. Althof et al., 2010) except that of "less than 0 seconds" will be a completely arbitrary choice. Given the reasons men seek treatment for EE, we argue that for the time being, subjective indicators should be emphasized more strongly than ejaculatory latency. It should also be noted, that while there will surely be little disagreement that unnecessary "pathologizing" of normal function should be avoided, it is paradoxical that a diagnosis (and thus a pathological label) is required in most countries in order to be able to help the patient by means of pharmacotherapy. However, it could conceivably be important to consider explaining these circumstances in the therapeutic relationship with the client/patient – there is nothing physically or otherwise wrong or dysfunctional with a short ejaculatory latency or concerns thereof, but there is something we can try to improve sexual satisfaction and well-being.

Waldinger and Schweitzer (2006) attempted to address the diagnostic issues by proposing two additional subtypes of EE as a function of IELT on the one hand, and subjective concerns on the other (in addition to "lifelong" and "acquired EE, both characterized by regular <1 minute IELTs). According to this system, individuals who occasionally and randomly experience short IELTs ("natural variable EE"), or have "normal" (i.e. >1 minute) IELTs but express subjective concerns over their ejaculatory function ("premature-like ejaculatory dysfunction") would not require pharmacological

treatment, but should receive psychoeducation, counseling or psychotherapy instead. While this system does recognize the legitimacy of subjective concerns among men who do not regularly ejaculate in less than a minute, it does not address the fundamental problems that may arise from being directed by IELT.

Finally, it is clear that EE treatment would benefit from increased and systematic efforts to develop and evaluate psychotherapeutic treatment interventions for EE. First and foremost, a substantial number of individuals experience who are prescribed SSRIs to treat EE quit treatment due to poor efficacy, adverse side effects, unreasonable costs or other reasons: in our ongoing data collection, 75 out of 155 patients (48.4%) who have begun pharmaceutical treatment after initial consultation have terminated treatment. In other words, there is clearly a substantial group of patients who would benefit from alternative treatment approaches. Given the scarcity of well-conducted studies investigating effects of psychotherapy for ejaculatory problems, and the well-documented efficacy of psychotherapy in numerous other domains of psychiatry and neuropsychiatry (not to mention the very low probability of negative side effects), there is every reason to be optimistic regarding the prospect of developing an efficient psychotherapy-based treatment intervention for EE. A recent, large-scale overview of the efficacy of psychotherapy conducted by the American Psychological Association concludes that *"[…] psychotherapy is effective for a variety of mental and behavioral health issues and across a spectrum of population groups. The average effects of psychotherapy are larger than the effects produced by many medical treatments."* A press release regarding the evaluation of psychotherapeutic treatment interventions can be found at http://www.apa.org/news/press/releases/2012/08/psychotherapy-effective.aspx

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Erotic Capital, Sexual Pleasure and Sexual Markets

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Abstract

Sexual pleasure typically comes at the very end of a long social process of selection, exchange and bargaining that is all too often overlooked. Erotic capital plays a crucial role in private relationships and sexual bargaining, in addition to its wider role as a personal asset in the workplace (especially in the entertainment industries), advertising and the media, friendship, politics, sport, the legal system and public life generally. This paper summarises my theory of erotic capital as the fourth personal asset, and why it can give women an advantage in sexual-romantic contexts, if they learn to exploit it. Sexual pleasure is most closely linked to erotic capital in fleeting relationships in the spot market: affairs, call girls and rent boys, casual hook-ups. This is at odds with the Western ideological emphasis on long-term relationships as the appropriate context for sexual relationships.

Erotic capital is just as important as economic, cultural and social capital for understanding social and economic processes, social interaction and social mobility. It is essential for analysing sexuality and sexual relationships. However it plays a role in virtually all aspects of life, including the labour market, the courts, politics, sports, the arts, popular culture, media and advertising (Hatfield and Sprecher 1986; Berggren et al 2010, 2011; Hakim 2010, 2011, 2012). The difficulties of measurement are no greater than for social capital or intelligence. In affluent individualised modern societies, erotic capital is becoming more important and more highly valued for both men and women. However women have a longer tradition of developing and exploiting it, and studies regularly find women to have greater erotic appeal than men. Further, men place greater emphasis on appearance and visual stimuli in sexual-romantic contexts, a sex differential that appears to be universal (Frank 2002).

Erotic capital plays very different roles within the three main forms of sexual expression. Spot markets for casual sexual encounters form a minority of all sexual-romantic activity, but spot markets reveal the crucial importance of erotic capital in generating sexual pleasure. One benefit of solo sex is allowing people to sideline their own degree of attractiveness, or lack of it. The long-term relationships dictated by monogamy help to ensure an egalitarian distribution of sexual activity, but at the expense of sexual pleasure for many people. National sex surveys, and even case studies of gay men, have generally failed to address the crucial role of erotic capital in private lives and sexuality.

Erotic Capital as the Fourth Personal Asset

The distinction and relationship between economic capital, cultural capital, and social capital was set out by the French sociologist Pierre Bourdieu in a 1983 German paper discussing the three forms of capital, and their convertibility. This seminal paper was translated into English in 1986, establishing a widely used typology.

Economic capital is the sum of the resources and assets that can be used to produce financial gains - such as money, land or property. Cultural capital includes human capital as defined by economists, and consists of educational qualifications, training, skills, and work experience that are valuable in the labour market and can be deployed to earn income. Social capital is the sum of resources, actual or potential, that accrue to a person or group from access to a network of relationships or membership in a group, tribe or network that can produce useful relationships - who you know as distinct from what you know.

Erotic capital is the fourth personal asset, previously overlooked by all social scientists, but equally valuable. In the 21st century, its social and economic value is steadily increasing - partly due to greater affluence, partly due to the shift towards white-collar and service sector jobs, and partly due to digital photography and the internet making everyone more visually exposed.

Societies and social groups can accord different values to the various types of capital, and can try to restrict their convertibility into financial benefits. Some individuals are well-endowed with all forms of capital; the poorest may have virtually none of any substance. Most people have varying combinations of personal assets over the life-course. Young people are most likely to be physically attractive, while older people are most likely to have money – so the two are often traded.

Erotic capital is a multi-faceted combination of physical and social attractiveness. Facial beauty is clearly a central element, although there are variations in ideas about what constitutes beauty, and personal tastes also vary. The latest studies show that symmetry, an even skin tone, and conventionality (within the local culture) are the key elements of attractiveness. So there is a large degree of agreement, across cultures, in judgements about who is attractive (Hakim 2011: 209-219). Among adults, attractiveness is an achieved characteristic, in large part, as illustrated by the *jolie laide*. The French concept of *belle laide* (or *beau laid* in the case of men) refers to an ugly woman who becomes attractive through her presentational skills and style. Great beauty is always in short supply, and is therefore universally valorised.

A second element is sexual attractiveness, which is quite separate from classic beauty. To some extent, beauty is about facial attractiveness in the main, while sexual attractiveness is about a sexy body. However sex appeal can also be about personality and style, femininity or masculinity, a characteristic of social interaction. Here too, personal tastes vary. Some women prefer men with well-developed muscles and strong athletic bodies, while others prefer a slender, effete, elegant appearance. These two versions of ideal masculinity are both depicted in Indonesian and Chinese operas: the refined, civilised, clever scholar and the forceful, dynamic warrior - the power of the pen and the power of the sword respectively. Despite such variations in tastes and styles, sex appeal is in short supply, and is therefore universally valorised.

A third element is liveliness and energy, a mixture of physical fitness, good humour, a zest for life. People who have a lot of life in them can be hugely attractive to others. In most cultures liveliness is displayed in dancing skills or sporting prowess. Some cultures also value wit and humour.

A fourth element of erotic capital is definitely social: social skills in interaction, the ability to make people like you, feel at ease and happy, want to know you and, where relevant, desire you. Some people in positions of power have lots of charm and charisma; others have none at all. Some men and women are skilled at discreet flirtation in all contexts; others are incapable. These skills have social value in earning the cooperation and support of other people.

The fifth element concerns social presentation: style of dress, face-painting, perfume, jewellery or other adornments, hairstyles, and the various accessories that people carry or wear to announce their social status and style to the world. Monarchs and Presidents dress for public functions to emphasise their power and authority. Military and other formal uniforms announce status, rank and authority, and carry erotic connotations for some people. Ordinary people going to a party or other social event dress to make themselves attractive as well as to announce their social status and wealth to any strangers they meet, or else to make style statements. The relative emphasis on sexy attire or social status symbols depends on the venue and event. People who are skilled at social presentation and appropriate dress are more attractive to others.

The final, sixth element is sexuality itself: sexual competence, energy, erotic imagination, playfulness and everything else that makes for a sexually satisfying partner. Whether or not someone is a good lover is known only to their partners. Of course this competence may vary not only with age but also with the partner's competence and enthusiasm, given the interactive element. A strong libido does not of itself guarantee sexual competence. However people with a strong libido are more likely to acquire the experience that eventually leads to greater skill. With a few exceptions, national sex surveys provide no information on sexual competence,[1] but they reveal dramatic variations in sex drive in all populations. A tiny minority of men and women are extremely sexually active (well under 10% of adults); the majority are moderately active; a minority are celibate (up to one-third of adults). It seems reasonable to conclude that sexual skill is not a universal attribute, even among adults, and extreme competence is a minority asset. This factor is listed last, as it applies only in private, intimate relationships with lovers, whereas the other five come into play in all social contexts, visibly or invisibly.

For men as well as women, all five (and potentially six) elements contribute to defining someone's overall erotic capital. The relative importance of the six elements may differ for men and women, and varies between cultures and in different centuries. Someone who scores low on facial beauty may still score high on sex appeal, liveliness in dancing, or social skills. In Papua New Guinea, it is men who decorate their hair and paint their faces with brilliant colours and creative designs. In Western Europe, women paint their faces with make-up, but men rarely do. The social and economic value of erotic capital is maximised in what can broadly be described as entertainer and hospitality occupations, such as lapdancing, nightclub hostess, or *geisha* (Frank 2002; Hakim 2011: 135-162).

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[1] The exception is the 1992 and 1999 Finnish surveys, which were replicated in Estonia and St Petersburg, Russia. Kontula (2009: 49) reports that only one-quarter of Finnish men and women regard themselves as sexually skilful, although they seem to be improving over time. Half of all men in St. Petersburg regard themselves as sexually skilful, more than in Finland. In Russia and Finland, there is large generational change in sexual skill among women, with half of the young women, but only one-quarter of older women rating themselves as sexually skilful (Haavio-Mannila and Kontula 1992: 169).

In some occupations, erotic and cultural capital are closely intertwined, as illustrated by the ancient Greek *hetaire*, Japanese *geisha*, Pakistani *tawa'if*, and courtesans of the Italian renaissance. Such women were admired as much for their artistic skills - in dancing, singing, playing music, painting, reciting or composing poetry - as for their beauty and sex appeal. Veronica Franco was a renowned poet as well as a famous courtesan (Masson 1975). The modern equivalents are the actors and singers who project sex appeal in films, videos and on stage, such as Monica Bellucci, George Clooney, Beyonce Knowles and Enrique Iglesias.

Erotic capital is thus a combination of aesthetic, visual, physical, social and sexual attractiveness to other members of your society, and especially to members of the opposite sex, in all social contexts. Just like intelligence, erotic capital includes skills that can be learnt and developed, as well as features fixed at birth. Women work harder at personal presentation and the performance of femininity and sexuality. As a result, they score higher on erotic capital than men, although assessments also show greater variation (Table 1). Even among children, girls are rated more attractive than boys (Table 2). Erotic capital is an important asset for all groups who have less access to economic and social capital, including adolescents and young people, ethnic and cultural minorities, working class groups, and cross-national migrants.

TABLE 1 DISTRIBUTION OF LOOKS IN THE UNITED STATES AND CANADA, 1970S

	American studies 1971		1977		Canadian study 1977-1981	
	M	F	M	F	M	F
Strikingly beautiful or handsome	2.9	2.9	1.4	2.1	2.5	2.5
Above average (good looking)	24.2	28.1	26.5	30.4	32.0	31.7
Average for age	60.4	51.5	59.7	52.1	57.9	56.8
Below average for age (quite plain)	10.8	15.2	11.4	13.7	7.2	8.3
Homely	1.7	2.3	1.0	1.7	0.4	0.7
N	864	1194	959	539	3804	5464

Source: Table 2 in D. Hamermesh and J. Biddle, 'Beauty and the labor market', American Economic Review, 1994, 84: 1174-1194.

TABLE 2 DISTRIBUTIONS OF LOOKS IN BRITAIN IN 1960S

Britain in 1960s	Age 7		Age 11	
	M	F	M	F
Attractive	51	57	45	56
Average	42	36	47	35
Unattractive	7	7	8	9
N	5605	5798	5605	5798

Source: Table 3 in B. Harper, 'Beauty, stature and the labour market', Oxford Bulletin, 2000, 62: 771-800. Percentages have been rounded.

Studies of Sexuality

Throughout the 20th century, erotic capital attracted little attention among social scientists. Very exceptionally, studies focus on physical beauty (Berscheid and Walster 1974; Webster and Driskell 1983), erotic stratification (Zetterberg 1966, 2002), emotional labour (Hochschild 2003), or courtesy and good manners (Elias 1994; Smith 2000; Loyal and Quilley 2004). Even studies of sexuality sidestep the role of attractiveness in private relationships. The global AIDS scare prompted the USA and many European and other countries to carry out national interview surveys of sexual attitudes and behaviour from the 1980s onwards. None of these sex surveys addresses attractiveness as a key factor in private lives and sexual markets – whether heterosexual or homosexual. With just two exceptions, none included measures of sex appeal.[2] Analyses and reports refer to human capital and social capital as the key assets deployed in sexual markets, as if sex appeal and sexual competence were irrelevant.[3]

Studies of gay meeting places, such as gay bars, clubs and bathhouses, show that some men are hugely successful in attracting partners, to the point where it is typically their choice as to who they pair up with, while others are ignored and often fail to attract any partner for the evening. In North American gay meeting places, it is typically the young, slim, white men with athletic and toned bodies who attract most attention. Sex appeal seems to matter more than facial beauty.[4]

Studies of gay sexuality focus fairly narrowly on sex appeal (sometimes labelled sexual capital) and the consequent sexual stratification of men in gay meeting places (Green 2008a,b). Martin and George discuss sexual stratification and the difficulty of defining sex appeal, given variable personal tastes and cultural variations in beauty ideals. They note that scarcity is the key to relative power in sexual markets, but seem to think that there should be a single hegemonic set of norms defining sexual capital in any cultural group, even though they know this does not happen in modern, affluent

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2 One partial exception is Zetterberg's 1966 sex survey which asked: 'Would you say that it is easy to make others fall in love with you?' and 'Thinking back over the last 12 months, how many people would you say had really been in love with you in that period?', for which results were never reported (Zetterberg 2002: 275). The 1992 and 1999 Finnish sex surveys replaced this approach by measuring 'sexual self-esteem' as follows: 'What is your opinion of the following statements concerning your sexual life and your sexual capacity? I have rather great sexual skills. I am sexually active. I am sexually attractive', thus combining erotic capital with sexual activity. Responses to these three items were scored on a 5-point scale from 'totally agree' to 'disagree totally'. Sex differences in scores are analysed in Kontula and Haavio-Mannila (1995: 179-183), showing that women have higher erotic capital than men although it declines rapidly with age. James Farrer (private communication) worked as a graduate student on the questionnaire design for Laumann's 1992 USA sex survey and lobbied (unsuccessfully) for a self-evaluation of physical-sexual attractiveness in that survey. The item was eventually included in the Chinese version of the survey implemented in 1998. However I have been unable to find any results for the Chinese survey. See also Note 1 above.

3 Laumann et al (1994) rely on human capital and social capital. Cameron (2002) notes that economics offers nothing to analyse or explain extramarital sexual affairs apart from human capital and risk. A major review of theories to explain human sexuality claims that the relative sexual power of men and women is located exclusively in social institutions and that social structure is the basis of sexual power (Weis 1998: 106). This extreme perspective accords no weight at all to individual attractiveness within social status groups and as a factor in upward social mobility.

4 However even gay studies can overlook the crucial importance of sexual attractiveness, as illustrated by Weinberg and Williams' (1975) analysis of the social structure of impersonal sex in gay bathhouses. See also Woods and Binson (2003).

multi-cultural plural societies (Laumann 2004; Martin and George 2006: 111, 127-8). Some scholars focus instead on sexual cultures, and explore the social norms shaping ideas about sexual attractiveness and the implicit sexual hierarchy operating in leisure venues and meeting places such as bars, clubs, public beaches, and holiday areas – in effect, sexual markets.[5]

In the 21st century, men in western Europe and north America are devoting more time and money to their appearance, and work harder at developing their erotic capital. Men work out in gyms to maintain an attractive body, spend more on fashionable clothes and toiletries, display more varied hairstyles. The English footballer David Beckham is a prime example, reputedly earning more from modeling and advertising contracts than from his profession as an athlete. Men now constitute an important part of the customer base for cosmetic surgery and Botox, around 10% to 20% of the expanding market in Britain. In Italy, former prime minister Silvio Berlusconi is a known devotee, looking twenty years younger than his 72 years. Women are gaining greater human capital, through qualifications and work experience, so they bring both economic and erotic capital to mating markets. Men now find it necessary to develop their erotic capital as well, instead of relying exclusively on their earning power in mating markets, as they did in the past.

My book presents the first complete theory on the role of erotic capital, and this is the first paper to address the links between attractiveness, sexual activity and sexual pleasure. However scholars are now starting to treat attractiveness seriously (Rhode 2010; Hamermesh 2011).

Links Between Erotic Capital and Money

All forms of capital are types of power, and can be converted into money. The most obvious exchange is between money and the three other types of capital, but most exchanges are more occluded than this. For example, we pretend to meet people socially because we genuinely like them rather than because they might be useful contacts in business. The link between erotic capital and money is contingent, not as predictable and reliable as with cultural and social capital. Erotic capital has a maverick, subversive, wild card character, one of the many reasons for trying to sideline and delegitimize it in Puritan capitalist societies (Hakim 2011: 63-86).

Scarcity of any asset produces scarcity value, social and economic value, status and prestige. Scarcity is at the root of all four types of capital, which are in effect disguised forms of money. All social exchange involves some element of *economic* transfers. Scarcity is also a key feature of sexual markets (Posner 1992).

All forms of capital are convertible into each other to varying degrees. Money can be invested to develop and buy erotic capital. Paying for plastic surgery or a gym membership can help to boost attractiveness. However the bottom line is that a wretchedly poor girl or boy can be so astonishingly beautiful and sexually attractive that their simple clothes and manners cease to have any importance, while an expensively groomed ugly person may still fail to attract admirers. This is why stories of the Prince who marries the beautiful peasant girl, or Cinderella, are so widespread across societies, and

[5] Laumann et al, 1994; Martin and George 2006; Green 2008a; Farrer 2010; Garcia 2010; Hakim 2012; and many articles in the Journal Sexualities.

why there are more female than male millionaires in a modern country such as Britain. Traditionally, men make their fortune through the labour market and business. Women can achieve the same lifestyle and social advantages through marriage markets as well as the labour market (Hakim 2000). Heterosexual marriage markets are structured by female sexual scarcity, women's preference for high income and generous males, and men's varying interest in offspring (Edlund 2005, 2006). In gay communities, sexual attractiveness seems to be the dominant criterion, across style tribes.

The Rising Importance of Physical and Sexual Attractiveness in Modern Societies

In the past, physical attractiveness was mostly innate, or not, and there was relatively little you could do to improve matters. Today, in affluent modern societies, extremely high levels of erotic capital can be achieved through fitness training, hard work and technical aids: diets, gyms and personal trainers, tanning beds and sprays, cosmetics, perfumes, wigs and hair extensions, cosmetic dentistry, cosmetic surgery, hair dyes and hairdressing, corsets, jewellery, a great variety of clothes and accessories to enhance appearance. Some people use tattoos and body piercing, which are modern versions of traditional practices in pre-modern societies. In African societies, facial scars in decorative patterns are still used. The ancient Mayans applied clamps to babies' skulls to produce the high foreheads and tall head shapes regarded as beautiful, for men and women. Body modification has a long history, and all cultures encourage people to conform to accepted standards of beauty. Modern societies allow more choice and diversity of styles, especially in the large multi-cultural metropolises.

As the technical aids to enhancing erotic capital increase, the standards of exceptional beauty and sex appeal are constantly raised. Expectations of attractive appearance now apply to all age groups instead of just young people making their sexual debut or entering the marriage market. Rising divorce rates and serial monogamy across the lifecycle create incentives for everyone to develop and maintain their erotic capital throughout life rather than just in the period before (first) marriage. Expectations for men are rising today, as women insist that partners look stylish and attractive rather than just dependable and pleasant good providers.

In the 21st century, standards and expectations are pushed higher also by the mass media's constant dissemination of images of celebrities and others who achieve the highest standards and become role models for others. Books offering advices on how to behave, how to flirt, how to make friends and how to conduct relationships, assist people in developing the relevant social skills. All the elements of erotic capital are covered in manuals on how to attract a spouse or a lover, dating skills and sexual technique.

In the past, mating and marriage markets were relatively small and closed, with matches based on class or caste, religion, location and age. Matches were often decided by parents or family based on criteria of economic and social capital. In today's self-service, open, and potentially global, mating and marriage markets, erotic capital plays a larger role than ever before. Social networking sites such as Facebook, and digital photography, force people to present themselves visually as much as through written communication, even to people they rarely meet face-to-face. Everyone is more visually exposed than in the past.

Two broader trends create an inexorable rise in the importance of erotic capital in *all* social interaction, in both public and private lives. First, increasing affluence raises demand for luxury goods and services. Beauty and erotic capital are luxuries that we seek out more and more in all situations. Second, the workplace is changing, so that social skills, charm and charisma are crucial now in many jobs. The shift from manual jobs in manufacturing to white-collar and service sector work makes erotic capital more important today. Good social relationships and smooth social interaction are crucial in many more occupations, including professional and managerial jobs that are sometimes thought to require only specialist expertise. For example, lawyers, political candidates and academics are more productive and successful if they are physically and socially attractive (Berggren et al 2010, 2011; Hakim 2011; Hamermesh 2011).

Mating and Marriage Markets

Sociologists show that couples are generally well matched on the factors that are most easily measured: education, age, height, and religion. Yet all the evidence from studies of mating and marriage is that men are willing to trade their economic strengths for women's good looks and sex appeal whenever they can.

Erotic capital also affects bargaining between partners in a couple. Whoever is the younger and more attractive partner is able to exploit their erotic capital to negotiate for compensating benefits from the less attractive partner. The greater demand for sexual access, the greater the power of the more attractive partner, because scarcity always confers value. Baumeister and Vohs (2004: 359) are wrong to believe their theory of sexual economics does not apply within long-term partnerships. Using the broader concept of erotic capital, sexual economics applies to bargaining within all couples (Arndt 2009; Hakim 2011, 2012).

Erotic capital has substantial social and economic value in the labour market and in public life generally. It colours informal relationships in the workplace, in what is variously labelled sexual harassment, or casual flirting and affairs (Kontula and Haavio-Manila, 1995: 194-9; Berebitsky 2012). In some occupations, erotic capital can be more important than economic or social capital, especially in the leisure and entertainment industries. Like social capital, erotic capital can be an important hidden factor enhancing success in all jobs, including managerial and professional jobs. Recent studies show that erotic capital adds 10%-20% to earnings, on average, across the workforce as a whole, and it is just as important as educational qualifications for income and success in adult life (Judge et al 2009; Hakim 2011: 170; Hamermesh 2011).

Erotic capital is obviously a major asset in mating and marriage markets, but it can also be important in labour markets, the media, politics, advertising, sports, the arts and in everyday social interaction. The large imbalance between men and women in sexual interest over the life-course means that women are well placed to exploit their erotic capital (Kontula 2009: 39, 175-6). A central feature of patriarchy has been the construction of 'moral' ideologies that inhibit women from exploiting their erotic capital to achieve economic and social benefits – at men's expense. Feminist theory has been unable to extricate itself from this patriarchal perspective and reinforces 'moral' prohibitions on women's sexual, social and economic activities and women's exploitation of their erotic capital (Hakim 2011: 63-86). In Puritan societies, even scholars claim that the benefits of attractiveness are unfair, are due to bias and discrimination, and should be eliminated (Rhode 2010; Hamermesh 2011).

The Male Sex Deficit and Women's Advantage

Even when men and women have equal amounts of erotic capital, the universal imbalance in sexual interest automatically gives women an advantage in heterosexual communities, and raises the value of women's sex appeal (Kontula 2009: 176).

The contraceptive revolution of the 1960s created the conditions for a massive increase in recreational sex, within and outside marriage, and an increase in erotic entertainments of all kinds (Hakim 2000: 44-56; Edlund 2006; Hakim 2011, 2012). This social change is often called the 'sexual revolution' in western societies, because it was supposed to have eliminated sex differences in sexual activity and attitudes. Free from fears of pregnancy for the first time in history, because the pill and other modern contraception gave women direct control, women were able to express their sexuality freely, and the 'double standard' in sexual morals was said to be outdated.

However, the spread of AIDS in the 1980s prompted a further change in sexual cultures, with a new emphasis on health and sexually transmitted diseases. The AIDS scare was also the catalyst for a spate of national sex surveys across Europe, North America and in other countries. These show conclusively that the so-called sexual revolution had only a limited impact on the sex differential in sexual activity and sexual interest. The gap between men and women was reduced, particularly among young people under 35. The trend towards later marriage extends the period when young people enjoy a relatively carefree sexual playground prior to marriage, sometimes characterised by philandering, libertinage and cheating (Anderson 2012). Despite this, substantial sex differences in sexual activity and libido are revealed, unchanged, in all countries where sex surveys have been conducted. Men express substantially greater sexual interest and desire, and are substantially more sexually active, with more partners. Since men need female partners, this produces a substantial male sex deficit, overall, and ensures that a commercial sex industry exists in all societies with a coinage, and that male demand outstrips female supply even when sex is paid for (Kontula 2009: 176).

Women whose sexual interest does not fade rapidly after childbirth or after age 35, and those who have a sexual flowering later in life, are in short supply. This overall scarcity of sexually active females greatly increases the social and economic value of women's erotic capital within majority heterosexual cultures.

The sixth element of erotic capital is sexual performance, a private and invisible factor that only arises within sexual relationships. The sex surveys cannot provide any direct information on sexual competence, obviously, although three surveys in the Baltic sea area asked about self-assessed sexual competence (Haavio-Mannila and Kontula 1992). It seems reasonable to assume that sexual skill is rising sharply in younger generations, as a result of many more opportunities for practice to make perfect. In Britain, magazines for young women today regularly include articles on sexual performance, and sex tips and advice are sprinkled across women's and men's popular magazines generally, to a much greater extent than in the 20th century. People have more opportunities to see naked bodies, male and female, in artistic and pornographic photos and films, whereas in the past some men never saw even their wives completely naked. Sexual knowledge and sexual competence are rising, especially in the younger generations. However the continuing imbalance between male and female sexual interest, and the increased emphasis on recreational sexuality mean that the value of women's erotic capital must be rising relative to men's due to their continuing scarcity within sexual markets and the general male sex deficit.

The fundamental sex difference in sexual motivation and sexual exploration is shown clearly by sex differences in sexual behaviour that are even larger among homosexuals than among heterosexuals. Studies show gay men (but not lesbians) tend to be much more active than heterosexual men, because the constraint of lesser female interest is removed. One indicator is the number of sexual partners in the last year, last 5 years, or ever. Among heterosexual men, numbers over a lifetime are typically in the range 10-11 compared to 17-35 for gay men. Maximum figures of 1000+ and 5000+ are reported for gay men versus 8-90 for lesbians (Leridon et al 1998: Table 5.5; Messiah 1998: 140-41).

Sexual Cultures, Sexual Markets, Sexual Expression

Erotic capital is activated and exchanged within specific social settings or markets. There are two ways of addressing the sexual cultures of private life. A comparative perspective will contrast, say, the sexual cultures of Russia, Brazil and Japan (Hakim 2011: 53-59) or the sexual cultures of particular social and ethnic groups within metropolitan cities (Laumann 2004; Laumann et al 1994). Another approach is to analyse the three types of sexual expression.

There are three distinct forms of sexual expression: solo sex; ephemeral sexual encounters; and partnered sex with some longevity within some type of wider relationship, often including children. Erotic capital plays a very different role in each of the three contexts, and in exchanges within them, and the potential for sexual pleasure also differs fundamentally between them.

One of the advantages of solo sex (Laqueur 2003), 'sex with someone you really love' as Woody Allen put it, is that it is accessible to people with low levels of erotic capital. The use of erotica for masturbation also gives men access to partners (male and female) with high levels of erotic capital, irrespective of their own erotic rank. This is porn fantasyland. In the long run, this must reinforce men's tendency to think they have a right to sexually attractive and compliant partners, even if they offer little in return – what Carole Pateman (1988: 194, 205) called the patriarchal 'male sex-right' assumption. Pornography can distort men's understanding of their relative standing in real-life sexual markets because it makes fantasy a reality and raises sexual self-esteem (Kontula 2009: 171).

At the other extreme, conventional long-term relationships normally include some sexual activity. Dating, cohabitation and marriage (or civil partnership) are the key forms in the self-service mating system of the western world. Elsewhere, there is often only marriage, arranged by families, with no preliminary courtship, and sometimes polygamy too.

Too often, scholars assume that having a main partner or spouse guarantees as much sex as you want, permanently (Posner 1992: 132; Baumeister and Vohs 2004). How wrong they are. All the recent national sex surveys report a large male sex deficit that becomes visible around age 35 (though it starts well before then) and increases steadily with age (Arndt 2009, 2010; Hakim 2011, 2012). Studies of long-term or marital relationships routinely find a large male sex deficit, which leads to bargaining over sexual access, the conditions for it, the goods and services demanded by wives to perceive an equitable exchange. Bettina Arndt's *The Sex Diaries* is a recent contribution, one of the best for its unblinking honesty. Even among young couples, men are more likely to seek extra sexual partners in casual hook-ups, and often try to justify

their cheating as reasonable, even when they refuse their partner the same privilege (Anderson 2012).

Many men, and some women in long-term relationships thus get involved in *fleeting sexual encounters*, alongside the larger numbers of dating single men and women, and the men and women active in the commercial sex industry. This middle category of sexual activity is the most diverse, with the largest variation between countries and cultures. Commercial sexual services are probably the only universal element, and even these vary in style between cultures. Countries that criminalise commercial sex push these activities underground or abroad, as illustrated by Sweden. Countries where these transactions are legal and/or socially accepted, such as Spain and Indonesia, display a greater variety and quantity of services (Lim 1997). Casual sex, hook-ups, 'flings', and extramarital affairs are the other main component of fleeting sexual encounters (Hakim 2012). Swinging is on the borderline between casual sex and partnered sex, since couples usually participate jointly, so that it can become one part of a long-term relationship. To some extent, fleeting affairs are the modern alternative to encounters within the commercial sex industry, which was often the setting for young men's sexual debut and the principal alternative to marital sex.

All three types of sexual activity have sub-cultures, some specific to the category (such as swinging or polygamy), and some common to all three categories, such as BDSM and fetish wear (Bergner 2009).

One underlying factor differentiating the three forms of sexuality is the relative role of fantasy. In solo sex the emphasis is on fantasy, visibly so with the use of erotica. In long-term relationships, everyday reality usually becomes dominant, and familiarity sometimes kills off mystery and desire in the process. Fleeting relationships are the location for 'fantasy-made-real' games that cannot last long without tipping into reality at some point (often the end-point). Closely associated with the dominance of fantasy is the question of who controls the script. Solo sex allows everyone full control of the fantasy script. Commercial sexual services allow the customer to be in control of the script, but he has to pay generously for this privilege. Hook-ups and affairs provide the most interesting strategic case studies of sexuality because no-one controls the script, it is entirely a matter for negotiation. This means that the person with the highest erotic capital generally has the greatest power to get what they want, sexually, and in style of relationship, unless the other partner can offer compensating benefits in exchange: money, entertainments, gifts of some sort, social status, social contacts, deference and admiration, tea and sympathy – economic, cultural or social capital (Croydon 2011; Hakim 2012). For marital relationships, state laws frame the script, and dictate a mutual sharing (or exchange) of money and sexuality.

From the perspective of economics, solo sex is non-market, or off-market, since there is no partner. Long-term partnerships are also partially off-market, since bargaining is limited to the two partners, normally. Fleeting sexual encounters constitute the spot market of sexual activity. Spot markets are markets in which commodities and services are traded for cash and delivered immediately, in contrast to the futures market which uses forward pricing. The concept is useful to distinguish very short-term sexual relationships from longer-term partnerships, which often include delayed gratification and long-term investments in property, children and other assets and activities. Spot markets focus attention on what is being exchanged. In the commercial sex industry widely defined, the trade is clear: money is exchanged for services – anything from telephone sex and lap-dancing to call-girls and dominatrix sessions. In contexts where

money is excluded or occluded, such as affairs, erotic capital becomes the primary, or even sole commodity traded or bartered (Hakim 2012).

In the fiercely competitive spot markets of gay hook-ups, partners tend to be closely matched on erotic capital and style group (such as twinks, bears, hipster, leather and clones) – as observed by Green (2008a,b). Very few settings occlude erotic capital in order to shrink differentials in sex appeal and style. For example, gay cruising in parks such as London's Hampstead Heath in the middle of the night permits sexual pairings that would be inconceivable in any other setting, because darkness obscures appearances and the no-talk rule eliminates social class indicators (such as accent and style of language). I am not aware of any routine heterosexual equivalent to the impersonal gay sex of bathhouses and other sexual venues (Weinberg and Williams 1975). This is further evidence of the large sex differential in sexual interest and behaviour.

Within heterosexual spot markets, someone with high erotic capital can choose partners with much greater economic, cultural and/or social capital on terms of parity of exchange. The obvious example is the liaison between a young and attractive woman and an older, successful man, married or single, who may score low on erotic capital or else does not have the time and inclination to invest in a long-term relationship – such as the 'trophy wife' and the 'sugar daddy' of North America and Europe (Croydon 2011), the '*velho que ajuda*' and *programmas* of Brazil (Piscitelli 2007), the *jineterismo* of Cuba (Garcia 2010), the 'no romance without finance' student-mistresses of Nigeria (Smith 2008), and the 'no money, no honey' convention of sexual liaisons in Jakarta (Murray 1991). As the French have always recognised, affairs cost a lot of money (Sciolino 2011; Druckerman 2007). These are all spot markets where exchanges are exposed clearly. The internet has created new spot markets for sexual encounters, including websites for sexual affairs and fleeting encounters where both parties are married, thus definitively excluding potential marriage aspirations. A study of the players in these sexual markets concluded that 'erotic power' was the crucial factor in the conduct of these relationships (Hakim 2012). Although the websites attracted professional and managerial men with substantial economic, human and social capital, women with high erotic power generally had the upper hand in these affairs, contrary to the men's expectation that their career success and money entitled them to be in control.

Men often think that being rich or successful confers high erotic capital. This is a misunderstanding – one that Dominique Strauss-Kahn appears to have made, whereas Silvio Berlusconi did not. In marriage markets, rich and successful men make welcome potential mates for women, even if they are ugly, unfit, and badly dressed, because they would be *legally obliged* to share their economic and other assets with any spouse and offspring, In the spot market of fleeting relationships, wealth is only an asset if a man (or a woman) is generous with their money and shares it liberally, immediately, with a partner, as there are no long-term considerations. Wealth can thus *compensate* for low erotic capital (or lack of time and care) in fleeting affairs. However professional success and bright career prospects have no value because they cannot be exchanged in the here and now of spot sexual markets. Similarly, an older woman who is sexy and physically attractive can be an attractive option for men of any age in spot markets, because men do not need to worry about the long-term prospects of her deteriorating health, looks, or infertility. High erotic capital enables her to be a player in short-term liaisons. The same logic applies to handsome, fit and engaging young men who have no money and status at all. They can do well in the spot market of affairs even if they remain poor prospects within marriage markets, as depicted in the French novel (now a film)

Bel Ami by Maupassant. In effect, spot markets require both parties to put their 'offers' on the table, ready for immediate consumption and exchange. In this context, anyone who lacks erotic capital has to reciprocate immediately with financial generosity, not as a gift, but as an entry ticket.

One of the most common errors men make is to think that the rules of the game applying in marriage markets apply also in spot markets. Among heterosexuals, they are completely different (Fein and Schneider 2000; Hakim 2012). The distinction between the two may be less well defined within gay communities, due to the absence of a clearly-defined marriage market (and laws) and greater emphasis on continuous sexual adventure and exploration even within stable partnerships (Green 2006, 2010; Anderson 2012).

Ephemeral relationships and spot markets are interesting for social scientists because they expose exchanges within sexual markets most clearly. They also approximate most closely to true markets as seen by economists, due to high turnover and transparency - which is why speed-dating and internet dating are studied as natural social experiments. These exchanges can also be present in long-term relationships, but in attenuated and occluded form because marital relationships encompass so many other aspects as well: family connections, financial and property investments, lifestyle choices, friends and leisure interests in common, children and inheritance issues, social status and rank, as well as sexuality - and the relative importance of all these components will fluctuate over time. In the western world, the contribution of all these elements is routinely occluded by the ideological emphasis on love rather than lust as the basis for companionate partnerships, which argues against honestly instrumental exchanges.

Case studies of gay sexuality can never be representative of the way sexuality plays out in the large and diverse heterosexual community. The enclosed and constrained culture of the gay bathhouse is not typical of the entire spectrum of heterosexual communities, settings and interaction. At a rough guess, 75% of gay sexual activity is located in spot markets, while 75% of female heterosexual activity is confined to long-term partnerships.[6]

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[6] My rough estimate relies on the results of the national sex surveys in north America and Europe. These show that:
- Over 90% of females insist on exclusive monogamy as the norm.
- The majority of women (4/5) reject the idea of sex with a stranger, whereas the majority of men (3/5) welcome the idea.
- Men are three times more likely than women to endorse casual sex.
- Men generally (and gay men in particular) are 5-6 times more likely than women to have multiple sexual partners in the last year or the last five years.
- Even in Sweden, only 6% of women versus 20% of men say the ideal is to have several lovers, and 20% of men have already had at least one affair outside marriage.
- All studies show gay men to have the highest numbers of partners and lesbian women to have the lowest number, with heterosexuals as the in-between group.
- People who endorse recreational sexual values are 2-3 times more likely to have gay sexual experience, while people who espouse conservative sexual values are 2-3 times less likely to have gay experiences

Since heterosexual women's insistence on exclusive monogamy and a focus on love and commitment as the condition for sex is the main constraint on male sexual expression and exploration, gay men have the option of a radically different lifestyle, and many take it. See Laumann et al (1994: 315, 534, especially Tables 8.4, 14.5 and 14.6); Wellings et al (1994: 237, 240, 210-11, especially Tables 7.10 and 8.5); Leridon et al (1998); Messiah (1998) Lewin (2000). See also Clark and Hatfield (1989).

These estimates are indicative of the large difference in lifestyles and sexuality in the two communities. So we need more studies of fleeting affairs among heterosexuals.[7]

Sexual Pleasure

It has taken me a long time to get round to showing where sexual pleasure fits into this picture of sexual activity. However I believe that social and economic factors, erotic capital, and the male sex deficit, are dominant everywhere, so that sexual pleasure comes last, at the very end of a complex process of selection, exchange and pairing. The analytical framework set out above leads me to several conclusions.

In principle, solo sex provides the best context for sexual pleasure. Fantasy can be given maximum play, and individuals have maximum control over the script and activities. This is why high libido people will always engage in solo sex in addition to partnered sexual activity. However there is the disadvantage of having to do it all yourself. And for many people the desire for connection with a desirable 'other' is just as important as sexual release.

Overall, marriage and long-term relationships are least beneficial for sexual pleasure, because they are dominated by practical realities, day to day bargaining and longer-term goals – at least after the first two years 'honeymoon' phase. However they offer emotional and financial security, reliability, comfort, predictability, and low cost in terms of time and effort expended on seduction.

Monogamy ensures that almost every man gets at least one sexual partner, so that few people lose out completely in the sexual competition. Monogamy enforces sexual democracy.

Spot markets provide the maximum potential for sexual pleasure because they combine fantasy and reality, adventure and control, risk and reward. In the case of sex industry encounters, there is also the predictability and control that comes from the exchange of money for erotic capital and the right to determine the script, which is most often the Girl-Friend Experience (GFE). (In the USA, where the sex industry is generally outlawed, call-girls are listed on websites offering the Girl-Friend Experience or escort services.)

However erotic capital and/or adequate funds are essential for being a player in spot markets. All the research evidence points to the most attractive people getting the greatest amounts of sexual pleasure because they get more of everything in sexual markets. Attractive people have more partners, greater choice of partners, more sexual activity of all kinds, more sexual adventures, more bargaining power and control in sexual liaisons, and almost certainly the greatest amount of sexual pleasure as a result (Hakim 2011).

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[7] One problem is the two-sided nature of heterosexual relations in meet markets: very often she is looking for a potential marriage partner, while he is only pursuing immediate sexual gratification (Cloyd 1976: 34). Only within marriage agency membership can we be sure that men also seek marriage partners. As many sex researchers point out, female reticence and lack of interest is the principal constraint on sexual exploration among heterosexual men, a constraint that gay men do not experience. One of the rare books to justify and even promote sexual cheating by men in stable relationships was written by a gay man (Anderson 2012).

I conclude that people get the greatest sexual pleasure, or get it more often, in affairs, casual hook-ups, with call girls and rent boys, than they do in stable or long-term relationships, where sexual expression has to compete with a myriad other goals and priorities. There is solid research evidence that sexual desire for a particular partner tends to fade after the initial 'honeymoon' period, roughly the first 2-3 years of a relationship, irrespective of age (Table 3 – see also Wellings et al 1994). Only affairs, or their equivalent, allow the constant renewal of sexual adventure, desire, excitement, and the sexual pleasure that follows (Hakim 2012).

TABLE 3 AFFAIRS IN FRANCE
PERCENTAGE OF MEN AND WOMEN WITH 2+ SEXUAL PARTNERS AMONG COHABITING MEN AND WOMEN AGED UP TO 45 YEARS

Time living together as a couple	0-2 years	5-10 years	15+ years
First marriages			
Men with 2+ partners			
within last year	8	7	7
within last 5 years	-	21	21
Women with 2+ partners			
within last year	2	2	5
within last 5 years	-	14	17
Second marriages			
Men with 2+ partners			
within last year	10	7	6
within last 5 years	-	25	19
Women with 2+ partners			
within last year	3	4	2
within last 5 years	-	12	13

Source: Extracted from Bozon in Bajos et al 1998, Table 10 page 209

This conclusion sits uncomfortably with the emphasis on love and sexual fidelity in marriage in the Western world. It is consistent with the French and Latin perspective on seduction and affairs as a major erotic entertainment and source of pleasure (Mosuz-Lavau 2002; Druckerman 2007; Sciolino 2011). These cultures (plus also the Japanese culture) place most emphasis on erotic capital, desire, flirting, sensuality, the role of imagination, and related pleasures (such as wine, food, and sexy lingerie) in sexual life.

I have shown that attractiveness has increasing importance in the 21st century (Hakim 2011). So I predict that people will invest more in their attractiveness in the future, given the importance of erotic capital in liberal cultures where sexual hedonism and recreational sex are not just permitted but actively promoted. The cosmetic surgery industry and the sexy lingerie industry are set to grow!

Conclusions

Weis (1998: 110) pointed out that most sex research has been atheoretical, despite a full century of sex research. My two theories of erotic capital, and sexual expression, provide a fruitful basis for future research, because they are grounded in the empirical research evidence from sociology, economics and psychology as well as sex studies (Kontula 2009; Hakim 2011). They help us to situate case studies of sexual activity (such as gay men) within a broader framework of how sexual markets operate, and what are the key factors shaping sexual expression.

Erotic capital is a multi-faceted fourth asset that is very different in character from economic, social and cultural capital. Erotic capital has a maverick, subversive, wild card character that can lead to its social suppression and denial. Erotic capital is an essential concept for understanding sexual relationships and markets. It is also important for understanding all social interaction and social processes in public and private life in the affluent cultures of modern societies in the 21st century. My thesis is that erotic capital has growing social and economic value in the 21st century, gives women an advantage - if only they are able to recognise it.

The social and economic value of erotic capital is clearly exposed in sexual markets, especially fleeting relationships. It explains the need for compensating gifts whenever there is a clear imbalance in age or erotic rank between partners. Erotic capital is a key factor in obtaining the fullest access to sexual encounters, maintaining a strong bargaining position vis a vis partners, and facilitating the route to sexual pleasure. This is shown most clearly among gay men and in casual liaisons.

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Differences in Levels of Sexual Dysfunctions in Lesbian, Bi-, and Heterosexual Women

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Introduction

A number of studies have focused on female sexual desire and sexual functioning in relation to sexual orientation (e.g. Burri et al., 2012; Bressler & Lavender, 1986, Nichols et al., 2004). The research on sexual functioning, and sex life satisfaction comparing bi-sexual-, lesbian- and heterosexual-identified women is not unanimous. On the one hand, it has been reported that bisexual women experienced more frequent and intense orgasms during a week than both hetero- and homosexual women (Bressler & Lavender, 1986), and Nichols and colleagues (2004) found fewer sexual problems (less difficulty reaching orgasm, fewer problems lubricating, less pain, and less sexual guilt) among lesbian women compared with heterosexual participants. Breyer et al. (2010) found that the risk for any sexual dysfunction was more common in heterosexual (51%) and bisexually identified women (45%) than in lesbian-identified women (29%). These findings imply that a same-sex orientation could be related to higher sexual functioning. On the other hand, low libido has been reported to be more frequent among lesbian women (Bryant & Devian, 1994; Lever, 1995), however, when controlling for relationship status, lesbian and heterosexual women seemed equally satisfied with their sex lives (Blumstein & Schwartz 1983, cited in Burri et al., 2012). Several other studies have also reported that no differences in sexual function disturbances were found between women in same-sex relationships and women in opposite-sex relationships (Laumann, Paik, & Rosen, 1999; Matthews, Hughes, & Tataro, 2006). Contradicting these findings, Burri and coworkers (2012) recently found a significant association between lifetime same-sex sexual experience and sexual dissatisfaction and sexual distress so that women with a same-sex sexual experience reported more sexual dysfunctions. The study by Burri and colleagues discusses an important diagnostic aspect, namely the inclusion of a measure of sexual distress in research. The diagnostic criteria of sexual dysfunction require subjective distress over sexual functioning, an aspect that some of the above mentioned studied did not take into account.

There is ambiguity relating to how sexual orientation should be understood. Some studies have used an items measuring self-reported sexual orientation identity, whereas others have inquired about sexual fantasies, or sexual behavior. In the Burri et al. (2012) study, a lifetime experience of same-sex sexuality was used (i.e. whether a participant had ever engaged in sexual activity with a member of the same sex). However, the researchers did not take into account at which stage of life this experience had occurred, or whether it was part of an identity developmental process, or if the experience was, for instance, experimenting in young adulthood and/or due to curiosity. The current study aimed to replicate some of the analyses of the study made by Burri and coworkers, but using a more stringent definition of same-sex sexuality. In particular, we

wanted to compare experiences of women who during the preceding year had felt sexual interest towards both men and women, or had sexual activity with both men and women, with those women with exclusive sexual preferences and behaviors during the preceding year. The sample used by Burri and coworkers included participants from both data collections of the Genetics of Sex and Aggression (description in e.g. Alanko, 2010), whereas the present study uses data from participants from the first data collection of the GSA sample only. This data collection includes information about opposite sex sexual attraction and sexual behavior, and as a result we can create more specific groups of exclusively heterosexual, bisexual and exclusively lesbian women, as well as those women who did not report any partnered sexual activity during the preceding year. Unfortunately, subjective sexual distress experienced by the participants was not measured in the first data collection.

The aim of the present study was to compare sexual functioning in women as a function of sexual orientation when sexual orientation was measured as 1) sexual interest; or 2) sexual behavior. The dimensions of sexual functioning used were desire, arousal, lubrication, orgasm, satisfaction, and pain.

Methods

Sample

The sample consisted of 2176 Finnish women aged 33 to 43. The sample is based on the first data collection of the Genetics of Sex and Aggression study. The sample and the data collection are described in more detail in e.g. Burri et al. (2012) and Alanko et al. (2010). Out of these women, a subsample, as described below, was selected.

The research plan was approved by the Ethics Committee of the Department of Psychology at Abo Akademi University in accordance with the 1964 Declaration of Helsinki.

Instruments

The Sell Assessment of Sexual Orientation (SASO; Sell, 1996). Six items from the SASO instrument were used to assess the existence of opposite- same-sex sexual interest and behavior among the respondents. The first two items inquire about sexual activity, separately for partners of male and female gender: *During the past year, on average, how often did you have sexual contact with a man/woman?* The response alternatives were: Never; less than 1 time per month; 1-3 times per month; 1 time per week; 2-3 times per week; 4-6 times per week; Daily. On the basis of the responses to the items, the participants were grouped into four categories: no sexual activity (n=117), heterosexual (n =2026), lesbian (n=18) and bisexual (n = 116). The categorizations were made based on behavioral reports (e.g. so that women who reported that they had engaged in sexual activity with both men and women during the past year were assigned as bisexual). Women who did not report any sexual behavior during the preceding four weeks were excluded from further statistical analyses, resulting in smaller group sizes. There were only two participants in the group considered to be lesbian, and unfortunately, no statistical analyses could be conducted that included this group.

The same procedure was then applied using the participants' reports of sexual *interest* instead of behavior, using the following questions: *During the past year, on average, how often did you feel sexual interest in a man/woman?* (response options were the same as for the former two questions) and *During the past year, how many different men/women did you feel sexually interested in?* (response options: none, 1, 2, 3-5, 6-10,

11-49, 50-99, 100<). However, when excluding women who in the FSFI reported no sexual activity during the prior four weeks, the group of lesbian women was too small to include in any analyses, consisting of two persons only.

The Female Sexual Function Index (FSFI; Rosen et al. 2000). Sexual desire, arousal, lubrication, orgasm, satisfaction, and pain were measured by items from the Female Sexual Function Index. The scale consists of 19 items measuring problems during the past four weeks. The scale measures six dimensions: desire, arousal, lubrication, orgasm, satisfaction, and pain. The scale ranges from 1 to 5 (items 1, 2, 15, 16) and 0-5 (the rest of the items). Higher scores indicate decreasing problems with sexual functioning. The alternative 0 indicates no sexual activity, or partner, during the preceding four weeks, and therefore participants not reporting sexual activity were in some instances excluded. The scale has been found to show good psychometric properties (a discussion can be found in Witting, 2008).

Perceived Relationship Quality Components Inventory (PRQC: Fletcher et al. 2000) comprises of eighteen questions out of which six were used in the present study. The answers were given on a Likert type scale, ranging from one to seven.

Statistical analyses

All statistical analyses were conducted with SPSS 19. The Generalized Estimating Equations regression procedure was used when appropriate, as it allows for appropriate control for data consisting of twins. In other cases analyses of variances were used for group comparison.

Results

A cross-tabulation of the sexual behavior and sexual interest variables, gives us that there is no perfect overlap of the phenotypes.

TABLE 1.

Crosstabulation of sexual behavior with and sexual interest in men and women.

	Sexual interest men exclusively	Sexual interest both men and women	Total
Behavior men exclusively	1477	97	1574
Behavior with both men and women	10	14	18
Total	1481	107	1588

Descriptive statistics and group differences are shown in Table 2 and 3. All sexual orientation categories displayed in Table 2 were based on sexual behavior during the preceding year, whereas Table 3 contains results from corresponding analyses when variables based on sexual interest were used to assign sexual orientation. As explained in the methods section, an additional exclusion criteria was used. Women who did not report any sexual activity during the preceding four weeks were excluded, rendering small group sizes of non-heterosexual women. Due to this, lesbian women were not included in the analyses, and also the group of bisexual women in the behaviorally based categorization, consisted of 20 women only.

Only one significant difference between the groups was found when using the behavior-based categorization. Bisexual women reported higher levels of sexual desire than heterosexual women.

TABLE 2.

*Descriptive statistics and comparison of heterosexual and bisexual women, based on reported sexual **behavior**, on the Femail Sexual Function Index, including only participants who reported sexual activity during previous four weeks.*

	Heterosexual n= 1597		Bisexual n= 20		Group differences
	M	*SD*	*M*	*SD*	*F*
Desire	1.58	0.65	1.93	0.77	5.25*
Arousal	3.15	0.78	3.21	1.03	0.173
Lubrication	4.24	0.48	4.26	0.55	0.030
Orgasm	3.42	0.94	3.54	1.22	0.122
Satisfaction	3.12	0.94	2.95	0.98	0.691
Pain	4.66	0.54	4.80	0.35	1.174
Total score FSFI	66.35	0.28	67.50	2.41	0.278

Note. Higher scores on the FSFI indicate less problems, scale range was from one to five. Lesbian women were excluded due to low number after excluding participants with no sexual activity during preceding four weeks.

* p < .05 p** <.01 p***<.001 [a] p = 0.06

When the categorization was based on the sexual interest variable bisexual women, compared to heterosexual women, reported a significantly higher level of desire, and a significantly lower level of sex life satisfaction.

TABLE 3.

*Descriptive statistics and comparison of heterosexual and bisexual women, based on reported sexual **interest**, on the Female Sexual Function Index, including participants who reported sexual activity during previous four weeks.*

	Heterosexual n = 1481		Bisexual n= 108		Group differences
	M	SD	M	SD	F
Desire	1.58	0.64	1.87	0.73	21.310***
Arousal	3.15	0.76	3.08	0.92	0.89
Lubrication	4.25	0.48	4.23	0.47	0.101
Orgasm	3.44	0.93	3.26	1.05	3.604*
Satisfaction	3.16	0.92	2.73	1.04	20.94***
Pain	4.67	0.53	4.65	0.54	0.212
total score FSFI	66.54	9.51	64.94	10.67	2.88

Note. Lesbian women were excluded due to low number after excluding participants with no sexual activity during preceding four weeks.
Scale ranged from 1-5 for the dimension, and for the total score from 0 to 95.
Low scores indicate more problems.

Relationships satisfaction as a moderator of the association between sexual orientation and sexual dysfunction

Relationship satisfaction was in itself a significant predictor of *sexual dysfunction* (as the total FSFI score, Wald χ^2 (1)=121.88, $p < .001$). No main effect was found for relationship satisfaction on level of *desire* for the categorization according to behavior: (Wald χ^2(1)= .22, p=*.ns*, but a significant main effect was found for the interest based categorization Wald χ^2 (1)=13.57, p= <.001. Also, relationship satisfaction had a significant main effect on *sex life satisfaction* using the interest categorization: Wald χ^2 (1)=219.71, $p < .001$.

In order to investigate whether partner satisfaction moderated the association between sexual orientation and sexual dysfunction, those associations that were found to be significant (desire, and sex life satisfaction), were reanalyzed with relationship satisfaction as a moderating variable.

No interactive effects of relationship satisfaction and sexual behavior-orientation were found on desire: Wald χ^2 (2)=2.4, p=*.ns*.

For the interest-orientation, interactive effects between sexual orientation and relationship satisfaction were found: desire: Wald χ^2 (2) =10.42, $p > .01$, satisfaction: Wald χ^2 (2)=280.55, $p > .001$. For desire, the interaction was caused by the fact that for heterosexual women, the association between relationship satisfaction and desire was significant, whereas for bisexual women the association was not significant. For satisfaction, the association between relationship satisfaction and satisfaction was stronger for bisexual women than for heterosexual women.

Discussion

Firstly, as studies on the topic have generated ambiguous results, the aim of the present study was to reassess previous research concerning whether frequencies of female sexual dysfunctions differ as a function of sexual orientation. Secondly, we were interested in elucidating whether any fluctuations in sexual dysfunctions as a function of sexual orientation could be explained by how sexual orientation is operationalized. To achieve this, we operationalized sexual orientation by sexual behavior and subjective sexual interest.

The overlap between sexual behavior and sexual interest did not match perfectly. This of course, is evident, as sexual interest is probably more frequent than actual sexual behavior. An interesting aspect, that unfortunately could not be studied here, is how well sexual orientation identity matches with both subjective sexual interest and actual sexual behavior.

Results regarding which sexual dysfunctions were affected, varied between heterosexual women and non-heterosexual women depending on the operationalization of sexual orientation in each case. When using behavior as a base for sexual orientation, the affected dimensions of dysfunctions was desire, but when using sexual interest as a base, then the affected dimensions were desire and satisfaction.

In a prior, printed version of this text, a group consisting of lesbian women was included in the statistical analyses. In that version, lesbian women were found to report more pain related problems, but higher levels of desire and arousal than heterosexual and bisexual women. However, there were some problems in these analyses, mainly due to a small sample size, and related to the scoring of the FSFI. That is, the finding about higher levels of pain reported by lesbian women was due to the fact that if no sexual activity has occurred during the prior four weeks, a score of zero is marked on

the FSFI. A low score on the scale indicates more sexual dysfunctions, and therefore sexual inactivity might be confounded with sexual dysfunction. When removing all participants who did not report sexual activity during the preceding four weeks, there were only two lesbian women with sexual activity (and no reported pain!). This means, that the finding of higher levels of pain was due to the sexual inactivity of these women, not a true experience of pain. Due to these problems, the prior analyses were omitted from this version of the paper, and analyses were only conducted with heterosexual and bisexual women.

The results of the latter operationalization, based on sexual interest, are similar to results reported by Burri et al. (2012) on the fact that women with same-sex sexual experiences reported more problems related to satisfaction. However, when using the sexual interest classification, a higher level of desire was reported by bisexual women than by heterosexual women. This finding is in line with other prior research (Lippa et al., 2006), but not with the Burri et al. study, which partly used the same sample as the current study. These contrasting results highlight the importance of choosing the operationalization for sexual orientation carefully.

The fact that the behavioral classification did yield a discrepancy in desire but not in satisfaction with sex life, as was the case when basing categories on sexual interest, should be rendered some thought. Could there be an aspect to sexual interest, linked to a higher level of desire, that results in sex life dissatisfaction? Perhaps it could be that if a high level of desire is not met by the actual sexual behavior, that is, is not lived out, it could result in sex life dissatisfaction. The interest dimension of sexuality might capture some ideal fantasy world of sexuality, whereas actual sexual behavior probably corresponds with relationship status, and how reality meets sexuality.

There are indications that frequency and type of sexual activities could mediate the association between same-sex sexual experience and, at least, sexual desire (Burri et al., 2012). However, the magnitude or direction of the mediating effects is not ambiguous. In our data, we had the possibility to check whether relationship satisfaction moderated the association between sexual orientation and sexual dysfunctions. This was found to be true for the sexual interest-operationalized associations with desire and satisfaction. It might thus be that relationship satisfaction relates to experienced sexual interest, but not on actual sexual behavior to the same degree. Also, group sizes were considerably larger in analyses based on the interest based classification and in the analyses using the behavior based grouping, results might be as reliable.

There are several limitations to the present setup. We did not have data on the participants' subjective sexual orientation identity. This means that there might be incongruence in the experiences of identity and behavior and interest. We make no claims as to whether the items used here are associated with the sexual orientation identity of the participants. The final group sizes were small, and some of the statistical analyses might therefore not be reliable, and should be repeated with a larger sample. We did not control for relationship status in the moderation analyses. Other limitations concerning sexuality related, questionnaire data, and possible problems related to that are discussed in e.g. Alanko (2010) and Witting (2008).

In conclusion, the aim of the study was to look closer at how operationalization of sexual orientation affects the outcome of reported sexual functioning. It was shown that operationalization did in fact have a great impact on the outcome, as the two operationalizations yielded different results. It is therefore, utterly important, to closely consider which aspect or dimension of sexual orientation is at hand, and what the implications of that choice might be. In research settings, a combination of interest and

behavior items is often used to measure sexual orientation. Such an operationalization is probably preferable if only one measure can be used, however, there are indications that sexual interest and actual behavior should be considered separately. One indication is that the dimensions appear to be related to different aspects of sexual dysfunctions, another is the fact that using only one dimension is not a good indicator of a more general concept of sexual orientation.

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Personal Values and Sexual Desire

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Introduction

Sexuality is a subject familiar to all people because in humans it generates profound emotional and psychological responses. Some theorists identify sexuality as the central source of human personality (Russon, 2009). In the theory of human motivation of Maslow (1954), a widely approved concept explaining human behavior, sexuality is considered to be one of the basic urges. In such way, sexual desire as a biological force would equate it with other important biological drives as hunger, thirst. Based on this assumption, one may think that it behaves relatively constantly thorough the situations. It is not so - the desire for sex is an aspect of a person's sexuality, thus varies enormously from one person to another, and it also varies depending on circumstances at a particular time. Sexual drive has usually biological, psychological, and social components. Studies of sexuality typically include sexual desire (fantasies and dreams), frequency of sexual intercourse, level of arousal, thoughts. One of the topics that would give answers to a variety of questions and would lay foundation to more but is theretofore sparsely researched is about the kind of individual differences that reflect in sexual behavior and lead to dissimilarities in the willingness to have sex.

Sexual Desire

Although time has passed, there still is no universal definition of sexual desire. Often it is confused with other aspects of human sexuality. In fact, sexual desire can be associated with sexual behavior but is simultaneously separate from it (DeLamater & Sill, 2005). Von Kraft-Ebing discussed sexual desire as a "psychological law" arising from cerebral activity and the pleasurable physical sensations associated with it already in 1886. Generally speaking, sexual desire is the predisposition to respond subjectively to sexual stimuli representing the cognitive valence of sexual arousal, and depending on the expected sexual incentives. Some researchers regard sexual desire as a personal cognitive experience but others (Vershulst & Heiman, 1979) stress as a relational aspect of sexual desire. The importance of sexual desire is hard to undervalue as it has become to be seen as a central motivational factor in human sexuality (Aron & Aron, 1991).

Basically sexual desire approaches can be separated into two: non-dynamic and dynamic approaches. The non-dynamic point of view is represented by authors emphasizing biological or cognitive origin of sexual desire. The biological explanation is mainly based on hormonal mechanisms, emphasizing the role of androgens as testosterone but there still is a lack of empirically proved data on the hypothesis (Andersen & Cyranowski, 1995). Kaplan introduced in 1979 a triphasic model in which she associates sexual desire with intrapsychic emotional forces that lead to sexual contact or

avoiding it (Andersen & Cyranowski, 1995) and that are produced by the activation of a specific neural system in the brain (DeLamater & Sill, 2005). Moser (1992) on the other hand has emphasized cognitive features of the construct.

The dynamic models are represented by authors like Leiblum & Rosen (1988) who have conceptualized it as a subjective feeling state that may be triggered by both internal and external cues, also saying that desire is both a setting event and a consequence of sexual activity. Singer & Toates (1987) are proposing that sexual motivation emerges from the interaction of external incentives and internal states. Levine (1992) supports the biological explanation highlighting sexual drive and the behavioral and cognitive efforts to seek sexual stimulation. Beck (1995) has defined it as a multidimensional construct, subsuming affective, cognitive and motivational factors but also criticizing the absence of definitional clarity and finding it to be a reason of the imperfect assessment devices on this subject.

In 2005 DeLamater & Sill divided the several models of sexual desire into two emphasizing either motivational or relational aspects of it which can also be understood as the internal or external nature of sexual desire. The basics of this dualisation are similar to the one of Andersen & Cyranowski as these approaches to the subject are also non-dynamic and the aforementioned dynamic point of view of Levine (1987, 1992) is also presented – he finds sexual desire to be defined through biologically-based sexual drive, cognitive processes and the psychologically based motivational processes that result in the willingness to behave sexually. In the paper of DeLamater & Sill (2005) the difference is also found in the opinions about the relations between desire and actual or potential actions.

The explanation of the content of sexual desire is even more complicated as it is a subject well-known to all people and the way they understand it might severely differ from the point of view of the scientists working on the subject. The nonprofessionals have found to use sexual fantasies, behaviors and genital arousal to determine their level of sexual desire (Beck, Bozman & Qualtrough, 1991) which means that the distinction between desire and sexual arousal that is supported by some authors does not appear in the grasp of the people whose opinions and experience are measured in the academical researches.

Personal Values

Prominent value researcher Milton Rokeach (1973) argued that the concept of values, more than any other, has great potential as a unifying construct in the study of human behavior. This is really interdisciplinary field, which has contributed to the research on social sciences but also on economy, medicine and many other fields' research.

Personal values are cognitive constructs that explain an individual's preferred life goals, principles and behavioral priorities. According to Milton Rokeach (1973, p. 5), "a value is an enduring belief of that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence". 'Preferable' means that one goal is preferred to something else, so that the values have a hierarchical order. 'Mode of conduct' refers in Rokeach research to the 18 instrumental values and 'end-state' refers to the 18 terminal values. Based on his approach, Shalom Schwartz and Wolfgang Bilsky (1987, 1990) generated a conceptual definition of values that incorporates the five formal features of values mentioned in the literature. Values are (1) concepts or beliefs; (2) they pertain to desirable end states or behavior; (3) transcend specific situations; (4) guide the selection

or evaluation of behavior and events; and (5) are ordered by their relative importance. Therefore, they made the theoretical assumption that values are cognitive representations of three types of universal human requirements. These three universal requirements to which all individuals and societies must be responsive are (a) the needs of individuals as biological organisms, (b) requisites of coordinated social interaction, and (c) survival and welfare needs of groups. If these three requirements are represented cognitively, they take the form of values. The crucial aspect that distinguishes the Schwartz Value System (SVS) from other approaches is that it expresses the motivational goal (Schwartz & Bilsky, 1987, 1990). Empirical evidence supports the existence of ten distinct types of values: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security (Schwartz, 1992). The relative importance attributed to each of these value types constitutes the individual's system of value priorities. These ten motivational types are organized into two dimensions based on the evidence that compatible types are in close proximity and competing value types emanate in opposing directions from the center. The first dimension is called openness to change versus conservation. This dimension opposes values emphasizing one's own independent thought and action against those emphasizing submissive self-restriction, which prefer an unchanging life and stability. The second dimension is called self-transcendence versus self-enhancement. Self-transcendence refers to promoting welfare of others but self-enhancement refers to valuing and hence promoting personal interests even at the expense of others.

Personal Values and Sexuality

Personal values as a predictor of sexual behavior have mostly been researched to improve the prediction of risk-taking sexual behavior of adolescence. That personal values and sexuality in this context have been related for longer is showed by the fact that in 1973 a book named "Adolescent sexuality in contemporary America: personal values and sexual behavior, ages thirteen to nineteen" by Robert C. Sorensen was published. Later it is found that irrespective of their sexual activity, girls view their sexual behavior being based on personal values (Paradise et al., 2001). Paradise et al. (2001) also found that the sexuality of adolescent girls is described by the difference in sexual activity. The participants were asked about the reasons for having or not having sex and finding the proportion of personal values in these explanations differing virgins, sexually active and inactive females. Values were considered to be the reasons for decisions in sexual behavior by 53% of the virgins but only 24% of the sexually inactive and 24% of the sexually active girls. Personal values were implicit in the two specific reasons for having sex that active girls chose most frequently - "I like/love the person" and "I like having sex". Only 24% of the sexually active girls exposited values and beliefs as their reason for having sex. As well, riskier sexual activity has been reported by people high on openness to change, hedonism (that is also a part of openness to change) and self-enhancement as Goodwin et al. (2002) used Schwartz's Portrait Values Questionnaire and self-reports to examine the sexual behavior of eastern Europeans represented by business people, doctors and nurses in the context of rising HIV infection in the area. As personal values are affecting adolescents and their incipient sexuality it is also influencing the way adults intrude and supervise it. Values-free sexuality education has been found to be impossible (Elia & Eliason, 2009). Irrespective of that the subject of sexual desire and personal values has been researched very sparsely. Although there has

been much discussion about things like the causes, loss, and maintenance of sexual desire, there has been little research into the positive relations between sexual desire and personal values. Although we may consider sexual desire mostly based on bodily component, personal values and beliefs constitute the cognitive component of desire which can influence sexual interest. Thus, a person may have sexual desire but his/her personal, moral or religious reasons refrain from acting on the urge. Or vice versa – a person does not have desire for sex but the values force her to engage in sexual behavior. Thus the ideal is situation there personal values and goals support the sexual activity.

The Aim of The Present Study

As explained before, personal values are considered to be the key motivators of human behavior and sexual desire is seen as a central motivational factor of human sexuality. There is a lack of information though on the question which of these important motivational factors affect sexual behavior of individuals most significantly and what kind are the relations between the motivators. The descriptions of value types of Schwartz lead to the hypotheses that sexual desire might be negatively correlated to tradition and security as supporting these values may allude to the deceleration of the manifest of the quest for pleasure. Based on it we hypothesize that (1) sexual desire is negatively correlated to the values of tradition and security. Hedonism and stimulation are both described in the Short Schwartz's Value Survey through pleasure and excitement seeking which hints at the possible coherence of these values and significant sexual desire, based on this we hypothesize (2) sexual desire is positively correlated to stimulation and hedonism. An exploratory hypothesis (3) is that participants low in desire value different values than in normal desire level.

Method

Participants. The participants were women and men with different social background (n = 207; 153 female; 54 male; mean age = 29.5; SD = 7.99; the youngest was 18 and the oldest 56). The participants were found by the academics and students of the University of Tartu using convenience sampling through suggesting the questionnaire online.

Measures. The participants estimated the importance of the ten values of Schwartz's structure of values (Schwartz, 1992). The Short Schwartz's Value Survey was used. The values presented were self-direction, stimulation, hedonism, tradition, conformity, security, power, achievement, benevolence and universalism and they were measured on a scale from -1 to 7. The participants were suggested to begin with rating the most significant of them followed by the most irrelevant and then rate the importance of the rest of the values presented.

Sexual Desire Inventory (SDI; Spector, Carey & Steinberg, 1996). SDI consists of two related dimensions - dyadic sexual desire and solitary sexual desire and separate question "How long could you go comfortably without having sexual activity of some kind?" SD was measured on a scale from 0 to 8. Maximum score is 109.

The participants were asked about demographic data – sex, age, education, occupation, marital status, the number of children and comments about the childbirth, the age of first sexual intercourse, the number of different sexual partners one has had, the memory of first sexual intercourse (positive or negative), the satisfaction with pres-

ent sexual life, the last time one reached sexual satisfaction (whether intercourse or masturbation).

Procedure. Participants filled in questionnaires mentioned above. All questionnaires were in Estonian. They were filled in on an Internet site www.eformular.com, which is a homepage constructed specially for collecting research data. Participants were informed about the sexual nature of some questionnaires and were told that filling these questionnaires may take time up to one hour. They were also told that their anonymity and confidentiality is granted. Participants had to generate code names for themselves, so the questionnaires could be unified later in the data processing.

Results

Personal Values and Sexual Desire

We examined the relationship between the three SD subscales and the total SDI score with personal values. All personal values that support sexual desire should have positive correlations to the SDI variables and all values that inhibit sexual desire, should have negative associations with SDI scales. The correlations in Table 1 indicate that almost all personal values (except for tradition and self-direction) have some kind of relationship with sexual desire.

TABLE 1. PEARSON R CORRELATIONS BETWEEN SDI AND PERSONAL VALUES OF SVS.

	Dyadic sexual desire	Solitary sexual desire	Comfortably without sexual activity	Total SD
Achievement	0.15	0.13	0.14	**0.17**
Benevolence	-0.15	-0.07	-0.12	**-0.14**
Conformity	-0.12	-0.09	0.00	**-0.13**
Hedonism	0.27	0.15	0.21	**0.26**
Power	0.17	0.17	0.15	**0.20**
Security	-0.10	-0.17	-0.03	**-0.16**
Self-Direction	-0.01	0.06	-0.08	**0.02**
Stimulation	0.20	0.11	0.02	**0.19**
Tradition	0.02	0.01	-0.03	**0.02**
Universalism	-0.15	-0.11	-0.12	**-0.16**

Note: N = 207

Gender Differences in the Relations of Personal Values and Sexual Desire

To examine the gender differences, t-tests were conducted. There was no significant difference found between males and females in average score on all personal values, achievement, benevolence, self-direction, conformity, tradition and universalism. In sexual desire – all differences were highly significant. Men exceeded women in all components of sexual desire.

TABLE 2. STUDENT T-TEST FOR TESTING GENDER DIFFERENCES IN PERSONAL VALUES AND DESIRE

	men	women	t-value	p
Average	4.461339	4.471620	-0.08164	0.935011
Achievement	0.914083	0.929107	-0.42010	0.674851
Benevolence	1.105412	1.124754	-0.69169	0.489917
Conformity	0.951134	0.942398	0.31069	0.756352
Hedonism	1.213734	1.125344	2.18410	0.030090
Power	0.819094	0.733903	2.00809	0.045946
Security	1.037613	1.092093	-1.99374	0.047506
Self-Direction	1.140245	1.144376	-0.14882	0.881844
Stimulation	0.964225	0.790441	3.05583	0.002543
Tradition	0.468079	0.480007	-0.29712	0.766678
Universalism	0.991908	0.997490	-0.19202	0.847913
Dyadic sexual desire	47.72222	43.43137	2.746257	0.006564
Solitary sexual desire	11.44444	7.41176	4.327774	0.000024
Comfortably without sexual activity	4.48148	3.15033	5.368693	0.000000
SDI total	67.87037	56.84967	4.546823	0.000009

Note: N = 207

Desire Differences in the Relations of Personal Values

To compare different values in those who have low desire we regrouped respondents based on their SDI scores (cutoff value <46). From 207 participants 36 (8 men and 28 women) belonged to this group.

TABLE 3. STUDENT T-TEST FOR TESTING DESIRE DIFFERENCES IN PERSONAL VALUES

	Low desire (n=36)	Normal desire (n=171)	t-value	p
Average	4.259747	4.512978	-1.74856	0.081865
Achievement	0.845578	0.941948	-2.35630	0.019401
Benevolence	1.166359	1.109887	1.75422	0.080886
Conformity	1.010309	0.930860	2.47452	0.014153
Hedonism	1.079851	1.162834	-1.76293	0.079402
Power	0.669379	0.774389	-2.13942	0.033584
Security	1.134809	1.065896	2.18098	0.030323
Self-Direction	1.141872	1.143599	-0.05369	0.957233
Stimulation	0.789750	0.845466	-0.82845	0.408381
Tradition	0.479537	0.476339	0.06875	0.945256
Universalism	1.004761	0.994197	0.31372	0.754050

Discussion

The aim of the present study was to find the relations between sexual desire and personal values of people with different gender and desire level. It was predicted that negative correlations with sexual desire will be found with tradition and security and the desire would be positively correlated to hedonism and stimulation but the results of the data processing were quite surprising.

Research results showed that personal values such as achievement, hedonism, stimulation and power were positively associated with total sexual desire score. In theoretical model, these values belong to the personal focus dimension, suggesting that high sexual desire is more egoistic than it would be expected. High levels of hedonism and power may be seen that this comes from the high scores on men. Power belongs to the self-enhancement region in the values model and it is traditionally been high among men. Comparing the means of value ratings, men exceeded women on power, stimulation and hedonism, so the fact that men value power more may explain its bigger influence on their sexual desire. It might also show that men see power more related to sexual activity than women and so would the level of their desire for sex predict their desire for power and the opposite way too.

At the same time there was also some gender differences found where women exceeded men. For them a negative association between desire and security was found that does not appear for men. This finding might be the most significant because of the actuality of the subject of sexually transmitted diseases and unwanted pregnancy. The knowledge about these risks accompanying having sex as the result of sexual desire is more and more known and specially threatening younger people who are forming a big part of all the participants of this study. They are also the ones who get more information about these threats from media and special programs focused on them than older people.

Psychoanalytic theorists contend that women are more related and more affiliated with others than men, whereas men are more autonomous and more individuated (e.g., Chodorov, 1990). Most theories share a view of women as more relational and communal, and of men as more autonomous and agentic. These gender differences in motives are likely to find expression as different value priorities. Specifically, they lead to the conclusions that men more than women give high ratings to power values in particular and also to hedonism, stimulation and self-direction values (Schwartz & Rubel, 2005). Women attribute more importance than men especially to benevolence values and also to universalism, conformity, and security values. Thus our results are in concordance with previous results on gender differences in personal values.

There is no significant association on the level of tradition and self-direction. The value of tradition was described in the survey as respect for tradition, religiousness, humbleness, accepting one's portion in life, avoiding extremes in actions and emotions. Self-direction was defined as having an independent thought and action; choosing, creating, exploring. The result that both of them do not have any statistically significant correlations with sexual desire is very surprising, because on the theoretical model they are in opposite directions on the circle. Usually the opposites behave differently in the research of personal values and adjacent values have similarities.

Personal values and sexual desire are both important motivational factors in human sexuality but without a crucial interdependent relation. All the significant correlations found were relatively low. In conclusion it can be said that although not all

of the hypotheses received confirmation in our study, there is broader understanding in the relations between sexual desire and personal values discovered in this study. Also we found that our results hinted to possible gender differences in the understanding of the concept of the basic values in sexual context. The mean level of sexual desire of people might be the same but the meaning of it may differ for males and females affecting also the relations of the desire and personal values. The values may affect more the variety in the sexual activity of people than their desire for it which is a subject that would need more attention in future studies as well.

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Sexocorporel in The Promotion of Sexual Pleasure

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Sexocorporel is an encompassing view of human sexuality that considers all of the physiological, emotional, cognitive and relational components involved in a sexual experience. Developed by Prof. Jean-Yves Desjardins at the Sexological Department of the University of Montreal, Quebec, in the 80s, it has since been applied, taught and refined by sexologists in Canada and various European countries. The promotion of sexual pleasure is a central goal in Sexocorporel sexual therapy. To understand how this is achieved, we will take a closer look at its concept of sexual health.

Sexocorporel proposes a definition of sexual health based on the ability to experience sexual pleasure (Desjardins 1996). In sexology in general, the role of sexual pleasure is often astonishingly neglected. Research on sexual pleasure is barely beginning (Komisaruk 2010). Non-sexual pleasures consist of sensorial, affective and cognitive components (Kringelbach 2009). In Sexocorporel, the same components are ascribed to sexual pleasure, and conditions are defined for their optimal functionality in order to allow for maximum pleasure: (1) *physiological component*: the ability to raise one's genital sexual arousal to orgastic discharge using the body in an optimal way to permit hedonic (pleasurable) physical sensations; (2) *affective component*: the ability to perceive one's physical sensations during arousal and orgasm combined with intense hedonic emotions and emotional release; and (3) *cognitive component*: the ability to give positive meaning to the experience. In reality, these components closely interact, for didactic purpose, we regard them separately.

The Physiological Components of Sexual Pleasure

Genital sexual arousal feels good. This observation seems common sense, and yet it is not a given. Many of our clients seek us precisely because they don't experience it that way. Strangely enough, many sex therapy schools don't particularly take into account the actual genital reality of a person's sexual experience. In Sexocoporel, this is a core issue. Genital sexual arousal is based on an innate reflex. This reflex can be triggered by a great number of sources and stimuli. In male fetuses, it can already be observed intrauterinely. It causes genital vasocongestion, an acceleration of breathing, a heightening of muscle tone, as well as a number of concomitant changes of the autonomic nervous system. Once genital vasocongestion reaches a threshold, and through the influence of a number of factors not altogether understood, a second reflex-like reaction is triggered – the orgastic discharge, accompanied by spasmodic muscle contractions and followed by resolution. Since Masters and Johnson, this sexual response cycle has been described and researched in physiological detail. The mere process of the cycle in and of itself, however, does not give us any indication of the quality of the experience, nor, in fact, whether it is perceived at all. Particularly in women, genital sexual arousal according to laboratory measurements may not necessarily be felt or perceived as pleasant (Meston 1995). Genital vasocongestion causes sensations of warmth, tingling,

tension, pressure, moisture etc. Unlike vasocongestion in other parts of the body, these sensations can be perceived in a pleasurable way unique to genital sexual arousal. They are not, however, automatically perceived that way.

Clinical experience, as in the case of anorgastic women, shows that the ability to perceive them is acquired through practice. These women often start out with very little pleasurable perception of their genitals. They may consult with the very question: "Do I have a clitoris at all? I feel nothing there." The suggestion to practice repetitive stimulation of the vulva and vagina is a successful intervention. Neurologically, this repetitive stimulation of peripheral sensory nerve receptors leads to a development of corresponding synapses in the somatosensory cortex and in the brain's pleasure centers. Many women reach adulthood without having had much occasion, permission or even encouragement to play with their own genitals and develop such synapses. This is one of the reasons why difficulties with orgasm, particularly in partner sex or during intercourse, are among the most common complaints in women, much more so than in men, who from early age on usually have tactile and visual contact with their genitals and hence a better chance of developing certain synapses. But even men in their habits of self-stimulation often don't make use of the full neurological potential of their genitals and may find their arousal compromised in partner sex.

This leads us to a second important physiological reason for difficulties getting aroused with a partner or deriving pleasure from this arousal. Desjardins observed that humans tend to employ their bodies in preferred and repetitive patterns during sexual arousal that are likely to have an influence on the perception and the emotional experience of this arousal (Chatton 2005). He called these patterns the *sexual arousal modes*. Empirical data show that there are essentially 4 different types of arousal modes, with very different consequences for the experience of sexual pleasure. Desjardins noted that the acquisition of a particular arousal mode was the result of a learning process. Parental and pediatric observations and video materials demonstrate that infants at the very young age of 3-6 months are first able to elicit sexual arousal by applying rhythmic pressure to their genital and pelvic region. Yang (2005), Hansen (2008) and others described self stimulation in children as applying pressure to their genital region through muscle tension while performing stereotypical, "dystonia-like" movements of the torso, pelvis and legs, a stretching and tightening of legs and arms, accompanied by neurovegetative symptoms typical for adult sexual arousal, such as irregular breathing, grunting, sweating and facial flushing. In some instances, even spasmodic discharges were observed. The children were always conscious and could be interrupted in their activity. Neurological and other disorders were excluded – the children were all healthy and developmentally adequate. Authors and pediatricians concluded that this was non-pathological, normal infantile behavior.

Desjardins called this arousal pattern the *archaic arousal mode* – as it is the first one accessible to the human, even before the ability to perform targeted movements with the hand. A number of persons, women more often than men, maintain this arousal mode lifelong, at least during self-stimulation. Women apply pressure to their genitals or mons pubis or lower abdomen with a fist, fingers, objects such as pillows, lying on their belly or pressing against furniture, through crossing their legs and rhythmically or continually squeezing them together, and a number of other techniques that exert pressure on the pelvic region. Hands may or may not be used, however, muscle tension is always involved. Tension can be so important that muscles are sore the next day. Breathing is shallow or may be arrested. Likely, most women who believe they reach orgastic discharge through fantasies alone are unaware they actually exert an important degree of pelvic muscle tension. This type of stimulation always solicits deep nerve receptors as well as proprioceptors. A number of women combine it with friction of the vulva, soliciting superficial nerve endings (*archaic-mechanical arousal*

mode). Men exert pressure on their penis or on neighboring structures such as the perineum or groin, often by squeezing parts or all of the penis with hands or objects, lying down on it, bending it down and squeezing it between the thighs, or rubbing it using great pressure with fingers or fist. Again, stimulation is combined with important muscular tension. Typically, the archaic arousal mode is very efficient in augmenting arousal, and an orgastic discharge can be reached within seconds or minutes. If much pressure is used, in men ejaculation may occur with a soft or partially erect penis. The orgastic discharge is often rather brief and focused, and the ensuing release of muscle tension is perceived as relaxing and pleasurable.

It seems to be in the nature of the sexual arousal modes that people like to stick to their habits. A number of persons acquire different modes and are able to switch between them, more stay with what first worked well. In an Italian study, 30% of women and 21% of men in a non-clinical sample of 345 persons exclusively used the archaic arousal mode to reach orgastic discharge (Santarelli 1987). In a non-clinical sample of 1417 Swiss women aged 17-65, 47% used the archaic mode in masturbation, 19% used it during partner sex (Bischof-Campbell 2012). In clinical practice, the prevalence of an exclusive archaic mode is much higher, as it is the mode most likely to cause difficulties in partner sex: it requires the same type of stimulation as during masturbation in order to increase arousal. Women require intense, forceful penetration accompanied by high muscle tension, or a certain amount of pressure on their vulva, as can be achieved by grinding the pelvis against the partner's pubic bone, or pressing a hand against it, or favoring rear-entry penetration while prone on the belly, with the possibility to squeeze the legs together and augment muscle tension. Arousal problems and coital or partner anorgasmia are frequent with these women. Men may find the pressure exerted by a vagina or mouth on the penis insufficient and prefer anal intercourse, or use a hand to press on the base of the penis. Coital erectile dysfunction is common from a young age on. Both sexes may rely heavily on stimulation through fantasies, role plays and other mental sources of arousal because the physical stimulation through the partner is not intense enough to suit their arousal pattern.

More common is what Desjardins dubbed the *mechanical arousal mode*. It can be found in more than 50% of men and about 40% of women. Its principle is stimulation of superficial nerve receptors through rapid friction of the genitals – the vulva or clitoris, the penis or parts of the penis. The stereotypical rubbing motion can be done with little conscious investment, automatically – hence "mechanical". Stimulation may start out more slowly and varied, and increase as arousal mounts, to show its typical rapid uniform pattern during the last minutes of the arousal curve, where it may require a very precise ritual focused on precise anatomical spots, e.g. "3mm left of the clitoral hood, with just this speed and just that pressure". Typically, muscle tension also mounts, though to a lesser degree than with the archaic arousal mode. There may be an arching of the spine and stiffening of the pelvis, legs and abdomen, with interrupted, short breathing. Typically, during masturbation the body is very immobile while the hand does all the work. Sexual arousal is felt very locally in the area stimulated. The mechanical arousal mode is usually a very efficient method of self-stimulation that leads to orgastic release within a few minutes.

Again, during partner sex, a person narrowly focused on the mechanical mode will require physical stimulation in a very similar way. For heterosexual men, this may be intercourse with increasingly rapid thrusting motions of the whole torso "en bloc", possibly requiring a vagina that supplies sufficient friction, i.e. is sufficiently tight and not too moist. Some men may prefer anal intercourse for its greater friction. Some experience erectile difficulties after childbirth if the vagina has lost tightness. Heterosexual women focusing on clitoral stimulation in masturbation may find penile-vaginal intercourse not particularly arousing, unless additional clitoral stimulation is performed. With a very narrow arousal pat-

tern, they may require stimulation of a precision their partner, for lack of biofeedback, can't supply. Intercourse may even be perceived as disturbing to arousal. In women with a broader mechanical mode, manual and oral stimulation by the partner can be an easy way to orgastic release. As in the archaic mode, if physical stimulation in partner sex is experienced as insufficient, persons with the mechanical mode may focus strongly on stimulation through mental input, fantasies, role plays etc. Persons with a narrow mechanical mode may find partner sex strenuous because of the mental strain or physical exertion necessary to maintain arousal.

Individuals exclusively favoring vibrator stimulation can usually be allotted to the archaic mode, as their body reactions are similar. Vibrators solicit vibration receptors. Usually, muscle tension and pressure receptors are also involved. The same is true for stimulation via water current, such as shower or pool jets.

Both archaic and mechanical modes typically employ high muscle tension in the pelvic region, and often in adjoining parts of the body. They use little body motion and have restricted breathing. We will see later how this can be a limitation to the experience of sexual pleasure. The two remaining arousal modes, the *undulating arousal mode* and the *arousal mode in waves*, have in common great mobility of the body, deep breathing, and are accompanied by much higher levels of pleasure. Women with these modes were found to enjoy arousal, sensations in their body and vagina, and orgasm, while women with archaic and mechanical modes solely enjoyed orgasm (Bischof-Campbell, 2012).

In the undulating arousal mode, the whole body moves around its vertical axis in all directions, in voluptuous fluid motions of varying muscular intensity. Exteroceptive and proprioceptive nerve endings are stimulated that way in all of the body, without a particular focus on the genital region. The undulating mode comes with a high degree of pleasurable sensations. Respiration flows freely. Movements are often slow and deliberate, to obtain maximum pleasure from the motion and the contact. Correspondingly, during autoerotic activity many parts of the body are moved, touched and stimulated. Likewise, during partner sex, the whole bodies are in varying sensual contact. The undulating mode is not geared toward orgasm, as the state of arousal itself, even if not particularly high, is so pleasurable that it can be fully satisfying. Typically, as the undulating mode goes with rather lower muscle tone, we find this mode more in women than in men, whose muscle tone physiologically is higher. Some tantra schools employ comparable techniques.

The arousal mode in waves combines undulating movements *around* the vertical body axis with a coordinated movement *in* the vertical axis called the "*double swing*": the pelvis is tilted so the genitals move forward during expiration and backward during inspiration in a swinging motion (the "*pelvic swing*"). Simultaneously, (the "*upper swing*"), the head tilts backwards and the sternum collapses during expiration. The double swing movement thus includes the whole spine arching outward during exhaling and inward while inhaling, with the neck doing the respective opposite. The double swing is part of the inborn mounting behavior in a number of male mammals. In the human, it is obviously not genetically inscribed, but we can observe it in other reflexive actions involving abdominal muscular spasms, such as coughing, laughing, vomiting or sobbing. It is visible in all strong emotional expressions of infants, while most adults have learned to suppress it when laughing or crying. It may be experienced during the spasms of orgasm. Movements of the mode in waves are of varying intensity, amplitude and rhythm. They solicit superficial and deep sensitive nerve receptors in all of the body, with a focus on the genital and pelvic region, thus allowing one to steer the rise of sexual arousal both during self-stimulation and during partner sex to a powerful orgasm.

In summary, arousal modes influence the experience of sexual pleasure by being more or less well suited for partner sex. Our clients are counseled to practice variation in their self

stimulation in order to broaden their sensual (i.e. synaptic) repertoire and more easily nourish their arousal through the physical contact with their partner. E.g. the sensitivity of the vagina can be augmented through repetitive touch, rendering penetrative sex more pleasurable for the woman, or a man can learn to stimulate his penis more slowly and gently to mimic the softness of the vagina during intercourse. Another relevant influence of arousal modes on sexual pleasure arises from their varying degree of muscular tension, breathing and movement. As this is so important but little known, we shall explore it in detail. Specifically, tonic (=continuous, as opposed to phasic) elevated muscle tension inhibits the experience of sexual pleasure in several ways: by influencing afferent sensory neurons, the blood flow and the autonomic nervous system.

Muscle Tension and Afferent Neurons

Elevated muscle tension invokes a strong stimulation of proprioceptive and deep sensory nerve endings, while it inhibits the perception of superficial stimuli. This can be easily explored by caressing one's forearm, once with the arm relaxed, and once with the fist clenched. The same type of caress will be perceived differently, particularly if it is "limbic touch". This slow and light caressing bypasses the somatosensory cortex and directly elicits pleasurable feelings in the left anterior insular cortex. It regulates emotional and hormonal responses and is believed to directly promote bonding with the touching person. Receptors are only found in hairy skin, and afferents are unmyelinated (Löken 2009). They react only when stroked at a particular speed (ca. 2 - 8cm/sec), and only that type of caress was associated with pleasure and wellbeing by test persons. Conversely, persons with a high muscle tension arousal mode, particularly the archaic mode, associate this touch with unpleasant perceptions. Possibly, the neurological input of high muscle tension blocks that of limbic touch, perhaps similar to the ways it blocks pain. The individual finds it ticklish and generally tries to avoid it. Some persons who "can't stand" tender caresses have been falsely psycho-pathologized with an incapability of bonding or "emotional frigidity", when in fact their only problem is the habit of tightening their muscles once they're aroused. This is an important example of the body-mind unity, and how what we do with our body can influence our emotions and social interactions. The ability to enjoy limbic touch and other caresses is learnable via modification of muscle tension.

Perhaps through similar mechanisms, elevated muscle tension in the chest, diaphragm and abdomen seems to inhibit superficial sensory nervous input from more distal body regions such as the genitals. Consequently, the sum of "hedonic input" is reduced, and the pleasurable experience is reduced. In some individuals, even the ability to raise arousal to orgasm is impaired if the diaphragm is blocked.

Muscle Tension and Blood Flow

The strong tonic pelvic muscle contraction in archaic and sometimes mechanical arousal modes inhibits the *diffusion* of sexual arousal. Let us keep in mind that elevated pelvic blood flow and genital engorgement are what feels warm, tingly, pleasurably sexual during arousal. Many striated muscles are stronger than systolic blood pressure and will stop the arterial blood flow within the muscle during forceful contraction.

Consequences are:

a) Instead of muscles engorging with blood and thus augmenting the pleasant feeling of sexual tension in the pelvis, muscular ischemia and concomitant biochemical reactions ensue that become unpleasant if contractions go on for too long.

b) Tonic muscle contraction also inhibits the blood flow to neighboring organs such

as the lower third of the vagina, inhibiting vaginal engorgement and lubrication. This explains why some women even at high arousal can't sufficiently lubricate. Also, lack of vaginal engorgement inhibits the vaginal tenting necessary for the perception of an inner vaginal space and the desire to be filled – a prerequisite for coital sexual desire. Instead, the vagina may be perceived as no space at all but something solid, a "clenched ball" or a "solid tube", as some women describe it. In some older men or men with vascular problems, tonic pelvic muscle tension seems to inhibit blood flow to the penis and can cause erectile problems.

c) If vasocongestion is confined to the outer genitals because blood flow in the inner pelvis is reduced, the area that feels pleasantly aroused stays very small and focused – just the penis, or just the clitoris. Arousal becomes a local and reduced phenomenon – as opposed to a body in fluid motion where increased blood flow is pleasantly perceived in the whole pelvis and other body regions. Likewise, an orgastic release is experienced as comparatively "small" if it involves just a tiny area, as opposed to larger parts of the body. Persons with an archaic or mechanical arousal mode tend to describe their orgasms as "nice", "brief", "like a good sneeze", and mostly enjoy the ensuing muscular relaxation.

d) Arousal confined to a small area of engorgement is very sensitive to disturbances: if proper stimulation is interrupted just briefly, what little vasocongestion there is can quickly drain – and arousal is lost. Women who need a very precise stimulation ritual or get easily distracted can be found in this category, as can men with erectile difficulties after a certain age.

Muscle Tension and The Autonomic Nervous System

Tonic muscle tension inducing ischemia seems to lead to an activation of the sympathetic nervous system going beyond the sympathetic activation necessary for sexual arousal. Too highly elevated sympathetic stress is detrimental to sexual arousal and pleasure (Ulrich-Lay 2010).

Tension of abdominal and pelvic muscles blocks the movement of the diaphragm. Breathing becomes shallow and rapid. This type of breathing activates the fight-flight-freeze branches of the autonomic nervous system, in a way that is not conducive to experiencing sexual pleasure. Once this breathing has set in during arousal, the need to reach orgastic discharge becomes powerful. With general hypoxia setting in due to generalized muscle tension, the body is in a veritable emergency situation, and release becomes a vital urgency. Persons experiencing this during their sexual arousal tend to aim for a rapid discharge – with the archaic mode, it can be after 30 seconds, with the mechanical mode after few minutes. There is no motivation to prolong sexual arousal, no pleasure in its increasing, only the anticipated pleasure of the discharge, the ensuing relaxation and re-oxygenization that constitute the main sensual joy of the whole act. Behind many cases of rapid ejaculation lies a mechanical mode, aiming at ejaculation and with little ability to enjoy the way there. These men may want to last longer for the partner, unaware that they themselves can gain pleasure from learning to slow down.

In summary, elevated tonic muscle tension, as can be found in a considerable number of people during sexual arousal, inhibits sexual pleasure physiologically in a number of ways. It is not, however, expedient to advise general muscle relaxation. While this can help to enjoy the experience of limbic touch and other exchanges of tenderness, it is not conducive to sexual arousal. Full relaxation of pelvic muscles usually interrupts the arousal reaction and resolution ensues. We are therefore confronted with the question of how to give the body the muscle tension it demands, while avoiding negative effects of tonic tension. The answer, obviously, is phasic muscle tension. This is best obtained through movement. Movement can

create important tension in certain muscles, while simultaneously relaxing the antagonists. In the undulating arousal mode, it is this principle that leads to elevated and prolonged states of pleasure. Since, in this mode, there is no particular focus of phasic muscle tension in the genital region, reaching orgasm becomes difficult or impossible. In contrast, the pelvic swing movement of the arousal mode in waves involves muscles that favor blood flow to the genital and pelvic region: the psoas muscles, lower abdominal muscles, and the pelvic floor. It serves to raise genital sexual arousal, while keeping the whole body in motion. For that reason, it is particularly well suited to physiologically provide a maximum of pleasure during sexual arousal and orgasm. Our clients are instructed to practice the movement until it becomes automatic and then use it during sexual arousal, along with deep abdominal breathing and undulating motions of the whole body – alone at first, and, once proficient, also during partner sex. It must be kept in mind that arousal modes are trained patterns that aren't easily changed. Therefore, clients must be warned that their arousal will be impaired when they first try.

The Emotional Components of Sexual Pleasure

A central problem in research on the emotional components of sexual pleasure is that people, when asked what they find pleasurable about sex, are likely to give hundreds of different answers, ranging from the physical, sensual joys to happiness with its bonding and love promoting properties to gratification of narcissistic needs (Meston, Buss 2007). Therefore, what one person considers sensually lousy sex may be highly gratifying to another because of its emotional implications. If we take a closer look at the emotional implications of sex, we find two major categories: 1) security, fusion and affirmation of the relational bond: Sex is pleasurable because it shows me he loves me / we can be really close / our relationship is celebrated / I am safe with her / he won't leave me, etc.; 2) narcissistic gratification: Sex is pleasurable because it shows me I am a sexy man or woman / I am desirable or lovable / I am sexually competent, etc. While these are important properties of the experience of the sexual act, they are not directly dependent on its quality. Instead, their pleasure-enhancing properties rely on a number of personal and relational influences that are prone to change, such as the current need for validation, the quality of the relationship, etc. Sex may be experienced as highly pleasurable in a new relationship precisely because it is proof of one's desirability and of the exciting new bond developing. The emotional biochemistry of new love is so powerful it can elicit sexual arousal and orgasm. After three years of marriage, however, biochemistry is back to baseline, the bond is well established, and we know beyond satiation that the other desires us. Such emotions are highly volatile and therefore unreliable in promoting sexual pleasure. Some forms of therapy aim at rendering them more reliable, others suggest role play and similar strategies to get the emotional tension back into the sex. Sexocorporel aims at enhancing the intensity of the emotional experience, be it amorous, in search of security, or self assertive, through corporal means and by enhancing the sensual hedonic quality of sex.

A core axiom of Sexocorporel is the neurophysiological unity of body and mind, and in particular, the fact that we perceive our emotions through somatic sensations; e.g. anxiety can be felt through a tightness of the chest, joy may be a "bubbly feeling in the stomach". Modifications on the level of the body can elicit or modify emotions – try deep abdominal breathing at a moment of anxiety, and through suppression of the sympathetic and stimulation of the parasympathetic nervous system, anxiety will go down just as much as you can amplify it inversely by contracting your chest and taking rapid shallow breaths, really getting yourself into fight-or-flight mode. Mobilization of chest and diaphragm play a central role in the promotion of sexual pleasure, as, through the autonomic nervous system, they help the

brain move from a hyper-attentive state into a state of slightly reduced vigilance that is essential for the experience of pleasure and letting go.

Furthermore, the intensity of emotions can be amplified by greater mobility in the chest, neck, jaw and mimic muscles. As a simple experiment, try a yell of enthusiasm that you put your whole body into. Then do the same yell with a clenched jaw, freezing your chest, neck and facial expression. It will not feel the same. Persons in archaic or mechanical arousal modes show muscular rigidity in the upper part of the body at high arousal and at the point of no return. The emotional intensity during arousal and the spasms of emotional release during orgasm are restrained through this rigidity. Interestingly, some persons release their emotional tension *after* orgasm, through spasms of sobbing or laughter. This is another way to let go, but it seems preferable to experience a voluptuous kind of emotional intensity during sex instead of a tearful one after. The upper swing movement of the arousal mode in waves can accomplish this. It is often somewhat harder to learn than the pelvic swing. A person having acquired the double (upper and pelvic) swing movement during sexual arousal will find both solitary and partnered sexual experiences to be of a greater physical and emotional intensity. In particular, feelings of relatedness with the partner, self confidence and masculinity/femininity are enhanced, and the whole sexual act is perceived as sensually pleasurable, not just its culmination in orgasm (Bischof-Campbell, 2012).

The Cognitive Components of Sexual Pleasure

The way you think about a sensual experience, the ability to give positive meaning to it, is a key cognitive component of pleasure (Leknes 2008). Cognitions have powerful top-down regulatory ways to amplify or dampen pleasure (Kringelbach 2009). Imagine sitting in a movie theatre with your aspired future love, and the mere coincidental touch of your desired one's arm sends shivers of excitement and promise down your spine. The same touch by a random but repulsive seat neighbor will not only have a different meaning, but will *feel* differently and cause other neurovegetative reactions. Behind this lies an unconscious decision process of how to subjectively interpret the situation, based on a certain knowledge about the possible threats and rewards of this experience. Such learned cognitions regarding sexuality include explicit cognitive predictions such as messages conveyed by the parents, as well as implicit, not necessarily conscious knowledge. Knowing that genital stimulation feels good is mostly due to simple associative conditioning: the repetitive experience of positive sensorial input leads to positive reinforcement. Simply put, experience teaches me that something, i.e. masturbation, is good for me. Infants, as we have seen, work on this cognition from early on. Cognitions, furthermore, also elicit their influence through beliefs that aren't based on experience, as we know from the placebo-effect: it suffices to "believe" or "trust" something will be good for me, and reward mechanisms in the brain are put into action linked with the expectation *and the experience* of benefit (Esch and
Stefano, 2005).

Conversely, believing something is bad for me can elicit an unsavory experience. As in many societies knowledge and beliefs regarding sexuality are skewed, messages about sexual pleasure tend to be more of an aversive or punitive rather than an encouraging nature. The expectation of shame or punishment interferes with giving positive meaning to the experience of sexual pleasure. Commonly, clients experiencing problems with sexual pleasure have great shame or just can't picture themselves as sexually fulfilled individuals. Importantly, persons using the archaic or a narrow mechanical arousal mode are more likely to struggle with feelings of guilt and negative cognitions about sex than persons with a moving mode. In the Swiss study, sexual assertiveness and pride about their own genitals were directly linked with

the amount of movement and variation the women used during sexual arousal (Bischof-Campbell 2012).

In therapy, cognitive approaches giving information and permission alone often are not sufficiently effective in breaking through the barrage of negative beliefs that may have been acquired very early in life. Therefore, in addition, Sexocorporel treatment strategies focus on inducing sensual experiences that trigger positive physiological reactions and thus induce positive cognitions. The repetitive experience of pleasurable sexual arousal challenges and is likely to modify negative beliefs. We invite the client to repeatedly practice conscious and varied genital stimulation along with the double swing during autoerotic activities. Invariably, clients find their negative cognitions dwindling. The personal physical experience of "nothing bad happening", and the triggered reward system convey a far more powerful message than the most sophisticated arguments of the gifted therapist: this feels good, therefore it is good.

In summary, Sexocorporel sexual therapy makes use of the unity of body and mind by influencing perceptions, emotions and cognitions through somatic modifications. It is aware of the existence of different sexual arousal modes – acquired patterns with profound consequences for the experience of sexual pleasure. It makes use of the plasticity of the brain by inducing new stimulation and movement patterns (the double swing). Based on a concise clinical evaluation of all physiological, emotional, cognitive and relational components comprising a client's sexuality, therapy promotes sexual pleasure by inducing individually adapted variations in stimulation, movement, muscle tension and breathing that lead to a greater sensual hedonic input, a greater emotional intensity and release, and a greater ability to give positive meaning to a sexual experience.

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The Origin of Sexual Arousal

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"More than anything else, arousal is what drives good sex. It is the spark. It is also the cornerstone of a sexuality based on pleasure rather than on performance. If you want more exciting and more satisfying sex, go the greater arousal."
Bernie Zilbergeld (1992).

A challenging question is why most of us are attached to specific turn-ons? What do our specific arousals reveal about who we are and what we're searching for? Why are certain people, images, and situations so much more stimulating to us than others? So far this has been discussed and studied surprisingly little in sexology.

Erotica and Arousal

Many professionals argue that top-grade arousals are the outcomes of eroticism. Eroticism can be understood as the multifaceted process through which our innate capacity for arousal is shaped, focused, suppressed, and expressed. We're borne sensuous and sexual, but we become erotic as we receive both overt and subtle messages about ourselves from our primary caretakers. Gradually we integrate these messages with our experiences of touch, as well as the highly personal mental images and emotions that go with them. Eroticism is the process through which sex becomes mentally meaningful.

Erotica includes the origin of the attraction between people. It is a fascinating journey into our dreams – it is a dream and promise of the desired intimacy and pleasure. Erotica is associated into sexual fantasies: it is foreplay for sexual arousal. Eroticism has even been argued to introduce spirituality into sexuality. It makes beloved feel an ideal target for our sexual desires and a perfect activator of our personal sexual needs.

Eroticism is the interaction of arousal and different challenges of living and loving. Each person learns gradually to associate particular kinds of obstacles with the heightened excitation. Associations that are sufficiently compelling are likely to be repeated, solidifying the connection still further. Many persons are more interested into great sexual challenges than to any easy pleasure.

An attraction pulls you toward the object of your desire. But this fascination comes up against one or more obstacles to overcome. This is actually a requirement for a truly compelling erotic response. We are the most intensely excited when we are a little off-balance, uncertain, balanced on the dangerous edge between ecstasy and disaster. Some fear that looking too closely at their attractions might dampen or destroy them. However, most people find that exploring their attractions deepens and enriches them. An ideal attraction is both lusty and romantic.

One of the most effective and enjoyable ways to unlock the mysteries of the Eros is to recall about your most compelling turn-ons. During the moments of high arousal the crucial elements – your partner, the setting, and perhaps some attractive twist of

luck – all mesh like instruments of an orchestra, producing a crescendo of passion. Look closely at peak turn-ons and you certainly sense that something close to the core of your being has been touched. These moments reveal an enormous amount about how your eroticism and self works.

Psyche and Arousal

Mind sets sexual interests and desire and starts up the processes for sexual arousal both at unconscious and conscious level. Strong arousal guarantees first-rate sexual experiences. A big question is if we are willing, and do we dare, to study and understand the true content and character of our arousals?

The core of our sexual interest derives from how we were liked, caressed and cherished as a child. Another determinant is how child's sexual curiosity was permitted or restrained by parents and was he/she taught to be afraid of pleasure. This affected the view and experience of the sense of the body and the individual value, in other words, sexual self-esteem. This all influenced to the capability to give and to receive admiration. A great number of persons have problems to confide that somebody can truly desire them sexually.

Sexual excitement and arousal is often a window into the deepest levels of our psyches and the deepest sources of our suffering and pleasure. Our imaginative power of the mind transforms our biological imperatives into the actual experience of sexual pleasure. Sex begins in the mind and then travels downward.

Sexual excitement and arousal requires that we momentarily become selfish and turn away from concerns about the other's pleasure in order to surrender to our own, that we momentary stop worrying about hurting or rejecting the other person. Anything that promotes worry or guilty over the other's welfare will diminish personal excitement and arousal. There needs to be a tension between selfishness and caring, and between using and pleasing the other. Familiarity may well promote intimacy, but it can also worsen the human tendency to worry and feel guilty about our loved one.

Intensity and quality of sexual desire is a subject of personal sexual self-esteem and how person feels him/her approved, valued and desired and how much he/she allows him/her be sexually selfish. High desire requires an ability to be present consciously while utilizing a full capacity of senses, and possessing an adequate mental vigor. The person has an ability to become predisposed to sexual stimulus in specific situation and ability to get aroused of it; in short, the situation suits fine with person's sexual script.

At heart of lusty attraction lies in the desire for sexual excitation and orgasmic release. It can be profound, utterly meaningless, playful, loving, or hostile. In most intense forms lust has an animalistic quality that can be exhilarating, frightening, or both. When you're feeling lusty your attention is focused primarily on whatever it is you want that produces and intensifies sensations of arousal, especially in the genital.

The Role of Sexual Stimulus

When it comes to sexual arousal, psychology makes use of biology. We often react into the complex sexual stimulus around us. No exciting picture, position or behaviour is automatically arousing. One person may get turned on by a particular picture or body type, while another person finds it boring. Same stimulus can evoke different responses.

One can get aroused merely by thinking or with help of mental images (often fantasies), but usually one needs for arousal some stimulation of senses. Arousal occurs when we can realize our fantasies or if other person's physical appearance is equivalent with our favorite image. Before arousal we estimate how well the potential partner suits with the sexual fantasy into which we try to adapt him/her. We focus into what we desire and into reinforcing the feeling of arousal.

Sexual fantasies are all the time at our disposal. Sexual fantasies are like microchips in which complex information is reduced and contained in a tiny and almost invisible space. Fantasies are like daydreams, mini-narratives that we use to generate excitement. Our fantasies convince us that we're not going to harm or betray anyone, and that if we get fully aroused, no one will suffer. Sexual fantasies always find a way of turning the "no" into the "yes" of pleasure.

In many cases sexual fantasy and arousal result from an unconscious attempt to solve previous problematic issues. We prefer enacting certain scenarios in bed because the details of such scenarios play a highly symbolic role in counteracting certain psychological forces that hold back our desire. They may be certain positions, seductions, verbalizations, aesthetic contexts, states of undress, or role-plying.

Pornography represents both a cause and effect of sexual fantasy. It is consumed only to the extent that it reflects the sexual preferences of its consumers. At the same time it provides images that these consumers then incorporate into their fantasies. Men's fantasies are more likely to be voyeuristic, while women's are more exhibitionistic.

Underlying causes of our pleasure are the same as they are in our most private daydreams. We are automatically scanning other people in our environment and looking for a possible match for our dreams. We are constantly, but subliminally, reading other people for cues that might interest and please us. Our unconscious mind is very fast in this assessment process. Some call this in positive cases as love at first sight.

When you see someone who looks sexy, it seems as if that person is making you feel aroused, even though the source of arousal is your own mind and body. The sexy other is simply a stimulus and an object of our desire.

Foundations of Sexual Fantasies

For many people sexual fantasies are the most hidden part of the sexuality. They stimulate and improve sexual feelings. They also allow to transform problematic experiences for strengths of which person can get pleasure. Fantasies can reveal our fundamental hopes and dreams; they provide chances to experience something new. Fantasies can be memories or images – generally they are actions of the imagination. Sexual fantasies are mental images which are erotically or sexually arousing. They help to identify environmental cues or signals as sexual. They are a window to the deepest levels of mind.

Sexual fantasies allow neutralizing beliefs and feelings that disturb sexual arousal. Fantasy warrants or guarantees a safe pleasure. In our fantasies we can freely objectify our partner, we can get aroused thanks to our selfishness and we can be sure that nobody will suffer therefore that we are fully aroused. One essential feature of fantasy and arousal is concept of identification. It is a feeling and idealization of the fusion with another person.

Typical sexual fantasies are conventional intimate images of lovers who are familiar with each other. Other popular fantasies include:

- Warming-up again some exciting sexual experience.
- Images of person's I resistibility and of seductive sexual power games.
- Images of "forbidden" sexual issues.
- Scenes of submission and dominance – use of force and sadomasochist.
- Image of sex with somebody else during the love making with the partner.
- Men are more often performing something to somebody – women are more often objects of the action.

Sexual fantasies have often their roots in feelings of guilt and shame. Guilt involves beliefs that we're hurting others, while shame involves beliefs that we're exposed and unworthy in the eyes of others. Guilt arises when we reject others; shame when we feel rejected by others. If we dislike ourselves or expect others to do the same, it is difficult to feel worthy of feeling either sexual desire or sexually desirable. We all have pathogenic beliefs that we are unworthy, also sexually.

Because shame and rejection are common experiences, many common sexual fantasies function to negate them. Solution to the problem of shame can be fantasies about genital worship and exhibitionist scenarios in general. For a man, the striptease is exciting because it features a woman who is shamelessly proud of her sexuality and body. In this spirit the man can free himself from his own sexual inhibitions.

Selection of popular sexual fantasies is affected by feelings that are associated with the experiences of childhood and youth.

- Guilty is relieved by fantasizing of several simultaneous partners – it compensates weak self-esteem that may include that person does not deserve to become desired and loved.
- Shame can be worked and processed with fantasies in which a partner can't help desiring oneself – or he/she is completely mad of our body.
- By fantasies that associate to fetishes person eliminates guilt's and worries that prevent sexual arousal.
- Feelings of helplessness and powerlessness are processed by fantasies of domination – mind will become free by feeling of helplessness – a person feels him/herself valuable enough to get all that attention.
- Many women try to withdraw their feelings of guilt by fantasizing of sexual coercion or rape.

Anxiety intensifies arousal by contributing to a generalized state of physical excitation. All forms of excitement, sexual and nonsexual alike, increase muscular tension, blood flow, and heart and breathing rates. Consequently, the body responds similarly to anxiety-provoking and sexually rousing situations. The cycle of attraction, guilt, excitement, remorse, and attraction is what makes many illicit affairs seem irresistible.

If we want to alter our sexual fantasies, we have to first eliminate the shame surrounding them. The main reason that sexual fantasies and preferences don't tend to change much, even as the motives for their creation do, is because they're pleasurable. Often feelings that inhibit the capacity for sexual pleasure have to be overcome by sexual fantasies.

The Core Erotic and Sexual Theme

Our most compelling turn-ons are shaped by a unifying scenario that can be called the core erotic theme (CET). It occupies a place at the heart of each individual's eroticism. CET begins its long evolution during childhood and is first sketched out in fantasies and daydreams. Also sexual stories and pornography can provide these shortcuts. It links today's compelling turn-ons with crucial challenges and difficulties from your past. It is a process how to create mentally arousing sexual scripts and a hidden formula into excitation and pleasure.

The core sexual theme evolves as a counterpart to challenges and possible conflicts in early phases of life. An objective is to confirm personal value, attractiveness and to become desirable. Self-esteem is reinforced when the profound personal desire is satisfied. Obstacles to realize the core sexual theme stimulate sexual desire and arousal. Balancing between safety and risk or danger brings sexual arousal as well as the forbidden nature of the relationship.

The core theme of sexual arousal includes what kind of mental images, situations and partners produce strongest and most intensive sexual, genital and psychic responses and reactions. This helps to select a partner. When one finds counterpart to this core theme in a real world, then a sexual peak experience comes true. It is worth exploring the dramatic elements of your strongest attractions as well as the features of real-life encounters that produce high levels of arousal.

Sexual Partner and Arousal

New lovers are both merged and highly separate. They feel merged because of the intense identifications that accompany falling in love and separate because their real lives are not yet interdependent. Because of the actual psychological distance each person can safely throw him or herself into the other's experience, including the other's sexual experience, without the risk of losing him of her in the process. The subjective intense feeling of union is with an idealized version of the other person, not with the whole person.

Whereas lust's primary objectives are arousal and orgasm, romantic attractions always include a craving for a mutual passionate bond with the other person. Nevertheless, both men and women crave opportunities to be responded to as sex objects. In a society we spend billions of euros and untold hours trying to make ourselves attractive sexual objects.

Men definitely tend to objectify women, but they do so in order to preserve their masculinity not primary to hurt women. Women definitely prefer sex in the context of love, but the purpose of this preference is to diminish their guilt as much as it is to establish a higher form of intimacy. Couples often unconsciously arrange to have arguments to begin with in order to create emotional distance. Sexual excitement can then safely emerge and help the couple re-establish a connection.

To objectify is to recognize the desired one as the other, to see clearly that he or she is outside oneself. This quality of otherness is absolutely essential for attraction. That person is invested with sufficient value to make him or her worthy of pursuit.

One consequence of the greater sense of psychological distance in the beginning of a relationship is the enhanced capacity for sexual ruthless or remorseless. It includes the dimension of sexual excitement in which we are entirely selfish and not concerned

about the excitement or well-being of our partner. It enables a person to surrender to the full force of his or her own rhythms of pleasure and excitement without guilt, worry, or shame of any kind. Without such ruthless we become enslaved to the feelings of the other person and can't get maximally, or sometimes even minimally, excited.

Longing is an important source of sexual arousal. Longing or even yearning for somebody represents a certain kind of fantasy and romance of that person. It is like a gap between desire and reality while longing we are without something meaningful. Also teasing renews longing, it is like a play to generate arousal sensually. Paradoxically cohabitation makes it difficult to long for a partner who is so much present.

Maintaining Sexual Desire in Long-Term Relationships

Maintaining of intimacy and adequate arousal can be promoted by objectifying other the target of desire. He/she can be recognized a separate human being of oneself and this detachment makes possible to treat other person as a sexual object. Feeling of differentiation enables bold sexual action and"selfish" arousal. Person can surrender with all his/her powers to become carried away by his/her sexual desire and pleasure - this ensures a maximum arousal. The more "perfect" you sense your partner the more your own sexual value increases.

Maintaining sexual desire in a long term relationship requires finding a balance between individuality and commitment.

- Maintaining own identity and differentiation while staying in intimate relationship with another.
- One does not need to be afraid to become rejected or fall into too much dependent.
- By means of disputes is created emotional distance that will increase sexual passion – relationship is at the same time safe but exciting.
- Sexual desire lives in the unknown world that is created by differentiation.

You presumably want that the charm of your partner has an impact on you. Therefore it is your duty to be actively responsible and to open keenly your eyes to the beauty of your lover. The greatest enemy of charm and attraction is a tendency that a person no more pays attention to this matter. Invisibly partners can't surely feel charming. Erotic partners learn to look at their beloved with fresh and admiring eyes.

Seduction of the partner ensures a continuing sexual desire with the partner. By seduction a person can increase partner's desire – that has first emerged in itself.

- Seduction means initiativeness, intensity and dominance – with seduction person can express the target and power of his/her desire.
- The target of seduction feels him/herself charming – seduction renews and increases partner's feeling of his/her charm – he/she feels him/herself more beautiful and self assured and that he/she has erotic power over the seducer.
- Seduction is an ability to generate to the partner actual dreams – which can help to carry out both own and partner's wishes and plans.
- Seduction of the partner and creation of intimacy still again is possible by improving own skills and by having a courage to implement them into action – every day.

Peak Sexual Experiences

In the most compelling arousals all fragments of the moment go together well in the mind. In these sexual peak turn-ons a person is fully present in the situation and entirely alive. These moments touch the core of our existence – they are person's self-actualization at its best. These special arousals include balancing feelings between the desired and promised ecstasy and the threatening destruction. A person is excited while breaking the prohibitions and facing the risks. It allows him/her to feel oneself "naughty".

During peak sex your body and all its senses spring to life. Without your inborn capacities to receive and process sensual stimulation, to build up muscle tension as you become aroused and to release it through orgasm, eroticism as you know it could not exist. You feel so much more because you become totally absorbed in whatever is turning you on while screening out all extraneous stimuli. You might think of this narrowing focus, an altered state of consciousness, as a "sexual trance". It is not unusual for men and women to be surprised by their own sexual capabilities and stamina.

During peak experiences the body tends to release its rigid postures as all emotional concerns spontaneously evaporate. Somehow you're able to revel in the joy of the moment and celebrate your childlike freedom. This includes letting go of inhibitions, becoming playfully experimental, or highly expressive.

The very same peak experiences that generate so much knowledge of the inner logic of your eroticism are also valuable hints of your core erotic theme. When you recall arousing experience and you assess its fascinating details and shivering feelings try to elaborate yourself an idea why these experiences were so exciting. Analyze this issue comprehensively and you presumably find some sensible memories of one or more prevalent problematic issues.

Sexual Arousal Is a Resource for Life

We can use sexuality and sexual arousal as a resource in our life. Arousal drives good sex and pleasure. The moments of highest arousal are windows to the deepest levels of our psyches. They include what is called the personal core erotic or sexual theme and a process how to become highly aroused, and finally, how to experience peak sexual experiences. In peak sexual experiences a person is mentally, sensually and bodily fully present.

A challenging question is what are we possible afraid if we reveal our sexual core issues to our partner? Actually we have a big chance to gain something important and pleasuring to our life. Ideally the relationships should be an open door to the unknown world. That keeps relationship stimulating. Sexual mind is skillful to observe sexual stimuli and to create arousing moments.

Good relationship is cultivation of intimacy that, however, respects privacy. It means that separation and presence alternate along the progress of the relationship. When partners have anticipation, they long for each other and there is a need to wait for a partner. Sexual arousal is likely when they meet each other. Sexuality also becomes effective with help of imagination.

Seduction is the essential skill in relationships. It increases desire and arousal and sets shared dreams. The key to continuing sexual interest and arousal is to tell to your partner how unique he/she actually is. We all love to hear it from our partner.

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Addressing the Disturbed Like Ripples in Water, Networking for Children Who Transe

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Foreword

Any self-respecting society should offer a welcoming home for all human talents, and at the same time offer guidance in order for these talents not to be expressed in violent and/or abusive ways The first is a precondition for the other.

Many individuals and groups are not welcomed in many different societies. The basis for rejections range from sin and crime, to illness and "degeneration", disorder and claims of non-existence. Individuals and groups are being targeted on grounds of religion, ethnicity, colour of skin, shape of body, family of birth, talents of eroticism, talents of attraction, talents of gender and so on for far too long.

There are numerous shades of unwelcoming cultural acts and strategies. All of them nevertheless seem to have one endpoint in common: The unwelcomed are offered no positive belonging in the societies in question.

Belonging

In 1968 Maslow ranks "love and belongingness needs" in the middle of his motivational hierarchy (Maslow 1968). In their explorative overview article of 1996, Roy F. Baumeister and Mark R. Leary reach far in proving the need to belong as a fundamental human motivation. According to them, a failure to satisfy a fundamental motivation should amongst other consequences, produce ill effects that go beyond temporary affective distress. A motivation can be considered to be fundamental only if health, adjustment, or wellbeing requires that it be satisfied. They show that human beings have a strong fundamental desire to form and maintain enduring interpersonal attachments (Baumeister & Leary 1996). That, I presume, should be recognisable to many.

Where there is no belongingness, there will be suffering and more or less successful attempts to acquire a sense of belonging. In our clinical work we all too often meet individuals who in distress express: "I feel that I belong nowhere!" (Almås & Benestad 2002).

While Baumeister and Leary link belongingness as a state reached through enduring interpersonal attachments, where the only prerequisite is to be human, we see that that it is not sufficient. Questions concerning what kind of human being you might be, seem basic for most individuals and groups before belongingness can be "granted". The state of belonging is reached through different qualities and abilities linked to being human. We need not merely to belong, we need to belong as something: As sexologists, as therapists, as Norwegians, Scandinavians, Europeans; as Christians, Muslims, Jews, Hindi, Buddhists; as normal, skilful, beautiful; as girls, women, boys, men; and

in the most advanced relations: As transpeople, intersex people, sex-dismissers, personal genders or eunuchs.

Belonging must be linked to numerous interpersonal frameworks of attachments. One common denominator for these attachments could be expressed as a cultural greeting of welcome to all human qualifications, abilities and talents.

Background

1. The author (hereafter: I) of this chapter has over the years become both a well-known sexological professional and transperson in Norway.

A long lasting and at times massive, exposure to the general Norwegian public has seemingly increased the level of transpositivity (Raj, 2002) in the Norwegian population. I am regularly stopped by people who want an autograph, who want their picture taken with me, or want their babies to be pictured in my lap.

To the extent that increased transpositivity can be viewed as a change to the better, all my exposures of both professional and entertaining motives, have resulted in what I call "third order of therapy" (Benestad, 2010).

One consequence appeared several years ago. A parent couple contacted me on behalf of their 9 years old "son", a son that since the age of three, had insisted that "he" was a girl. The parents had done their best to convince their child to "the contrary", but to no avail. By and by they had realized that the more they refused their child's wishes for unusual gendered expression, the sadder "he" would become. Now they wanted the assistance of a professional who they, through the powerful means of media, had come to respect. Mother said: "*We understood that even if our child is really a girl, this is compatible with a good life!*"

I have since met and worked with a number of families with children who express gender differently from other kids. I have been contacted by their parents, their other peers, some times by kindergarten and school officials, some times by health professionals, some times by friends of the family, and at times by the kids themselves. When the child mentioned above learned about me, she sent a letter decorated with hearts and stars to "Esther Pirelli, Grimstad". The letter found me. She wrote that she needed to meet me.

My way of responding to these needs were developed in meetings with this first family and has over the years clinically proved extremely efficient in relieving the pain involved when a child does transe. I apply the latter term in order not to label the child with concepts from the adult world, concepts that have a tendency to lead individuals on to one particular way of displaying their gendered talents. Likewise I never use terms like "born into the wrong body", since I find these terms apt to strengthen the body alienation experienced. I was also inspired by one transman's own words: "I never say about myself that I was born into a wrong body, because if I had been born into another body, I would not had been me!"

The basic question for all is:
What about our little Bess
who never wants to wear a dress,
and what about our little Ron
who loves to put the dresses on?

Children of variant gender are in general not positively valued in Western societies. On the contrary, they are most often met with resistance ranging from violence through silence to pathologization.

2. From the very start of these experiences I had some basic knowledge of children who transe, and this knowledge has not been changed while I have been working on behalf of their needs.

The frequency of the phenomenon exceeds by far the frequency of transpeople in the adult population. Still children who transe consequently over a period of more than six months according to ICD10 or DSM IV criteria, are awarded a diagnose of "Gender Identity Disorder in childhood" (GID). Nevertheless, a number of children, as they approach the age of puberty, lose interest, seize to transe and are no longer disordered. (Cohen-Kettenis & Pfäfflin,, 2003).

There are no scientifically validated methods to separate those who continue their gender variant behavior from those who don't, before the change actually happens. Even though there are indications that the more profound the cross gender identification, the more probable is a continued transgendered career (Wallien et al, 2007 and 2008). This implies a substantial challenge when deciding whether or not any kind of treatment does or does not affect the child's behavior and concept of self. Thus far no proof exists that any kind of clinical intervention can change these children's ways of expressing themselves (Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis et al 2008).

There are substantial grounds for believing that variant gendered behavior in adults is based on neurobiological qualities (Gires 2006; Govier et al 2010; Rametti et al 2010 and 2011). These neurobiological qualities will in this chapter be named: Transe talents.

In 2011 The World Professional Association for Transgender Health (WPATH) issued new guidance for the treatment of transsexual, transgender and gender nonconforming people, which states the following:

"The expression of …identities that are not stereotypically associated with one's assigned sex at birth, is a common and culturally-diverse human phenomenon that should not be judged as inherently pathological or negative."

The conceptualization of transsexualism (and other trans-states) to be neurobiologically based, raises questions of ethics for those who might attempt to prevent them from developing into states of trans and/or homosexuality (Cohen-Kettenis & Pfäfflin, 2003). It also questions the psychiatric dominance in the treatment of the atypically gendered.

There is substantial support to say that many people with transe talents have experienced childhood and adolescence as painful and traumatic (Pardo 2008). The trauma often being that of retention because they learned to hide and disguise their talents in fear of negative sanctions by peers and/or society (Almås & Benestad. 2009). Retention promotes fear, shy alertness, alienation and lack of belonging.

In western societies boys who want to be, or do act like girls are perceived as more disturbing than girls who want to be, or do act like boys. The little Rons are far more often taken in for examination than the little Besses. Thus the clinical knowledge of the boys exceeds that of girls.

The sum of knowledge about these children's psychological status is that they do not differ significantly from other children on any scale. This holds true except in the children experiencing poor understanding and support, who display more anxiety than

the reference groups (Cohen-Kettenis et al 2008; de Vries et al. 2011). Anxiety has been suggested as a contributing factor to so-called GID. The impact of alienation is not likewise considered (Wallien et al, 2007).

It is reasonable to believe that this increased anxiety is a consequence of the resistance the children have met in their family, their extended networks, and in society as such. This alienation expressed in later life will often come out as: "I felt that I belonged nowhere!" and/or "Something was wrong with me, I just couldn't figure out what". Working with adult transpeople, the fear of being not only rejected, but actually trashed, can be followed back to their earlier memories.

The majority of children who transe grow to be adolescents and later adults, who are either gay men, lesbian women or transepeople (Cohen-Kettenis & Pfäfflin, 2003). In most western societies these are people at higher risk of psychological problems and suicide (Hegna et al, 1999). Thus children who transe carries an invisible sign saying: "*I am in for major problems, please assist my living.*"

Selection

There are three fundamental selections present in my clinical work:

1. Those who seek my assistance have generally been made aware of me through media, and they are not deeply troubled by what they have heard or seen.
2. The children I have assisted, have had the power to convince their parents that there might not be coherence between their genitals and their mental experience of gender.
3. My life as unspecified transe, transe professional, performer, physician, family therapist, specialist in clinical sexology, and professor at the University of Agder, has led me into this very way of working. In my work I certainly see my own experience and example as a therapeutic tool. The personal is also professional.

I nevertheless believe that this way of working can be utilized by professionals and networks that are not likewise selected.

Attitude

The pathologization of gender identity disorder be it in childhood, adolescence or adult life, is a burden that opposes positive belonging and thus imposes suffering where suffering is not necessary. After having received a letter from the "GID clinic" in Oslo a couple of years ago, where it was stated that one child in the family "suffered" from "Gender Identiy disorder", the mother and the child (15 at the time) exclaimed: "*No one is suffering from anything in this house!*"

To address the clients and their families with the aim of preventing either homosexuality or transsexuality represents an attitude that cannot be hidden, and that will support, enforce and/or induce the discomfort that is stated by the diagnose. The diagnose per se also contributes to the alienation and sense of being "wrong".

Since trans talents are compatible with good quality of life, and since these talents cannot be removed, these clients must be met in an ambience of transpositivity (Raj, 2002).

Course of Action

At the time when I was addressed by the first parent couple, I had experienced little or nothing within the Norwegian health care system for me to find it safe to refer the children to those who were and are set to treat transsexuals. I had on the contrary, experienced the actual healthcare workers not to be transpositive and to perceive the trans-expressions as a sign of sickness. When contacted, the child was offered centralized treatment away from home. Based upon the experiences stated above, I constructed what one might call a therapeutic motto: ***There are no grounds to see these children as disturbed or disordered, but there is substantial support for saying that they do disturb people of their networks. Thus the therapeutic aim must be to treat the disturbed, namely parents, peers, professionals of kindergarten and schools, health professionals and others that might be of significance.***

This treatment should be offered where the children live, first to those closest to them, then the intervention can be extended like ripples in water. My idea was that by rendering the child a transpositive environment, most trouble if not all, would decrease and at best evaporate.

Grounds for the Course of Action

Systemic therapy training made me realize that closed systems are non-existent. In human relations the systems of the one greatly influences the systems of the other, and the closer the relationship, the more powerful the mutual influences. The way we are met by others is as significant as the way we meet ourselves, and these two sides to the life experience are mutually dependent. Belonging arises in this interdependency and ***belonging is to be perceived by others the same way as you perceive yourself, and the belonging is positive when that which is being perceived is added a positive value*** (Benestad, 2002).

The kids who transe, display a perception of self in their expression of gender. The individuals in the kids' networks are disturbed by these expressions and are in need of tools to perceive the children the way they perceive themselves. All involved need an attitude that renders that which is being perceived, a positive value.

The course of action has to be "transpositiv networking". The child shall be included in the proceedings to the extent that the need for inclusion is uttered by the child itself. Transpositivity can hardly be conveyed to the children if they feel that they represent some major problem for their networks, a problem that is confirmed by the fact that they are referred to far away specialists. One child of nine who was invited to take part in a meeting between me and adults in the child's home said: "*It is you adults who create all the problems, so you better solve them. I prefer to play with my cat!*"

Like Ripples in Water

From the very start of this endeavor, I have found it advisable to start with the very significant others, then to an extended family and then move on to kindergarten/school, neighborhood and/or community. Most places the children live in a dominant, binary, heteronormative world. They need an alternative world where they can get a sense of positive gender belonging. Positive belonging resonates with "welcome" and "home".

In the process of giving power of gender understanding to a network, I basically apply the same tool with all groups. The name of the tool is "Gender euphoria", and that tool is a seminar on gender where I display insights and options through talk, interactions and power point slides (Benestad. 2002, 2010).

The seminar has several focuses:

- It is genuinely transpositive, intersexpositive and gender diversity positive. No human with grounds to feel well, must be made sick or disturbed.
- Parents and peers are freed from feelings of guilt. They have done nothing to induce these feelings in the child.
- It demonstrates biology as the sum of systems that sustain life, and I describe some "counter biological" systems that do not sustain life - like those that do not offer positive belonging.
- It shows the great diversity of nature, a diversity where no particular phenomenon can be divided in two parts like we divide gender. The two commonly known genders are named the "gender majorities", the rest gender minorities.
- Different states of intersex are on the level of basic biology used to deconstruct the gender binary.
- Stories of mythology and art are used to demonstrate the valuing and devaluation of androgyny in cultures and history.
- Free extracts from literature: "The Little Prince" is used to demonstrate that individuals' perceptions of gender can not be truly sensed by others from the outside, in that every human being can be perceived as a box that may contain any gender or genders.
- After a reasonable thorough deconstruction of gender, a reconstruction follows. This reconstruction demonstrates seven levels of gender affirmation.

  The levels are:

  1. Somatic sex (biological sex is already deconstructed)
  2. Reproductive sex
  3. Gender identity
  4. Body consciousness
  5. Body picture
  6. Gender role
  7. Talents of attraction

  On all levels several options are offered:

  1. Female/feminine/girl/woman/gynephilia
  2. Intersex/transe/androgyne/bibodied/bisexual, polysexual, transesensual
  3. Male/masculine/boy/man/androphilia
  4. Unsexed body/neither or/gender refuser/asexual

  The seminar explores all levels and all relevant combinations of somatic sex, procreative sex, gender identity, body consciousness, body picture, gender role and attraction talents.

This reconstruction leads to seven sexes/genders:

1. The female genders
2. The male genders
3. The transe genders
4. The intersex genders
5. The no-genders or gender refusers
6. The free, fluid, personal and/or not committed genders (more are certainly welcomed)
7. The eunuch genders

All these variables are rendered a clean bill of health.

- The end of the gender euphoria seminar focuses on the child in question. Examples are given, illustrated by images of and by children from the different networks that I have been working with. Parents of the children are quoted. All this certainly in open understanding with the people involved. Knowledge of the fates of kids who transe are conveyed and the euphoric bless of positive gender belonging is emphasized.
- After this phase of rendering grounds for words, concepts and other tools of understanding, there is rich time for questions, wonderings, disagreements, sharing and in-depth reflections.
- All involved are given all the time they need to think the questions over and make their own decisions as to support or not support the child's expressions of gender.
- It is also emphasized that is must be as easy for the child to change gender in one way as it must be to change it back or into a third or fourth path.

One somatic male child looked at her mother when the mother said to her that she could be a girl: "*Mama, will you never force me into wearing boys' clothing anymore?*" and the mother replied: "*No, I will not, but you may well use them if you like.*"

Ordinarily the first gender euphoria seminar is followed by a second one. That is another seminar that includes head of kindergarten/school professionals and health professionals that work within the local kindergarten/school systems. The family doctor and sometimes also relevant religious leaders are invited. The parents, sometimes siblings and sometimes other close family members are always present. The child is offered to take part if she/he/hir/sinhir/ze (O'Keefe, 1999) so wishes The content and presentation of the gender euphoria is the same as in the first "ripple", and is ordinarily followed by the organizing of a "responsible group of assistants", sometimes named "the troops" or "the secret service group".

If the child chooses and is supported to display the preferred gender at school and in society, a third ripple is performed with the same content as the first ones, and now all professionals of kindergarten/school and local health system and all parents of children in the kindergarten, and when in school, the fellow pupils and all the parents of all kids on the actual school level, are invited.

In small societies I have also offered a public gender euphoria seminar in the local cinema house or some other public and convenient venue as a fourth ripple.

The troops stay together and meet for as long as assistance seems necessary.

In between or in addition to these main and basic ripples, some specialized actions may come in handy:

1. Direct talks with the child. These talks need no particular focus, but should convey the many options of gender belonging, the importance of learning the bodily offers of pleasure, including that of erotic pleasure, the notion that no person is born into a wrong body, that bodies can to various degrees be adjusted to become more fit for the owner, and that the change of gender expression should be as easily changed in one direction as in the other etc. etc.
2. Direct talks with chosen friends of the child. This is particularly helpful when the child (or adolescent) finds it appropriate, and it is especially helpful when the child (or adolescent) needs some "front troopers" when he/hir/she/sinhir/ze is going to come out in kindergarten or at school.

Results/Experiences

The networking described is a way of addressing the disturbed, based upon clinical insights aiming for positive gender belonging. There has not been performed systematic protocol driven scientific research on the effect of the networking. The research design needed to assess effect is difficult as randomization is ethically problematic, there are no particular reference groups, no comparable group of children who transe with similar selection as mine, that has been followed and offered alternative treatment. Nevertheless my experiences and observations point unanimously in a positive direction: The tension felt in the network seems to be greatly reduced, and the level of transpositivity seems likewise to increase. There are clear signs of better functioning for the kid who transe both in school, in social and family life. The children seem more able to attach to both people and society. They become more at ease, seem to develop better self-esteem, display more talents and actions of both feminine and masculine connotations. They also involve a greater variety of friends of both gender majorities, when they before played with kids of the other major somatic sex. Gender related shame seems to be close to absent. The children's bodies and sex-organs are not made into no-subjects. The children are trustful and clinically judged not in as great a hurry to have their bodies altered, as those who have kept their talents secret and/or have been opposed by their networks.

To give a better understanding of the effect of networking like ripples in water, I enclose some parents' rapports:

What it has meant to us to have contact with Esben Esther Pirelli Benestad (hereafter EE): We are the parents of a child born as a boy, but who feels like a girl. We discovered this by the age of approximately 3 years. When the child was a little more than 4 years of age, the situation was so stressful that we realised that we needed professional help. After some looking around, we found EE's office. EE gave us an appointment, an understanding talk and literature suggestions. We, the parents, travelled to meet EE. We had a good talk where we experienced an interested and engaged physician who took our problems seriously. -----

We were confirmed that the best thing we could do was to accept the child. EE also made it clear that we had to be open for the child to change mind at a later stage and return to male, and that we in such case should affirm.

For a long time we had thought of letting our little boy live like the girl he claimed to be, and being confirmed that this phenomenon was real, we decided to go all the way. She

got a girls name, girls clothes and girls toys. In addition we started to inform family and friends of our decision. Amongst other means, we used information from EE's books.

Three months later, based upon EE ideas, we called in a "meeting of the network". This meant that EE supported by the PPT office (pedagogical/psychological services) came to where we live and held an information meeting. Our "network" consisted of family, friends, professionals of kindergarten, family doctor, community nurse, the PPT and professionals from primary school. In this meeting EE informed about transsexualism in general, thereafter about children with gender identity problems in addition to the special issues of our situation. There was also time for questioning.

For us this meeting was very important because we were assisted in explaining the situation and not least in confirming that this is not only a phenomenon, but a diagnose. That made is easier for us to get support in the family and in the kindergarten to treat our boy as if he had been born a girl.

The summer after we, children and parents, travelled to Grimstad for follow up. We had a very good meeting there, and our child was well received. In the winter after EE visited us at home since hir had another task near by. Closer to start of school for our child, EE once again supported by the PPT, came to give a talk/information meeting for those employed by the school. It was very useful for the teachers to have some background knowledge in order to meet and interact with our child. In addition it gave us as parents a better starting point to make the school arrange and support our child in everyday schoolwork. Furthermore mother made a talk at the teachers' planning day before start of school that she based upon the knowledge she had received from EE earlier.

We have also had the advantage to be able to contact EE by telephone or mail if we have had problems or questions. There are numerous issues to consider when one shall bring up a child with gender identity problems, but we have had good support in taking our own decisions for our child, based upon good information and experiences from EE.

It has also been of great significance that EE received us even if our child was only 4 years old. It we had had to wait to the child grew older to get help to cope with the situation, it would have been of great harm to the child's psyche.

Now our child has been living in "girl expression" for 5 years, and she has become a safe and trustful child with good self confidence. We have been met with understanding and accept in our community, because of the knowledge and information we have shared. Through EE we have been brought in contact with other families in the same situation, which has meant much for our child. To have someone who mirrors you so that you shall not feel alone in the world, is very important for your self-esteem.

This very child close to four years of age, had been playing with "colouring books". She basically used the colours pink and purple, letting in some yellow at times for a princess' hair. This one is right before she was allowed to live like a girl:

This is made six weeks after the permission to express as a girl.

Mother says: "That's how it goes when one is allowed to be one-self!"

Another couple describes the effect of the gender euphoria seminar:
We made the decision to let our male-born child live as a girl about a month before the start of a new school-year. She had just turned 7 years, and had already one year in school behind her - as a `boy`. Her school has about 310 students from 6 to 13 years. To make this new start in her life as good as possible, the headmaster gave us three hours of a planning-day, for EE to educate all school staff on the subject. None of them had ever experienced something like this, - I suppose not even heard of it, and it`s not a secret, that many of them were quite shocked, or at least disturbed by the situation. And they were obviously very skeptic.

What EE did in these three hours, was almost a little miracle. S-he gave a solid lection of the gender-issue, both in a medical and social aspect, and managed to turn all their skepticism to comfort and optimism ! After half an hour they were smiling and laughing! When they left the lecture, they were quite different people, really...

You could tell that they felt on top of the situation, - and not encumbered by it!

The result of this education of the school-staff was, that our child got a very good start of her `new life` in school, and she has had no problems in school what so ever since.

Conclusion:
Children who transe, represent a group at higher risk of severe psychological complications than ordinary children. This can be understood as a consequence of lack of positive belonging. In the tradition of most health care systems, children who transe, are looked upon as suffering form a mental disorder, and they are referred to a centralized "treatment". This treatment may hurt the children, since it but to a minor degree can meet their real and everyday challenges, and because the mere structure of approach conveys ideas of pathology, of not being right.

Instead of viewing the children as disturbed, we can perceive them as children who disturb. This disturbance is then reflected back to the children as sanctions of denial and rejection. The pain and trauma provoking meeting, is primarily between the child and the child's network.

By decentralizing the therapeutic, educational work, and by directing it toward the people that are disturbed by the children, a network of transpositivity can be developed around the child, a network that represents an alternative to the "common" world. In this alternative world the children are far less prone for trauma as it offers a hearty welcome to their transe talents.

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Cognitive Hypnotherapy and Psycho-aromatherapy for Couples with Unpleasantness

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Abstract

In modern Europe, including Latvia, many sexual problems arise from personal and relationship distress with reduced couple`s sexual life, deprived motivation of both partners, unpleasantness without androgen insufficiency syndrome and neurological or psychiatric impairment in the patient's sexual history. During sexual status examination males and females frequently complain about negative sexual thinking, slapdash sexual connection, difficulty identifying feelings, constricted imaginal processes, as evidenced by a scarcity of sexual fantasies.

A new integrated model of psychosocial and psychotherapeutic management for such couples aims to restore emotional and physical closeness to the partner focusing on sensuality and sexual satisfaction more than on planned intercourse or extreme sexual activity. Treatment approach in such couples is done by using cognitive hypnotherapy (CHT) and psycho-aromatherapy (PAT) for improving emotional and physical pleasures, for acquiring self-management strategies.

Key Words
Personal and relationship distress, unpleasantness in couple, a cognitive hypnotherapy, a psycho-aromatherapy.

Background

Negative or stereotypical sexual thinking and interpersonal problems by attitude of mind and attitude of body in couple, fixed desire to give and receive each time remarkable orgasms and extreme intimate pleasure nowadays colors many aspects of the partner-relationship areas. The fear of intimacy, inability to form commitment in couple can influence the sexual response cycle [1].

Sexotherapeutic approach from the standpoint of bio-psycho-social sexology for couples with psychogenic unpleasantness caused by personal and relationship distress nowadays includes cognitive hypnotherapy (CHT) combined with psycho-aromatherapy (PAT). CHT by deep mind-body relaxation reduces the absens of sexual fantasies/thoughts and changes the negative experience of the couple`s relationship [2, 3]. In world practice with PET scans (positron emission tomography) of patients brain sections during psychodynamic cognitive hypnotherapy is shown that hypnotherapy might alleviate suffering by decreasing the activity of somatosensory cortex involved in the experience of suffering and negative thinking [4].

Smell is our most emotional sense, it affects our feelings and thoughts, coital pleasure. Psycho-aromatherapy by the nose, by the olfactory nerves, by the organ of smell in our brain, by amygdala – a centre of emotions in the limbic brain system – *brings out the happiness sense* and *the sexual fantasy* [5]. Essential oils by use an aroma lamp through their fragrance and unique molecular structure can directly stimulate the hypothalamus, which releases chemical messengers that can to uplift and to influence intercourse. Combination of the several aromatherapy scents nowadays is applied in practice for synergistic and more effective psycho-aromatherapy result [6, 7]. Such combined therapy helps patients can overcome emotional exhaustion or deprivation, painful impression, a feeling of intensive dislike.

Aim of the study was to approve CHT and PAT in heterosexual couples, who suffered from the deprived motivation of both partners and unpleasantness.

Material and Methods

During one year period 12 heterosexual married and unmarried couples (males=12, females=12, aged 27-59, conjugal and unconjugal life period 2-14 years), suffering from painful impression and deprived emotions, reduction in coital pleasure was treated. Group A (couples=8) received 4 weeks CHT, 60 minutes long one session, once a week, and PAT by using *Sandalwood, Rose, Jasmine* essential oils, twice a week. Group B (couples=4) received 4 weeks only PAT twice a week. Stages of the psychosexual evaluation (complaints, sexual examination, psychiatric, family, relationship hystory) were investigated by the interview method.

Traumatic Life Events Questionnaire (TLEQ) [8], a 23-item self-report measure of different types of potentially traumatic events was used in 12 females and 12 males.

Hypnotic Susceptibility Test (HST) [9] determined by Clarke J.C & Jackson J.A. protocol before the CHT course helped us to assess the hypnotic susceptibility for group A females and males (suggestion, imagery responsive, dissociative capacity, cognitive flexibility, and CHT contraindications – psychotic reactions, paroxysmal states).

The intensity of painful impressions in couple was determined by using "0-10" Numeric Rating Scale [10]. Intensity of couple's well-being was measured by 5-points Visual Analogue Scale [11]. Individuals in couple was asked to keep a Pleasure Diary. An individualized compact disc with suggestions for self-practices at home between sessions was made and given each couple. Our own practice standards were verified during follow-up throughout three and six months after treatment course by re-reporting about life quality from females and males, *p value* [12] in statistical significance testing was determine.

The inclusion criteria for investigation were: a full psychosexual and social assessment of males and females, and health certificate; without androgen insufficiency syndrome and neurological or psychic impairment in the patient's sexual history; without heavy breathing or allergic reactions; full consent to participate in the study. There were no exclusion criteria: having not been to mandatory medical examinations; use addictive substance, medicine.

Results

Analysis of TLEQ data showed that chronic relationship distress during last 2-7 years, emotional abuse, aversion to and avoidance of genital sexual contact with partner,

difficulty identifying feelings, frustration, dysfunctional communication patterns in heterosexual married and unmarried couples were issues that aroused in a sexual dissatisfaction with unpleasantness. Analysis of NRS and VAS data showed significant improvement in 5 group A couples (62%; n=8; p <0.05), and 1 group B couple (25%; n=4; p <0.05).

The results indicated decreased intensity of the painful impressions in group A females from 5.57 at the beginning of CHT and PAT session till 1.14 at the end of the session, in males accordingly – from 6.33 till 1.0 (p < 0,05). Follow-up assessment at 3 and 6 months after treatment course indicated lasting reduction of the painful impressions and sensations in group A couples, which can be explained by benefits of positive self-influence during CHT and PAT and mind body relaxation practice at home by compact disc.

Analysis of the hypnotic susceptibility by HST: group A (males=5, females=6) - had good suggestion and imagery responsive, cognitive flexibility and dissociative ability. There were no contraindications for hypnotherapy.

Division of the male and female patients with sexual relationship problems in couple according to the HST, NRS and VAS before the treatment course and at the conclusion of the treatment course and during follow-up is shown in Table 1.

TABLE 1. CHARACTERISTIC OF GROUP A AND GROUP B MALE AND FEMALE PATIENTS WITH SEXUAL RELATIONSHIP PROBLEMS IN COUPLE RESULTED BY METHODS

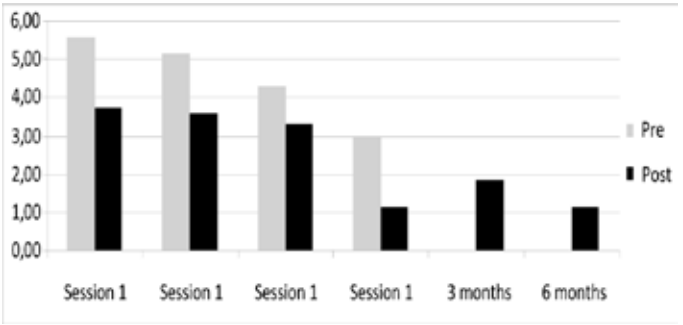
Methods	Before the treatment course	At the conclusion of the treatment course and during follow-up
Hypnotic Susceptibility Test (HST)	*Group A couples*: 6 females — had good suggestion and imagery responsive, 5 males – had cognitive flexibility and dissociative ability; there were no contraindications for hypnotherapy	–
Numeric rating scale (NRS)	*Group A couples*: 7 females (87%; n=8) and 7 males (87%; n=8), and *group B couples*: 4 females (100%; n=4), and 3 males (75%; n=4) – severe painful impressions: 7-10 items of valuation; p < 0,05	*Group A couples*: 5 females (62%; n=8) and 5 males (62%; n=8), and *group B couples*: 1 female (25%; n=4), and 1 male (25%; n=4) – no or mild painful impressions: 0-3 items of valuation; p < 0,05
Visual Analogue Scale (VAS)	*Group A couples*: 7 females (87%; n=8) and 5 males (62%; n=8), and *group B couples*: 4 females (100%; n=4), and 3 males (75%; n=4) – had resulted low level of couple`s well-being: 5 points of valuation; p < 0,05	*Group A couples*: 7 females (87%; n=8), and 6 males (75%; n=8), and *group B couples*: 2 females (50%; n=4) and 1 male (25%; n=4) – had resulted high level of couple`s well-being: 5 points of valuation; p < 0,05

During CHT patients were sitting in chairs. For the personal and relationship distress in couple management we used such hypnotherapeutic procedures as relaxation induction, distraction, time distortion, processing of psychotraumatic events, meta-

phorical, imagery techniques, self-hypnosis with ego–strengthening, positive sexual thinking suggestion and possibility to experience holistic sex by communication in lovemaking, joyful sexual fantasies. An individualized compact disc with suggestions for self-practices at home once a day between sessions and after treatment course was made and given to each group A patient and was used by all group A patients during treatment course and follow-up.

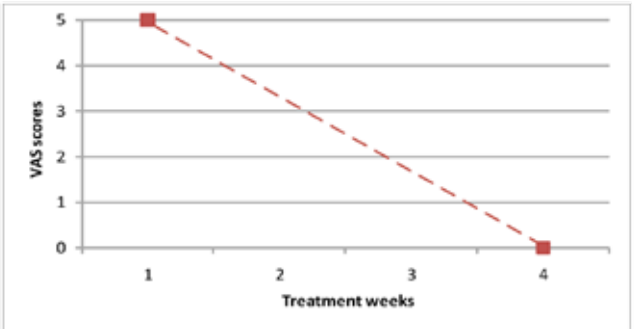
Intensity of the painful impessions in group A females and males during CHT and PAT sessions and follow-up according to NRS is shown in Figure 1.

FIGURE 1. INTENSITY OF THE PAINFUL IMPESSIONS IN GROUP A FEMALES AND MALES DURING CHT AND PAT SESSIONS AND FOLLOW-UP ACCORDING TO NRS.



The dynamics of couple`s well-being scores according to VAS during CHT and PAT course in five group A couples (p <0.05) is shown in Figure 2.

FIGURE 2. THE DYNAMICS OF COUPLE`S WELL-BEING SCORES ACCORDING TO VAS DURING CHT AND PAT COURSE IN FIVE GROUP A COUPLES (P <0.05).



Follow-up assessment at 3 and 6 months after treatment course indicated lasting reduction of the painful feeling intensity, which can be explained by benefits of positive self-influence during CHT and PAT and mind body relaxation practice at home by compact disc.

Analysis of Pleasure Diaries showed that during CHT combined with PAT deficient of sexual fantasies, stressful interpersonal problems was replaced by growth of emotional intimacy, relationship quality. Males and females at couples noted new

capacity to imagine and experience *that nostrils sense dizzy fragrance, which arouses the sexual interest of another, that genitals, all body are filled with honeyed pleasure*. 4 females noted, that CHTcombined with PAT helped not only to combat with stress and emotional trauma and to get back sex drive, but also - to be pregnant. Group A males noted, that they could begin their sex drive at a point of neutrality and become aroused by the intimacy of his partner. Four group A couples at their diaries noted about increased vaginal sensation and vaginal pleasure, prolonged erection. Smells maked males and females feel sexier about themselves, helped to achieve good flirting and foreplay.

The research was worked out with following international human rights and standards of physicians` ethics.

Discussion

Psychogenic unpleasantness in modern Europe is caused by relationship distress with reduced couple`s sexual life, deprived motivation of both partners and interpersonal problems with intimacy in couple. The current study showed that during cognitive hypnotherapy combined with psycho-aromatherapy females and males achieved increased interest in their partner, emotional and physical closeness.

It is in accordance with recent research about necessary for both members of the couple to be involved in the new treatment if they are willing to do so [13, 14]. It is in accordance with recent research about emotional and interpersonal aspect of intercourse and necessity to develop not only genital contact, but also non-genital contact, to be creative, to foster lover`s talent and energy [15].

The current study showed, that during cognitive hypnotherapy combined with psycho-aromatherapy – females and males achieved increased interest in their partner, emotional and physical closeness. The current study showed that psycho-aromatherapy for female and male in couple can be also as *mating-place* for display behavior and the act of pairing for reproductive propouse.

Psycho-aromatherapy via sexocorporal approach is valuable tool in the armament of the sex therapist. It is in accordance with recent research about sexotherapeutic approaches like cognitive hypnotherapy, sexoanalysis, sexocorporal approach for couple with sexual desire disorder and pleasure problems as an efficient tools if the therapist wishes to act on the patient`s conscious and unconscious, to help male and female in couple change subjective experience of sexuality [16, 17].

Conclusion

1. One month combined treatment course – cognitive hypnotherapy and psycho-aromatherapy is an effective treatment with improving quality of sexual life for heterosexual couples with deprived motivation of both partners and psychogenic unpleasantness.
2. To use self-evaluation scales, an individualized compact disc with suggestions for self-practices at home, keeping a pleasure diary during treatment course and follow-up can help couple to assess own self-esteem and sexual well-being.
3. Use cognitive hypnotherapy and psycho-aromatherapy for couples helps clinicians and sex therapists to improve their treatment repertoire.

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Sexology in Russia

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Introduction

Historically, Russian sexual culture is a way from seasonal erotic and mating rituals of the Slavic tribes and people, which promoted positive attitudes towards pleasure and reproduction, through epoch of soft domination of Christianity with its restrained and tolerant attitude to sexuality, the brief flowering of erotic culture in the period of revolution and, at last, the dark times of repressive sexual morality from the end of 20s for about half a century.

Prohibition of Freud's ideas, repressions, and change in sexual morality led to a prolonged delay in sexological researches, as well as to distortion of all social manifestations of sexuality in Soviet Society, violation of sexual rights and freedoms, homophobia, spread of sexual violence, on a background of complete lack of sex education, only with supporting maternity entirely. The darkness for Russian sexology continued till the end of 60s when a totalitarian regime became softer.

In the 70s a powerful state medical sexology system providing care to all the population had been created and designed for both treatment and sexual outreach by professor ***George Vasiltchenko*** who was the pioneer of modern medical sexology in USSR and Russia. The concept of sexual constitution as a part of a human general constitution had been developed. It explained that people are so different in sexual life because they are differing in anatomy and physiology of their sex systems.

At the same time a small group of enthusiasts joined in the struggle for personal sexual rights, against violence and homophobia. ***Igor Kon*** was their well-known leader.

Two persons created the basis of modern Russian sexology in dramatic collisions because Igor Kon criticized sexopathology for its "excessive" biological approach to sexuality, and George Vasilchenko, creating power medical sexology school, believed that homosexuality is paraphilia because this libido orientation doesn't lead to reproduction.

After the collapse of USSR rapid movement in sexual culture led to partial restoration of sexual rights and freedoms and the development of sexual outreach. This process was accompanied by distribution of pornography, prostitution and sexual violence, increasing the number of abortions and reduced birthrate. All attempts of sex education at schools faced with strong opposition from the bureaucracy and the Church had failed.

Today Russians formally live in almost liberal sexual culture but it is not supported by the state at all, there are anti-gay extremism and no sex education. In trends of consolidation state and religious world, it is difficult to expect progress in sex education at schools in the nearest future.

Russian Medical Sexology

Russian medical sexology consists of a patient care, training, forensic sexology and expertise, and academic institutions. Sexologists are joined in Russian Sexological Society. Since 2007 the society brings together about 100 sexologists, it is active in the field of outreach, education, and training.

Russian medical sexologist is psychiatrist.

In Russia officially the organization of medical sexology care takes place in cities with population of more than 250,000 people in specialized state departments of medical and psychological family counseling. Therefore, in small towns people seek sexological assistance from urologists and gynecologists.

Studies

Sexuality reduction syndrome in drug and alcohol abuse, Methodology and method for transcultural opinion surveys in sexology, Prezigotic sex determination theory and behavioral way for baby's sex choosing before conception are three contributions in Russian sexology.

Sexuality Reduction Syndrome in Drug and Alcohol Abuse

From sexology to addictions psychiatry, Sexuality Reduction Syndrome in addicted persons was described with the goal to emphasize the importance of sexuality in these diseases.

A combination of three symptoms is constantly found in drug and alcohol abuse:

a). Reduced libido;
b). Subordination of libido to pathological inclination to drugs;
c). Failure of self-criticism.

The syndrome has specific dynamics and three degrees of severity, it vary in different types of addictions, and it helpful in diagnostic, treatment, rehabilitation, and prophylactic because it destroys the myths of positive effects of alcohol and drugs towards sexuality.

Methodology and Method for Transcultural Opinion Surveys In Sexology

In social sexology, studying sexuality attitudes, it was taken into account that duality of opinions polls is evident not only because a researcher obtains information about a social group, but also because people who fill in questionnaires, receive helpful information. Developing this position, a special methodology for writing questionnaires was created, and questionnaires about sexual health were written and successfully tested in some social groups. Methodology allows minimizing language differences in results of survey, which allows improving communication between researchers.

Prezigotic Sex Determination Theory and Behavioral Way for Baby's Sex Choosing Before Conception

In populational sexology, theoretical and applied studies support the declaration that reproductive health programs should recognize the centrality of sexual health. The prezygotic sex determination theory explains the behavioral method for baby's sex choosing; proposed addition to human sexual rights and ethics suggest that no person, organization, or government should not restrict the right of couples to choose the sex of the future child; training for professionals and program for couples provide right to receive sexological information. In this context, sexologists should think not only about personal sexual and reproductive rights but about the same rights for a Couple, do not necessarily love or married couple, but a couple which acts to conceive a boy and a girl.

Conclusion

Russian sexology today is a multifaceted consolidation of recognized and well-known concepts, approaches, methods, with original theories and methods, developed in the framework of national sexological school.

Russian sexological community is open for communication, information sharing, participation in educational projects and research.

Between Professional Ambivalence and Multidisciplinary Harmony

A Qualitative Study on Sexologist as a Profession

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Abstract

This study is part of the larger research project that explore the evolution of sexology profession in Sweden, and additionally compare some of these trends with other European sexologists. More specific, this study aims to get in-depth knowledge of Swedish sexologist's own descriptions of themselves and their profession. Data was collected through qualitative research interviews with 34 professionally active sexologists and members of The Swedish Association for Sexology, [SFS], 26 women and 8 men, aged 34 – 88 years. Results show that the informants can be divided into medical and therapeutical sexologists, all of whom identify strongly with their primary profession prior to becoming sexologists. Physician as sexologist has given way to healthcare professionals such as social workers and nurses, whereby sexology has been transformed into a female-dominated field in Sweden as well as in other European countries. This paradigm shift has created tensions between different approaches. Based on varying skills and educational backgrounds, different groups of sexologists have emerged: pioneers, competence sexologists, entrepreneurs, research sexologists and the non-professionals. Competition is not experienced toward others within the interdisciplinary realm of sexology, but rather between those who have professional authority and those non-professionals who strive for legitimacy in the field.

Introduction

The evolution of sexology profession has then been an on-going process since the mid-1960s in Sweden (Dahlöf, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010). Professionals have since then chosen to join different sexological networks and associations, to undertake training in sexology, and/or do research within a broader sphere of sexology. The first Swedish courses in sexology were offered sporadically in the late 1960s and more regularly from 1974 (Dahlöf, 2008). Today, courses in sexology at basic and advanced (master) levels are available at several Swedish universities within different subjects as for example medicine, psychology, social work and sociology.

The Swedish Association for Sexology,[SFS], was founded in 1980 with the aim to promote networking, to exchange experiences, and promote scientific and clinical collaboration. Membership is offered to professionals or those in non-profit positions working with sexological issues. Requirements for an authorization for Nordic sexologists were accepted in 2000 through the Nordic Association for Clinical sexology, [NACS], and the first authorizations were carried out in 2002. The impetus was to endow various clinical sexological activities with a hallmark of quality, and to clarify the sexologist's skills for those seeking help.

NACS has also developed and adopted ethical guidelines for professional sexologists (retrieved December 8, 2011, from NACS: http://www.nacs.eu/index.php?1, 44). The intention is to clarify and establish guidelines for those who work professionally with sex therapy, sex counseling, sex education and sexual research, and to inform and protect those who seek help. The sexological guidelines state that these should be a supplement to the guidelines that apply for the basic professional sexologist. These specific sexological guidelines relate, inter alia, to the sexologist-client relationship and focus the sexologist's responsibility for maintaining high professional standards and for the dependent relationship that can arise in a therapeutic situation.

So far, we know some about professionals active in clinical sexology. In 2001, Fugl-Meyer and Giami (2006) performed a survey geared towards 143 sexologists with an median age of 50 years (24–81 years). The majority were women working as nurses, midwives, psychotherapists or doctors. Among psychotherapists, the group consisted of marriage and family therapists, psychologists and social workers. Most were employed in the public sector and nearly all had at least a post-graduate education in sexology, while almost two-thirds also had training in psychotherapeutic modalities. More than a quarter had participated in sexological research, published scientific reports and participated in sexological conferences and seminars. However, in-depth knowledge about Swedish sexologists'own descriptions of their profession is still missing, and also about their reflections on trends in the on-going professionalization process in Sweden.

Objectives and Research Questions

The overall objective is to explore the evolution of sexology profession in Sweden, and additonally to compare some of these trends with other European sexologists. More specific, this study aims to get in-depth knowledge of Swedish sexologist's own descriptions of themselves and their profession.What characterizes the sexological professionalization process in Sweden and how can it be pronounced (e.g. education, authorization, ethical rules and organizations)? How do professional sexologists describe themselves (e.g. age, gender, sexual orientation, professional background)? And, how do the sexologists describe their profession (e.g. professional activity, target groups, working models and professional authority)?

Method, Participants and Procedures

Qualitative interviews have been selected as the research method in order to elucidate the research questions that deal with the sexologists' own descriptions of their profession. The ambition of qualitative studies is to explain and illuminate the character of a phenomenon and its meaning (Kvale, 2009; Starrin & Renck, 1996), in this case the professionalization process concerning the sexologists in Sweden. The intention was to gain a deeper understanding of the area of research and to highlight the complexity of the inquiry (Widerberg, 2002).

Through a brief solicitation notice on the homepage of SFS, informants were able to report their interest and consent to the study according to the provided research ethics guidelines. The association consists to date of 102 paid members (retrieved December 8, 2011, from SFS: http://www.svensksexologi.se/), of which 34 members announced their participation in the study. The sample consists of 26 women and 8 men aged 34–88 years, working in different parts of Sweden.

An interview guide was conducted with topics to be covered: professional background, professional content and specialization, and finally professional network. These themes were used as gate ways for the interviews, where the informants were encouraged to describe factors of importance and their approaches to the sexological profession. The informants were interviewed individually during 60–90 minutes. Each interview was recorded on tape and subsequently printed verbatim.

An empirical analysis model was employed by adherents of the Chicago School (e.g. Abbott, 1997; Gerhardt, 2000) in the attempt to broach the descriptions provided by the sexology professionals concerning their work. More specifically, an initial structuring of the chosen themes were conducted and thereafter analyzed with the support of the selected theoretical frame work (e.g. boundaries, professional authority, and professionalism). The aim was to seek for trends, patterns and common themes in the data, but also to seek for variation and diversity in order to get a complex and sterling picture of the research area. The descriptive results are presented according to the following themes that have arisen during the analyses process: a) medical and therapeutical sexologists, b) professional ambivalence and competence, and c) multidisciplinary harmony and tensions.

Results

Medical and Therapeutical Sexologists

The majority of the informants were middle-aged, heterosexual and partnered women, as confirmed in previous research on sexologists and sexology students (Dahlöf, 2008; Fugl-Meyer & Giami, 2006; Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010). Overall, the informants consisted of an interdisciplinary group of professionals. Almost all had a basic profession within the health and human services sector; about one-third had social work degrees, a third nursing or midwifery diploma, and less than a third a medical degree specializing in gynecology, psychiatry, neurology, or a degree in psychology. According to this it is possible to divide the informants into ”medical” (e.g. nurses, midwifes, medical doctors) and “therapeutic” (e.g. counselors, psychologists, social workers with further education in psychotherapy). Thus, other studies show that the educational background of the sexology students in the new millennium is different from previous decades, in that physicians have more or less disappeared from the field (Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010).

The informants stated that they lacked sexology in their basic education and therefore felt a strong need for further training when they began their careers. Many had several courses in basic and clinical sexology, and accentuated the importance of sexological competence. Furthermore, three of the informants had earned a doctoral degree, one an honorary doctorate, and a few others were currently doing sexological research. Overall, the interviewees emphasized the importance of sexological research and pointed out the value in taking part of current studies, engaging oneself in research and/or work in environments steeped in critical thinking.

The older informants had been trained in or outside their country by other prominent sexologists before there Swedish courses in sexology existed. Thereafter, several had been involved in starting sexology programs and courses. A male sexologist and physician, 79 years old, told about his search for literature on the subject at his old university library in the early 1960s:

If you went to a library to borrow some books, they looked sternly at you and said: "No, you do not get to borrow these books, they belong in the head librarian's toxic cabinet!"

In addition to performing clinical work, some of those interviewed also worked as teachers, like some of the professionals in the Fugl-Meyer and Giami study (2006). They lectured in their "special areas of interest," e.g. sexual paraphilias, gender reassignment, sex therapy, sexuality and disability, etc., during conferences and training days and/or as course instructors at the university level. The importance of participation in this wider dissemination of knowledge were emphasized by these informants. A female social worker and sexologist, 51 years, enthusiastically stated that she was training staff in the treatment of sexuality for people with disabilities, which was much appreciated.

Professional Ambivalence and Competence

Regardless their background in sexology the interviewees appeared in doubt regarding calling themselves sexologists - what are actually the criteria? And is there even such a title (c.f. Fugl-Meyer & Giami, 2006)? Sex counselor, sex and relationship consultant, or sex and relationship therapist were examples of job titles that some interviewees used instead, sometimes voluntarily and sometimes at their employer's request. This ambiguity makes it difficult for the public to know who to turn to when seeking help, according to several informants. A male social worker and sexologist, 38, said:

My business card says social worker, B.A., certified sex counselor from NACS. But ... ordinary people ... maybe it's a little difficult for them to understand all the titles; I usually say that I am a social worker and sexologist. And then it's more like an explanation ... to make people understand the kind of education I have.

Only a small number of the informants had sought for an authorization as sex counselors or clinical sexologists, and none as a sex researcher. The reasons were several; the application process was perceived as too cumbersome, there were difficulties in meeting the required criteria for experience in sexological counseling and therapy training, and many experienced the filing fee as too high. In addition, several of the informants already had licenses covering the practice of their primary professions and did not give priority to an additional authorization as a sexologist. Nevertheless, the majority emphasized the importance of an authorization because it serves as a stamp of approval, to the benefit of sexologists themselves and for the clients and the communities they encounter in their work. A female sexologist and psychiatrist talked about why and when she uses the title authorized clinical sexologist:

I think that it puts greater [professional] authority behind it. So, I use it when I make statements or write anything related to sexology, but not when my work concerns psychiatry. I imagine that it is relevant in terms of showing that I am ... stating something I am competent to speak about!

Several pointed out that it is too much "amateurishness" in the field, and too easy for people to call themselves sexologists. Then, authorization was seen as an important way of being able to distinguish between those who are regarded as competent, and

those who are not, as well as specific ethical guide lines for sexologists. A female sexologist and social worker said with emphasis and revolt:

> *Of course, I know that the authorization is a very important part. Anyone can call himself or herself a sexologist! […]. So the authorization still shows that you have a certain amount of training, you have supervision, you have had personal therapy and whatever else you want. It offers some guarantee that we are working ethically, compared to many others!*

Most of the older informants had been grandfathered into the association as authorized clinical sexologists. This means a dispensation from the current guidelines and rules; many years of working experience with sexological issues, and/or having created sexological courses and training before there were any available. Sometimes this was a way of showing gratitude to those who have worked with sexology their whole professional lives.

Multidisciplinary Harmony and Tensions

The interviewees stressed the importance of viewing sexuality from a holistic perspective and from different scientific fields. Most of those interviewed worked alone and a few in pairs or in teams where both medical and therapeutic sexologists were included. The medical sexologist group reported that they collaborated across clinical boundaries when possible. The opportunities for interdisciplinary work were appreciated by informants who believed that it is often necessary, in order to help the individual or the couple. In general the interviews showed that the medical sexologist treats sexual problems based on physiological perspectives, which means that the sexual physiology was in focus but in a social and psychological context. A sexologist and physician described this as follows:

> *I work from a sexuo-physiological model, one can say. I also see emotional life as some kind of physiological input. It gets transformed into physiology when the soul takes it in, and stress gets created, for example. It's a very important factor, stress reactions of various kinds. They bring on disturbances in sexual functions.*

Others stated that they worked mainly from an informative and educational standpoint, and rarely met clients more than for a few sessions. If a client has a cancer diagnosis, sexological issues were overshadowed by disease progression or recurrence. A female sexologist and nurse said that her patients usually need concrete advice and only come once or at maximum 6–7 times. Several of the therapeutic sexologists instead described an eclectic approach to working models and theories, which were linked to the primary profession or to additional training in psychotherapy. A female sexologist and social worker explained how she and her colleague work together:

> *We have worked very systemically. Sometimes, it is one of us that drives the conversation and the other reflects. And then we all reflect openly in the room. […] We both have Gestalt training and we use some constructs from it. And our psychotherapy education is psychodynamic. It's so much Freud.*

Those who worked with couples said that they proceeded from communications theories, since a previously significant sexual problem may disappear once a couple begins to talk about sexuality. Others described their work at different levels based on the so-called PLISSIT model (Annon, 1976), where the first level indicates permission to talk about sexuality (Permission); the second about sex and relationships (Limited Information); the third offers specific instructions (Specific Suggestions); and the fourth provides sex therapy (Intensive Therapy). Others used sensuality exercises (Wagner & Kaplan, 1993), as a model for treating low or absent sexual desire. The aim is then to reduce the client's or couple's worry or performance anxiety often associated with sexuality when there has been some type of resistance or dysfunction for some time.

Even though the informants stated that the ideal way of working is interdisciplinary, several in the same time described difficulties; it can create tensions and competition between different perspectives. It is also complicated to agree on particular systematic theories and models that all sexologists should proceed from. A male social worker and sexologist reflected:

> *I think it is difficult to agree. I think it is simply the problem with working in the interdisciplinary mode. That we should see it as an asset and not a hindrance. I think it's a pity that there are "forces" [...], that there are trends that you should keep it in medicine or psychology. I believe that sexology belongs in the hands of many sciences. And social work and sociology are but two sciences among many! There could be many more, there could be economics, law, etc. The most important thing is to broaden your vision and to see that sexology is everywhere!*

Another cause of tension was that sexologists sometimes must perform the same duties, despite a difference in basic education, and in addition with different salaries. Some considered this to be difficult or questionable. Others believed that this way of working is positive because it strengthens the role of the sexologist and thus the entire subject area.

Many enthusiastically described the significance of sexological associations (e.g. SFS, NACS). Easier access to current research from different scientific perspectives and opportunities to make connections and find collaborators, both national and international, were then mentioned. Some informants told that they had been instrumental in starting up networks and associations in sexology in the 1960s and were known as charter members. But some criticisms appeared as well; there have been times where the same people had been sitting too long on the boards, and there had historically been a medical dominance. The consequences were that it had been difficult for young or new members to reach senior positions, and there had been too many men in leadership positions, given that the majority of the members were women.[1] A female social worker and sexologist became dejected when she looked back over the 20 years she has been a member:

[1] The current SFS board consists of five women and two men (Retrieved December 8, 2011, from: http://www.svensksexologi.se/).

The association was with these guys at the top. [...]. Supposedly sexology is an interdisciplinary profession, and then it becomes important that it's not, just medical experts who are sitting in power!

Several of the informants pointed out that it is necessary to have supervision when working with sexology; this is confirmed by the sexologists in Fugl-Meyer and Giami's (2006) study, where 90% have supervision. But only a few of the interviewed sexologists had in fact supervisors with sexological competence, since there are only a few such supervisors available in Sweden. A female sexologist and social worker described instead informal supervision in groups with other colleagues in medicine and psychiatry. Others talked about older or more experienced colleagues who acted as mentors. A male sexologist spoke about his colleague who read every single journal that he wrote over 25 years and was willing to give feedback based on his medical perspective. A female sexologist enthusiastically described her contact with "Y", her mentor, and said:

And Y's importance cannot be emphasized enough! We've been calling him all these years if it is something we wondered about or if we needed special supervision.

Overall, it became clear in the interviews that the sexologists were part of a relatively limited group, both nationally and internationally, where many had known each other for years. Through their sexological networks, informants met regularly and maintained and deepened their contacts over time. These personal and professional ties helped to strengthen the interdisciplinary cooperation, but also contributed to tensions created and maintained by some fundamental differences in the primary professions, and sometimes between individuals. However, the main tension described was not between different groups of well-educated sexologists, but against those who were claiming the sexological competence without being regarded as qualified by the informants.

Sexology as an Interdisciplinary Landscape – a Discussion

The image that has emerged of the sexological landscape in this study can be described as many large and small islands with bridges between them (cf. Fournier, 2000; Light, 1988). Inside this metaphor, the bridges are interconnected between various disciplines and professions within the multidisciplinary field of sexology. The study also showed a shift among the younger sexologists from a medical dominance to a more psychosocial therapeutic emphasis (cf. Dahlöf, 2008; Löfgren-Mårtenson, 2008; Löfgren-Mårtenson & Fugl-Meyer, 2010). In hierarchical terms, this can be expressed as the classical medical profession has given way to semi-professionals such as for example social workers and nurses.

The results also showed gender-related changes and shifts, and that sexology increasingly had transformed into female-dominated field, as confirmed by the Fugl-Meyer and Giami study (2006). In the large groups of social workers and nurses, i.e. the therapeutic sexologist group, the majority were women. Internationally, this trend is also present in other European countries as for example the United Kingdom (Wylie, de Colomby & Giami, 2004), Finland (Kontula & Valkama, 2006) and Denmark, Norway and Italy (Giami & de Colomby, 2006). Nowadays it is also true in France as

well (Giami, Chevret-Méasson & Bonierbale, 2009), even though it used to be male dominated (Giami & de Colomby, 2006).

Among those interviewed occurred smaller groups of sexologists; *The Pioneers* began their sexological career in the 1960s-1970s, with a dominance of physicians and doctors, often without a formal education in sexology. These informants described their work as a ''life calling" and stated a strong personal commitment, which can also be expressed as Pioneers holding a strong professional identity and also significant authority as sexologists (cf. Johnson & Lindgren, 1999). *The Competence sexologists* stressed the importance of solid competence with a basis in clinical practice and extensive training, both in their primary profession and in terms of further education. Much like the Pioneers, this was a group with a sense of a strong professional authority, often rooted in their primary profession. Another group, *the Entrepreneurs*, was engaged in private practice full or part time. In some cases it was because they had felt opposed by their employer in the workplace and therefore had "giving up" and opened their own office. Whatever the reason, we can conclude that a new so called commercialized professionalism is emerging, which is not only focused on professional competence but also on entrepreneurial skills. Dellgran and Höjer (2005) have labeled these measures as a strategy of professionalization (other strategies are as previously mentioned the authorization, sexological training, membership in sexological associations, mentoring, networking and research). There are varying levels of professional authority among the Entrepreneurs, mainly depending on the primary profession of the sexologist. Even though only a few of the informants had earned doctoral degrees the group of *Sexology researchers* had a high reputation and status among the remainder of the various sexological groupings. Research related to clinical practice and treatment was valued highest by those who were affiliated with the practice of clinical sexology. Finally, the interviewees described a group that was not listed among the informants. This group, the *Non-professionals*, was lacking in human services training and extensive courses in sexology. Sometimes, this group had a prominent role in the media and represent sexologists as online advisors, in magazines or on television, but their formal competence was perceived as ambiguous by the informants.

Competition did not seem to be experienced in relation to other sexologists within the interdisciplinary field, or toward those who are perceived as having a "solid" education. Instead, borderlines were drawn mainly between those who considered themselves to belong to the sexological landscape and have professional authority in the field, and those who did strive to obtain this, i.e. the Non-professionals.

There was also further boundary work (Fournier, 2000; Light, 1988), that may be even more complex, i.e. the Pioneers' desire to continue belonging to the sexological landscape without being questioned or deprived of their professional authority based on long-term work. Another strain against boundaries occured in the striving of women and younger people seeking more senior positions in the sexological associations. Additional cross-border activity took place between the different scientific domains, where medical and psychosocial, psychodynamic or cognitive therapy models were pitted occasionally against each other. However, it was noteworthy that sexologists were more inclined to emphasize collaboration, transparency and respect between the different domains and rather close the borders against those who were not considered sufficiently competent, regardless of domain.

Hence, is it possible to classify sexologists as practitioners of a specific profession? Were we to base our evaluation on criteria such as systematic theory, professional au-

thority, ethics, professional culture and societal sanctions (e.g. Johnson & Lindgren, 2001), it would be doubtful. Those working as sexologists belonged to groups that were much too interdisciplinary, in order for common systematic theories to apply. In addition, some sexologists already belonged to classic professions such as physicians; their main occupation and professional identity were already cemented, while others may be seen as semi-professionals such as social workers and nurses. As for specific ethical guidelines, they did not claim a major importance for sexology as a profession when there were already ethical standards in place for the various primary professions. Thus, they became important markers only in the boundary between qualified sexologists and those who lack specialized training. The authorization can be viewed in a similar manner; its most important function was to keep the Non-professionals away, since the majority of sexologists already had official licenses, post-graduate degrees or doctorates.

The concept of a profession is certainly relative (Wingfors, 2004:16), but perhaps professional competence is a summation that can describe a phase of the professionalization process that has appeared in this study. Indeed, the interviewees were very well educated and the majority had long research-based university education behind them, even if sexology was not part of their basic curriculum. The interviews revealed a clear desire to achieve competence, professional standing and professionalism rather than an expressed desire to become a specific profession. In addition, the informants had expressed that trust and confidence are key concepts of the practitioner's legitimacy. This tendency to speak of professionalism rather than of professions is also true among several professions (cf. Fransson, 2006).

At the same time there was an emerging ambivalence toward both the concept of profession and professionalisation, since there was uncertainty over the correct definition of a sexologist. The criteria for who gets to use the title are ongoing, both among sexologists themselves and among the public and those seeking help. Sexologists also maintain that sexological competence should meet the societal shifts that constantly occur where sexual norms and behavior patterns are concerned. Just as these concepts change and evolve, the process of sexologist as a profession is ongoing, and the criteria should continue to be discussed and analyzed.

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Hospital Districts Implementing Sexual and Reproductive Health Promotion in Finland

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Abstract

Hospital districts are prominent regional actors in the promotion of sexual and reproductive health. The Ministry of Social Affairs and Health gave a regional co-coordinating role in the Sexual and Reproductive Health Action Plan to hospital districts. Following implementation of the action plan, survey questionnaires were sent to the hospital districts. The information detailed below is based on National Institute for Health and Welfare's (THL) compilation of the survey results. All the districts replied to the questionnaire in late autumn 2011.

A regional working group for the promotion of sexual and reproductive health has been formed in a third of hospital districts. An internal co-ordination group has been formed in half of the districts. Almost half of the districts have a named contact person in the area of sexual health.

The action plan recommends health centre- and hospital-based services provided by sexual counsellors. In the majority of hospital districts, sexual counseling and/or therapy have been organised. Also, the majority of hospital districts have professionally trained sexual counsellors or therapists.

In ten hospital districts, clinical pathways were formed for the identification, examination and treatment of post-partum depression and sexual violence. But, in the area of sexual counseling, which requires specialist know-how, a clinical pathway had been formed only in four districts.

At least half of the districts reported that information about sexual health was included in patient guidelines concerning childbirth, gynaecological surgery, prostate cancer, coronary heart disease and breast cancer. Only one hospital district addressed sexual health in a patient guideline relating to depression.

A systematic follow-up for sexual and reproductive health promotion actions was not yet established in any of the hospital districts. Only five districts included the promotion of sexual and reproductive health in their own action plans.

The action plan for sexual and reproductive health is to be evaluated and updated in 2012.

Introduction

Finland's first national Sexual and Reproductive Health Action Plan was completed in 2007. Its main goal is to promote good sexual and reproductive health among the population. The action plan sees sexual and reproductive health as part of public health, and the promotion of sexual and reproductive health is included in general health

promotion. The programme is multidisciplinary, that is, its implementation is based on co-operation between different sectors and fields of administration. The action plan contains national, regional and local-level goals. Many of the regional goals and measures concern hospital districts.

In the 2000s, promotion of sexual and reproductive health has been adopted on the European health and welfare promotion agenda. Many countries are establishing country-specific sexual and reproductive health programmes. At the EU level, sexual health constitutes one of the priority areas in the promotion of young people's health. In 2010 the World Health Organization's Regional Office for Europe and the German Federal Centre for Health Education (BZga) published the Standards for Sexuality Education in Europe. The Finnish National Institute for Health and Welfare (THL) has translated the standards into Finnish.

Finland has also added provisions on sexual and reproductive health promotion to its legislation. Under the Finnish Health Care Act (1326/2010), local authorities must provide their residents with family planning advice and other services that promote sexual and reproductive health. In addition, the Council of State decree (338/2011) on welfare clinic services, school and student health services and preventive oral health services for children and youth includes an obligation to implement measures in accordance with the Sexual and Reproductive Health Action Plan. For example, health counselling must also promote the health (including mental health) and psychosocial well-being of individuals and their families in the area of sexual health. Counselling that supports the sexual maturation and development of under-school-age-children, schoolchildren and students must be included in general health counselling and health checkups, in a manner that suits the developmental level of the child or young person.

In spring 2009, the Finnish National Institute for Health and Welfare and the Finnish Ministry of Social Affairs and Health conducted a survey concerning the implementation of the Sexual and Reproductive Health Action Plan in the hospital districts. The survey of the hospital districts was repeated in autumn 2011 as part of the final evaluation of the programme. This article contains a summary of the main results of the survey. In addition, the results from 2011 are compared with the results obtained in 2009.

Material and Methodology

In November 2011, the Medical Director and Chief Nursing Director of each hospital district were sent a web-based survey in the form of a questionnaire to determine the achievement of the goals and implementation of the measures specified for the hospital districts in the action plan. Each hospital district was asked to fill in and return one questionnaire. After the actual survey, one reminder questionnaire was sent to non-respondents. In addition, personal contact was used to encourage a response.

The questionnaire included questions concerning the individuals and working groups responsible for sexual and reproductive health promotion; the training of specialists; the arranging of sexual counselling and sexual therapy clinics; clinical pathways; guidelines for patients; development of treatment procedures and other procedures; support for abortion patients; the monitoring and planning of sexual and reproductive health promotion; and future challenges. The questionnaire contained 31 questions. Seven were open-ended questions and the rest were multiple choice questions.

All 20 hospital districts in Mainland Finland responded to the survey. Frequency distributions were compiled of the answers using the Webropol software (a data analysis and survey tool), and the topics mentioned in the open-ended questions that were relevant for the evaluation of the action plan were included in the report. The results have been reported in accordance with the goals and measures specified for the hospital districts in the action plan.

Results

The Individuals and Working Groups Responsible for Sexual and Reproductive Health Promotion

Slightly less than half of the hospital districts had appointed a sexual health contact person. In most cases, the contact person had been appointed already in 2009. An internal planning and co-ordination team had been established also in slightly less than half of the hospital districts. Most of the contact persons were midwives, nurses or gynaecologists who were qualified sexual counsellors, psychotherapists or sexual therapists. The responsibilities of the contact person included maintaining contacts with specialised care and primary health care; being in charge of the co-operation team (or acting as the chairperson of the team); communication; training; co-ordination of the hospital district's network and other co-ordination.

Nearly one third of the hospital districts had appointed a regional sexual and reproductive health working group. In addition to representatives from specialist care and primary health care, most of the working groups included representatives from universities of applied sciences. Universities and local authorities' educational administration were rarely represented in the working groups. Social administration was not represented in the working group of any hospital district. The most important activities of the working groups included co-ordinating co-operation; acting as a network of specialists; surveying the current state of sexual and reproductive health and available resources; surveying the availability of basic and further education; drafting regional operating models; and communication. Arranging training courses and implementing the health promotion action plan in practice were also mentioned as activities.

Compared with 2009, in 2011 hospital districts had more sexual health contact persons and internal planning and co-ordination teams. The responsibilities of the contact persons had not changed. Only a slight increase was seen in the number of regional working groups, and their activities had remained mainly unchanged. In 2011, social administration was no longer represented in the regional working groups. In addition, educational administration and universities were less frequently represented in 2011 compared with 2009.

Methods to Improve Patient Care

Fifteen hospital districts had qualified sexual therapists and counsellors or employees who had completed the sexual health education provided by universities of applied sciences (60 credits). In total, the hospital districts employed 33 sexual therapists or people who had completed sexual health studies at a University of Applied Sciences and 143 sexual counsellors. In addition, five people were currently taking studies in sexual health and counselling.

Seventeen hospital districts had a sexual counselling and/or sexual therapy clinic. The clinic was usually at the gynaecology and/or obstetrics facility, and patients were

referred there by a nurse or a doctor. In some hospital districts, the services of a sexual counsellor or therapist were provided by such units as the urology, surgery, oncology or spinal cord injury outpatient clinic, or the outpatient clinic for expectant mothers suffering from fear of childbirth. A few sexual counsellors and therapists also provided guidance and counselling for patients in hospital wards. Some sexual counsellors and therapists provided counselling in addition to other duties. Some had regular consulting hours. In three hospital districts, those in need of sexual counselling used private sector services or there were no sexual counselling and/or sexual therapy services available.

Most hospital districts had established clinical pathways between the hospital district and primary health care in areas such as antenatal screening, treatment of expectant mothers with substance abuse problems, breast-feeding guidance, induced abortions and treatment of miscarriages, as well as further treatment of patients with abnormal Pap smear findings. Twelve hospital districts had a clinical pathway in place for the diagnosis and treatment of sexually transmitted diseases (STDs). Ten hospital districts had established clinical pathways for the identification, examination and treatment of patients with postpartum depression and patients who had experienced sexual violence. For sexual counselling, which requires specialist knowledge, a clinical pathway only existed in four hospital districts.

Compared with 2009, the use of clinical pathways had remained unchanged or had increased slightly. Clinical pathways for sexual counselling, which requires specialist knowledge, had been implemented during the follow-up period, because in 2009 they did not exist in any hospital district.

Almost all hospital districts reported that sexual health-promoting information was included in written patient guidelines concerning childbirth. At least half of the hospital districts that responded to the survey reported that sexual health-promoting information was included in patient guidelines concerning gynaecological operations, prostatic cancer, coronary artery disease and breast cancer. Only four hospital districts addressed sexual health in their patient guidelines concerning multiple sclerosis, three in patient guidelines concerning Parkinson's disease and one in patient guidelines concerning depression. Compared with 2009, the patient groups that the guidelines were addressed to had remained unchanged.

Eighteen hospital districts reported that they offer efficient, long-standing means of birth control to women who repeatedly sought abortion. About half of the hospital districts offered special support and free-of-charge birth control to women who repeatedly sought abortion, and systematic psychosocial support to women who experienced abortion. Half of the hospital districts kept a record of the number of repeated abortions.

Monitoring and Planning

Actual systematic monitoring of sexual and reproductive health activities or promotion of the activities is still rather sporadic in the hospital districts. Six hospital districts had not organised systematic monitoring of sexual and reproductive health promotion among the population, or the monitoring was not a routine procedure. In their open-ended answers, the hospital districts reported the use of the following information for monitoring: THL's statistics and registers; local authority-specific statistics on the number of abortions by age group; statistics on Baby Friendly Hospital Initiatives;

infectious disease statistics (STDs); and information obtained from the patient information system and customer feedback.

The hospital districts used their own statistics for the monitoring of the population's sexual and reproductive health as follows: the number of patient visits; diagnosis and procedure codes; the number of births and childbirth-related interventions; the number of induced abortions and sterilisations; the number of Chlamydia cases; the running of the outpatient clinic for expectant mothers suffering from fear of childbirth; and customer satisfaction surveys. In addition, hospital districts used patient information systems for their own monitoring.

The hospital districts reported that the abortion, birth and infectious disease registers were the most frequently used THL statistics for the monitoring of sexual and reproductive health promotion. Only two hospital districts used THL's SOTKAnet (= Statistics and Indicator Bank), which includes information on disease incidence and the use of medication and services.

In 2011, five hospital districts had included sexual and reproductive health promotion in the hospital district's action plan, and two hospital districts were planning to do this. In 2009, only three hospital districts had included this topic in their action plan. Other regional initiatives included the following: starting sexual health surgeries; establishing a regional working group; starting the training of sexual counsellors in the area; designing clinical pathways; training personnel in sexuality-related matters; arranging regional training courses; improving the recording procedures; developing online courses and other online materials and implementing them; establishing a working group for the planning of education; developing a family training model; starting a breast-feeding outpatient clinic; and carrying out various projects related to the area of sexual and reproductive health.

Future Challenges

The hospital districts saw the following as the most important content-related challenges in sexual and reproductive health promotion: integrating this area into other health promotion programmes and clinical pathways; getting primary care units involved in the improvement of this area; enhancing co-operation with primary health care (such as joint clinical pathways), ensuring equal availability of sexual counselling to all; and co-ordinating, resourcing and organising sexual health promotion work. Decreasing the number of abortions and STD cases, early intervention (substance abuse, financial problems and mental health problems) and the effects of an aging population on sexual and reproductive health were also mentioned as individual content-related challenges.

According to the hospital districts, administrative structures should be developed to support the promotion of sexual and reproductive health. This includes measures such as improving and co-ordinating the co-operation between specialist care and primary health care (including joint clinical pathways, a patient information system, better knowledge of sexual counselling in primary care); utilising various networks; increasing personnel resources in sexual counselling and the planning and co-ordination of sexual health promotion; establishing a working group to co-ordinate, assess and improve sexual and reproductive health promoting activities in the area; specifying the duties of sexual counsellors and establishing posts for them; and strengthening the role of the sexual health contact person.

Discussion

Now that four years have passed since the publishing of the Sexual and Reproductive Health Action Plan, most hospital districts are implementing the programme. Regional and hospital district-specific differences in the implementation of the programme are substantial and to some extent still dependent on the contribution and activity of interested individuals. Most hospital districts have professional sexual counsellors and therapists available. Together with gynaecologists they have had a central role in the promotion of the action plan and the development of co-operation networks in the hospital districts.

Even though the intermediate evaluation showed that the promotion of sexual and reproductive health has improved from 2009 to 2011, the hospital districts should continue to:

1. Establish multidisciplinary working groups, particularly for regional co-operation and co-operation with primary health care; or expand the responsibilities of the current working groups to cover sexual and reproductive health.
2. Appoint a person and/or persons to co-ordinate sexual and reproductive health promotion in the hospital district. The analysis showed that there was much variation in the organisation of sexual counselling and/or sexual therapy services, and the services were often targeted only at specific customer and patient groups.
3. Describe, organise and resource sexual counsellors' work in the hospital districts. The analysis showed that the job descriptions of sexual counsellors and sexual counselling resources varied between the hospital districts.
4. Enhance the use of the skills of professional sexual counsellors and therapists. The analysis showed that the hospital districts have many qualified professionals, but their skills are not fully utilised.
5. Systematically analyse and develop patient guidelines from the sexual and reproductive health perspective. The analysis showed that the existing experience could be used in this work through national-level co-operation and co-operation between the hospital districts. In this way, uniform national-level patient guidelines could be developed and hospital districts' resources could be saved.
6. Include the promotion of sexual and reproductive health in the hospital district's action plan and health promotion programmes and evaluate clinical pathways from the perspective of sexual and reproductive health.
7. Clarify the primary health care unit's role in sexual and reproductive health promotion and strengthen co-operation with primary health care.

In 2009, representatives from the hospital districts and various organisations considered it essential to establish a national-level co-ordination body in order to support their work and to promote more extensive co-operation and systematic development. At that time, the continuity of national-level co-operation was considered sporadic. In 2010, the Sexual and Reproductive Health Unit was established at the National Institute for Health and Welfare. Its job is to promote sexual and reproductive health through means such as developing services related to this area.

Compared with 2009, the promotion of sexual and reproductive health is somewhat more systematic and extensive in 2011. However, there are considerable differences in activity between the hospital districts. Nevertheless, the national action plan has clearly activated and expanded regional promotion of sexual and reproductive health.

Pleasure and Danger:

The Struggle Over Sexual Pleasure in Feminist Literature

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Sexuality has long been a contested domain for feminism. According to Carol Vance (1984), in both the nineteenth and twentieth centuries feminists viewed sexuality concurrently as an area of control, domination and danger as well as a domain of exploration, pleasure and agency. Vance explains that the feminist tension lies between two extremes: to focus merely on pleasure and satisfaction in relation to sexuality which would ignore the patriarchal structure in which women act, and on the other hand, to speak only of sexual violence and oppression which would ignore women´s experiences with sexual agency and choice.[1] Following up on Vance´s understanding R. Claire Snyder-Hall (2010) adds that the second-wave of the American feminist movement was torn apart over questions related to sexuality, finding themselves on "opposite sides of a series of contentious debates about issues such as pornography, sex work, and heterosexuality, with one side seeing evidence of gender oppression and the other opportunities for sexual pleasure and empowerment."[2]

The aim of this paper is to reflect on the struggle over sexual pleasure in feminist literature with special focus on radical feminism and its legacy. What is the content of this legacy and how are feminist writers today dealing with it, is one question I wish to answer. I start with a dialogue of the premise of most feminist work on sexuality, namely that sexuality is socially constructed and after that I go on to give an account of two recent feminist perspectives on this struggle, those from Katherine M. Franke (2001) and R. Claire Snyder-Hall (2011). Both have important contributions to make regarding the feminist sexual struggle but what are the ways forward in current society?

The Social Construction of Sexuality

"Sex as we know it – gender identity, sexual desire and fantasy, concepts of childhood – is itself a social product. We need to understand the relations of its production".[3] In these words of Gayle Rubin (1975) she puts forward an increasing theoretical insight within feminist circles during the mid-seventies, that is to say that our sexual emotions, desires and relationships are shaped by the society we live in. Up to then most

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1 Carol S. Vance, "Pleasure and Danger: Toward a Politics of Sexuality", *Pleasure and Danger: Exploring female sexuality,* ed. Carol S. Vance, London: Pandora Press, 1992 [1984], (1 – 27), 1.

2 R. Claire Snyder-Hall, „Third-wave Feminism and the Defense of „Choice"", *Symposium*, March 2010, vol. 8/No.1, (255 – 260), 255.

3 Gayle Rubin, „Traffic in Women. Notes on the „Political Economy of Sex"", *Deviations. A Gayle Rubin reader,* Durham & London: Duke University Press, 2011, [1975], (33 – 65), 39.

theoretical and sexological approaches assumed that sexuality was a natural energy, a life force, an instinct or even the most unchanging of all drives.[4] Against such essentialist and ahistorical theories feminist writes started arguing that sexuality is not simply a natural or a biological fact; sexuality is grounded in biology, but biology alone does not cause the patterns of sexual life. Sexuality has a history, or more accurately, many histories. Therefore, one should not think of sexuality as something apart from social meanings, defining it in an absolute sense. Rather one should think of it in a social-cultural context, understanding sexual behavior as socially scripted, in the meaning that it is learned and acted out within a social and historical context, which means that different social contexts can have different social scripts.[5]

But, is there anything new in this? Isn´t this an interpretation that a host of sociologists, historians and anthropologist also did maintain during the 1970s, theorists like Mary McIntosh, Jeffrey Weeks, Jonathan Katz and Michel Foucault? [6] So, what exactly is the feminist angle here? The answer to this question is *gender*, or to be more precise, the correlation most feminist understand there to be between the social construction of sexuality and the social construction of gender. A clear example of this interpretation can be found in the work of professor of law, Catharine A. MacKinnon in the 1980s. MacKinnon's post-Marxist theory of sexuality treated sexuality as a social construct of male power and located it within a theory of gender inequality. Her view of sexuality becomes most clear in the following words: "I see sexuality as fundamental to gender and as fundamentally social. Biology becomes the social meaning of biology within the system of gender sex inequality much as race becomes ethnicity within a system of racial inequality. Both are social and political in a system that does not rest independently on biological differences in any respect." [7]

A feminist theory of sexuality then, in MacKinnon´s and many other radical feminist views, treats sexuality as a social construct of male power. This theory holds that men have historically had the privilege to define sexuality and forced that understanding onto women. Hence, the crucial meaning of male-constructed sexuality hence is: male dominance and female submission. In accordance with this analysis, MacKinnon labels the social position of women in patriarchal societies as *rapable*. To be *rapable* is a social position, not biological. Women are raped because they are women; they are raped because of gender. Gender and sexuality cannot be separated; gender is a social hierarchy, a matter of domination and subordination. It is a systematic inequality in power, and furthermore; it has been rationalized and consequently justified as natural. The naturalness of male-female sexual relations means that rape of women is inevitable and even more than that; it is integral to the way inequality between the sexes takes place in real life! [8]

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4 Jeffrey Weeks, *Sexuality*, New York: Routledge/Ellis Horwood Ltd and Tavistock Publication Ltd, 1986, 24.

5 Stevi Jackson, *Heterosexuality in Question*, London: SAGE Publications, 1999, 31.

6 See e.g. Mary McIntosh, "The Homosexual Role", *Social Problems,* Vo. 16 No. 2, Autumn 1968; Jonathan Katz, *Gay American History*: *Lesbians and Gay Men in the USA*, New York: Crowell, 1976; Jeffrey Weeks, *Coming Out*: *Homosexual Politics in Britain,* London: Quartet, 1977; Michal Foucault, The *History of Sexuality*, New York: Pantheon, 1978.

7 Catharine A. MacKinnon, *Toward a Feminist Theory of the State*, Cambridge, Mass & London: Harvard University Press, 1989, preface xiii.

8 Catharine A. MacKinnon, *Toward a Feminist Theory of the State*, 244-245.

MacKinnon´s theory is alarming for a number of reasons, foremost among them as it seems to me, the interpretation that because of gender oppression in patriarchal societies all women, more or less, live under the conditions of constant sexual danger. One possible outcome of such an interpretation is sexual anxiety at the social level, but even a theoretical view that makes a strong opposition between a feminist sexual view and an anti-feminist one. In this context Carol Vance points out that it is imperative that any feminist interpretation of women´s sexual situation accounts for the differences among women, arguing that on a social level, women´s relationship to sexuality is diverse, not singular. The same would apply to feminist theories of sexuality; it is diverse, not singular. Not denying the dangers of sexuality for women, i.e. violence, rape or exploitation Vance writes: *Social movements, feminism included, move toward a vision; they cannot operate solely on fear. It is not enough to move women away from danger and oppression; it is necessary to move toward something: toward pleasure, agency, self-definition. Feminism must increase women´s pleasure and joy, not just decrease our misery. [. . .] To persist and amid frustrations and obstacles, feminism must reach deeply into women´s pleasure and draw on this energy*.[9]

Vance´s response (1984) has been well-received. Feminist writer, Audre Lorde (1984), wrote on the "erotic" describing it as a powerful resource within all women which could work against male oppression and transform women´s social life conditions.[10] Feminist theologian Carter Heyward (1989) went even further, insisting that if women only would receive the erotic as a divine power it could move women through fear and danger toward healing and blessing.[11] Coming back to these contributions later in my paper I shall finish this section by accounting for somewhat different response to MacKinnon´s sexual theory, the one of feminist anthropologist, Gayle Rubin (1984).

In a sexual-constructivist way Rubin makes clear that all that we call "sexual", in our societies, similar to what is called masculine or feminine, is a construct that can only be fully understood when positioned in relation to other social, cultural, political and economic areas. In her view an interpretation of sexuality like MacKinnon´s and her allies' strikes back on feminism. In her mind it is biologically deterministic which is quite remarkable as biological determinism[12] is exactly what feminism has always tried to fight?[13] Criticizing feminist discourse on sexuality for being "less a sexology than a demonology" she goes on to argue that radical feminists put most sexual behavior in the worst possible light by presenting the "most disgusting pornography, the most exploited forms of prostitution, and the least palatable or most shocking manifestations of sexual variation."[14] As an outcome of this provocative analysis she

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9 Carol S. Vance, "*Pleasure and Danger*: Toward a Politics of Sexuality", 24.

10 Audre Lorde, *Sister Outsider*, Freedom, Berkeley CA: Crossing Press, 1984.

11 Carter Heyward, *Touching our Strength. The Erotic as Power and the Love of God*, San Francisco: Harper Press.

12 It is most common to understand biological determinism to be the idea that people's attitudes, behaviors, affinities, and other qualities are determined – in part or in whole – by their biology. The main feminist motivation for making a distinction between sex and gender, like Gayle Rubin did as early as in 1975, was to counter biological determinism, i.e. the idea that women´s biology (sex) was their destiny.

13 Gayle S. Rubin, *Deviations. A Gayle Rubin Reader,* Durham & London: Duke University Press, 2011, 72.

14 Gayle S. Rubin, „Thinking sex: notes for a radical theory of the politics of sexuality", 301.

puts forward an analytical distinction between gender and sexuality claiming that their relationships are "situational, not universal, and must be determined in particular situations."[15] Going against the grain of much feminist thought in the mid-1980s Rubin thinks that it is vital to separate, not only sex and gender,[16] but even sexuality and gender in order to be able to reflect more correctly on the structures of sexual stratification. One important reason for this proposal is her understanding that it is necessary to fight the deep-rooted idea within radical feminist circles, flourishing especially in the 1980s, that sexuality is inherently dangerous for women. This certainly well-intentioned feminist viewpoint, Rubin maintained, could easily play into a very reactionary sexual, political agenda that in the end would support oppressive sexuality for women. Feminism, in her view, could not and should not deliver universal answers to the problems of all women´s sexuality; it should not be treated as a grand theory of human sexuality![17]

Sexual Reality and Sexual Ideals: The Road Forward

In an article from 2001 professor of law, Katharine M. Franke, notes that most feminist legal theory seems to have continued along the radical feminists´ road since the 1980s; that is, to render sexuality as dangerous for women, positioning them as victims.[18] Critical of this narrow approach Franke argues that if legal theorists continue to overemphasize violence, dependency and danger in the sexual context, the risk is that they lose all together the imagination of the female body as a "site of pleasure, intimacy, and erotic possibility".[19] Mackinnon´s legacy, in Franke´s view, has contributed to the common interpretation within legal feminism that *no* to *sex* to mean *yes* to power.[20] Franke does not, however, dismiss MacKinnon´s theoretical contribution all together; to the contrary, she thinks she is right about a great deal. However, what she thinks MacKinnon is totally wrong about is overstating male sexuality as violence and determining female sexuality as a "terrain fully colonized by male power".[21] What she wants to get rid of, just like Gayle Rubin, is the radical feminist legacy that feminism is the privileged site for analyzing sexuality.

Gender and sexuality, as we have already seen in the radical feminist interpretation above, are two sides of the same coin, meaning that women are totally subordinated to men in all life conditions. Given such an interpretation one can say that it is nothing but "logical" that *no* is the only feminist answer to any sexual question. But, is that really an acceptable conclusion? Shouldn´t we instead ask why sexual activity and what our culture labels as *sexual* has become more important, more dangerous and even more sacral than everything else that is not called "sexual", asks Franke and continues

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15 Gayle S. Rubin, Deviations. A Gayle Rubin Reader, 97.

16 Here Rubin is referring to the sex/gender distinction that she herself invented in her long famous 1975 article "Traffic in women" – see note 3 in this paper.

17 Gayle S. Rubin, *Deviations. A Gayle Rubin Reader*, 90.

18 Katherine M. Franke, *Columbia Law Review*, Vol. 101, No. 1, Jan. 2001, 181 – 208.

19 Katherine M. Franke, *Columbia Law Review*, 182.

20 Katherine M. Franke, *Columbia LawReview*, 197.

21 Katherine M. Franke, *Columbia Law Review*, 198.

by suggesting that we should try to de-sexualize our culture. Franke writes: "Assault is bad; rape is much worse. Workplace harassment is bad; workplace sexual harassment is much worse. Emotional betrayal by a spouse is bad; adultery is much worse. Exploitative working conditions are bad; exploitative sex work is much worse."[22]

Franke´s question above is not new. It ponders the same issue and the same question that Gayle Rubin already asked in her long famous 1984 article "Thinking sex". What is the reason for these serious moral judgments in the context of sexual activity? The complex answers to that question will not be discussed here in any detail. The keys to that answer lie in a comprehensive cultural analysis which would consider in depth the role of religion, both historically and currently. Sadly enough, religion today, not least conservative, religious groups seems to be the best allies of radical feminist views on sexuality, something that researchers working with human sexuality, public health, social policy and development have recently articulated.[23]

In my opinion Franke is right when she opposes the normative dualistic view of most legal feminism which depicts male and female sexual identity as opposites. This framework tells us that what is sexually good for men is at the same time bad for women, what sexually empowers men subordinates women and what subjectifies men objectifies women. This dualistic view, which to be sure, has had its support in most sexological theories until recently, has led much legal feminism to the conclusion that it is both possible and necessary to use law to tame sexual danger. That conclusion per se is interesting enough and could be discussed extensively, especially in the context of Nordic sex-law legislations.[24] I will, however, ignore that challenge and neither will I consider what lies behind such an optimistic faith.[25] Here it will have to suffice to confirm that I agree with Franke in her conclusion that radical feminism is too moralistic and sorely needs a better theoretical foundation for its view of sexuality. In addition, I argue that neither does it pay enough attention to the plurality of women´s sexual choices and experience, nor does it highlight the crucial feminist principle of self-determination. In my continuing reflection on feminist views of sexual pleasure I shall look more carefully into those issues.

Snyder-Hall (2011), whom I mentioned at the outset of this paper, has compared the sexual view of the second-wave feminism (what I have called radical feminism) to a third wave feminism (developed after the mid-1990s) observing that third wave feminism seems to seek to unify the ideals of gender equality and sexual freedom that came apart during the ´sex wars´ in the late 1980s.[26] Her findings emphasize that the third wave feminists highlight sexual freedom to a much higher degree than those of the second-wave. Snyder-Hall reminds us of how liberal feminism, back to Mary

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22 Katherine M. Franke, *Columbia Law Review*, 199.

23 Sonia Corrêa, Rosalind Petchesky, Richard Parker, *Sexuality, Health and Human Rights*, London & New York: Routledge, 2008, 53 – 79.

24 Here I am referring to the so-called Swedish Approach to sex-work which e.g. Iceland has legislated (2010). For a recent discussion on this approach see the United Nations Development Program's report from July 2012: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

25 Katherine M. Franke, *Columbia Law Review*, 206.

26 R. Claire Snyder-Hall, "Third-wave Feminism and the Defense of „Choice"", 255. By the term "sex wars" she most certainly is referring to MacKinnon and other radical feminists´ writings during the 1980s on e.g. pornography and sex-work.

Wollstonecraft up to the 1970s, has always stressed the moral principles of freedom, autonomy and self-determination for women. These principles apply of course to the context of sexuality. A good example of such feminist claim can be found in the book *The Feminine Mystique* (1963] by one of the fore-mothers of second-wave feminism, Betty Frieden, who argued that due to cultural norms women were denied the opportunity to autonomy and self-determination. Her point was, however, not that gender equality, would threaten women´s sexual pleasure; to the contrary, in her belief it was its precondition![27] This belief changed when radical feminism entered the stage during the 1980s. Its aim was not gender equality, but to "transform the entire multifaceted sex/gender system that advantages men at the expense of women."[28] Radical feminists focused their attention on the private sphere, critiquing the family, marriage, love, normative heterosexuality, sexual pleasure and sexual violence, all of which became the subject of radical scrutiny. Once again Catharine A. MacKinnon defines what danger sexual pleasure poses for women in a patriarchal culture like the Western one we live in:

> *Sexual desire in women, at least in this culture, is socially constructed as that by which we come to want our own self-annihilation. That is, our subordination is eroticized in and as female; in fact, we get off on it to a degree, if nowhere near as much as men do. [. . .] I´m saying femininity as we know it is how we come to want male dominance, which most emphatically is not in our interest.*[29]

These few lines show in a nutshell what alternatives there are for women! Cultural force and institutional power of male dominance make it practically impossible for any heterosexual woman to have an equal relationship with any man. Every woman, or so it seems, who lived with or slept with a man was seen as helping to maintain the oppression of her sisters! Gender inequality meant sexual danger for women; sex was to be avoided. The radical feminist proposal then was that women were called upon to refuse to have sex with men and become "political lesbians" if not sexual ones.[30] To be sure, this line of argument lead to a series of splits and subsequently many straight women left the movement.

I think it is safe to say that the endeavor of second-wave feminist movement, especially the radical part of it in the mid- and late-1980s, to resolve the conflict between gender equality and sexual pleasure was not a success. The offer was both too rigid and unrealistic. That conclusion begs the question: must there be one feminist perspective on sexual pleasure? My answer it straightforward: Of course not! Third-wave feminists, R. Snyder-Hall notes, reply in similar way seeking to reintroduce the ideal of sexual freedom and gender equality into a renewed feminist discourse.[31] Trying to be inclu-

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27 Betty Frieden, *The Feminine Mystique*, New York: W.W. Norton and Company, Inc., 1983, [1963], 317.

28 R. Claire Snyder-Hall, "Third-wave Feminism and the Defense of „Choice"", 257.

29 Catharine MacKinnon, *Feminism Unmodified. Discourses on Life and Law*, Cambridge Mass. and London: Harvard University Press, 1987, 54.

30 Alice Echols, *Daring to Be Bad: Radical Feminism in America 1967 – 1975*, Minneapolis: Minnesota University Press, 1989, 233.

31 Rebecca Walker (ed.), *To Be Real: Telling the Truth and Changing the Face of Feminism*, New York: Anchor, 1995, xxxii.

sive, defending e.g. pornography, sex work, sadomasochism, and butch/femme roles, third-wave feminism, Snyder-Hall writes, attempts to be respectful of the wide variety of choices women make as they attempt to balance equality and pleasure which includes that they show respect for plurality and self-termination.[32] Similar movement with focus on plurality, health and human rights can be verified in much recent sexological and human rights literature.[33] In my concluding words on the struggle over sexual pleasure in second- and third-wave feminist literature I shall try to make some connections between these two intellectual branches.

My first remark is to confirm that the feminist discussion accounted for above of the relationship between gender equality, sexual pleasure and women´s subordination seems to leave us with three alternatives to conceive of women´s sexual pleasure: One, to avoid it all together, two, to transform it into something wholly harmless and sweet, and three, to meet it as it is in reality, that is with its possible dangers. Alternative one and two, it seems to me, are not interesting. The first one, which I have considered in detail, is rigid and moralistic and eventually caused the feminist movement to split. The second alternative seems also moralistic, however in a different way, painting almost a pastoral picture of sexuality, highlighting only its soft and healing sides. I argue that such depictions became quite common, especially in theological feminist and pro -feminist literature during the late 1980s and early 1990s, in which sexuality is described as romantic, sacred and holy.[34] Sexual desire, Nelson thinks is "more than a genital expression", it is "intrinsic to the divine-human connection" and one of the "great arenas for celebrating the Source of Life".[35] Heyward describes sexual desire as the experience of God maintaining that its true aim is friendship or mutuality. Heyward writes:

> *Sexuality is not only a source of pleasure and danger in our lives. It is a source of relational mystery and yearning between, among, and within us. A sacred power, eros moves from and toward a deep, shared sense of unknownness that we will never move beyond or comprehend completely. We cannot know fully "who we are" sexually because we cannot know fully the power of God.*[36]

I agree with Franke and many other writers that to empty women´s sexuality of any risk of a confrontation which shame, loss of control or objectification is like "selling women a sanitized, meager simulacrum of sex not worth getting riled up about in any case."[37] This means that I cannot accept the second alternative as either adequate or appealing.

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32 R. Claire Snyder-Hall, „Third-wave Feminism and the Defense of „Choice"", 259.

33 Sonia Corrêa, Rosalind Petchesky, Richard Parker, *Sexuality, Health and Human Rights*, London & New York: Routledge, 2008; Lotta Samelius and Erik Wågberg, *Sexual Orientation and Gender Identity*: *Issues in Development*, 2005, 15–16, http://www.sida.se/Global/Nyheter/SIDA4948en_Sexual_Orientation_web%5B1%5D.pdf. [April 21, 2012]; Pinar Ilkkaracan and Susie Jolly, *Gender and Sexuality. Overview Report, 2007*, 10, http://www.bridge.ids.ac.uk/reports/CEP-Sexuality-OR.pdf. (May 9, 2012].

34 Carter Heyward, *Touching our Strength. The Erotic as Power and the Love of God*, 1989; James B. Nelson, *Body Theology,* Louisville, Kentucky: Westminster/John Knox Press, 1992.

35 James B. Nelson, *Body Theology*, 22.

36 Carter Heyward, *Touching Our Strength*, 124.

37 Katherine M. Franke, *Columbia Law Review*, 207.

This leaves us with the third alternative, which views sexual desire and pleasure as we know it in the real world – sometimes unclean, offensive, chaotic, filled with contradictions and complexities! This knowledge which disturbs radical feminists but is entirely marginalized in most feminist and theological sexual-ethical literature up to now, is however, confirmed in recent social justice- and human rights literature about sexuality and health which I referred to above.[38] Sexuality, these reports hold, most often is close to danger, control, objectification and shame. These facts may be hard to accept, but none the less are the tough conclusions of those reports. Given the well-known dangers that are to be found in the arena of sexual pleasure feminists, I argue, do well in facing reality, joining the social justice and human rights movements that call attention to persistent problems that are linked to sexuality, not least traditional heterosexuality. Heteronormativity must not control feminist discussion in the future with its male-female pattern in focus. Rather than to concentrate on male-female sexual pleasure, like the radical feminists did, feminists must discuss sexual diversity, like transgender people and intersex persons. Of course, feminists are not in total ignorance of these perspectives but my final words are still to exhort feminists working with sexual pleasure to leave the narrow frames of male-female relation integral to a classic feminist perspective on sexuality, as well as the view that sexuality for women is always linked to danger and violence. Portraying women mainly as being victims is not helpful, as it leaves us, as a society, without the possibility to bring about change. Besides being both depressing and inaccurate it can be played into the hands of conservative religious perspectives of sexuality, highlighting women´s chastity. There is no doubt in my mind that feminists have a lot to contribute with regard to the issue of sexual pleasure from a feminist perspective, i.e. concerning violence, shame and suffering. But, in order for that contribution to become successful, the classic feminist perspective needs broadening, so that an understanding of gender as integral, context-specific and inclusive of men, transgender and intersex persons, is possible. Feminists working on the theory of sexual pleasure should connect their work to the ongoing struggle in the world for sexual rights for all, stressing that women are one social group, among many others, who are in need of sexual rights. To join the ongoing, wide-world struggle that seeks to promote sexual rights for all includes most certainly women´s freedom, sexual pleasure and gender equality.

[38] See note 33 in this paper.

The Case of Legal Control over Homosexuality in Finland in Comparison to Other Nordic Countries[1]

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Introduction

Finland comes behind other Nordic countries[2] when it comes to the recognition of same-sex relations. Whereas in all the other Nordic countries homosexual couples enjoy equal marriage rights and adoption possibilities to heterosexual couples, in Finland the inequality between gay and straight families is still strong: the registered partnership[3] is like a crippled version of the marriage with limited rights, in addition, Finnish adoption laws still require a woman. However, historically thinking there is little new in the Finnish delay. In other Nordic countries homosexuality was decriminalized already before the end of the Second World War, the very same period when Finland had the strongest persecutions against homosexual relations, and it was only in 1971 that same-sex fornication as a crime was abolished in Finland.

In this article I will show that behind the different legal traditions were unalike, even contradictory discourses on homosexuality that gained support in these countries. The discourses that were mainly developed in German speaking Europe spread differently to Scandinavia than to Finland. In this article the focus is put on different scientific discourses that tried to explain and conceptualize male sex relations in the late 19th century and on their impact on national criminal codes in Nordic countries. At first, the historical background of legal control over same-sex intimacy is discussed, after which the focus is put on those countries that went through their codification processes in the 19th century. It will be shown that Finland actually followed the German - and actually - Nazi German perceptions of homosexuality and how it later used those ideas in its own policies against homosexuality. The further the article goes the narrower becomes the focus: the general European view is followed by zoom into Finland and primary sources.

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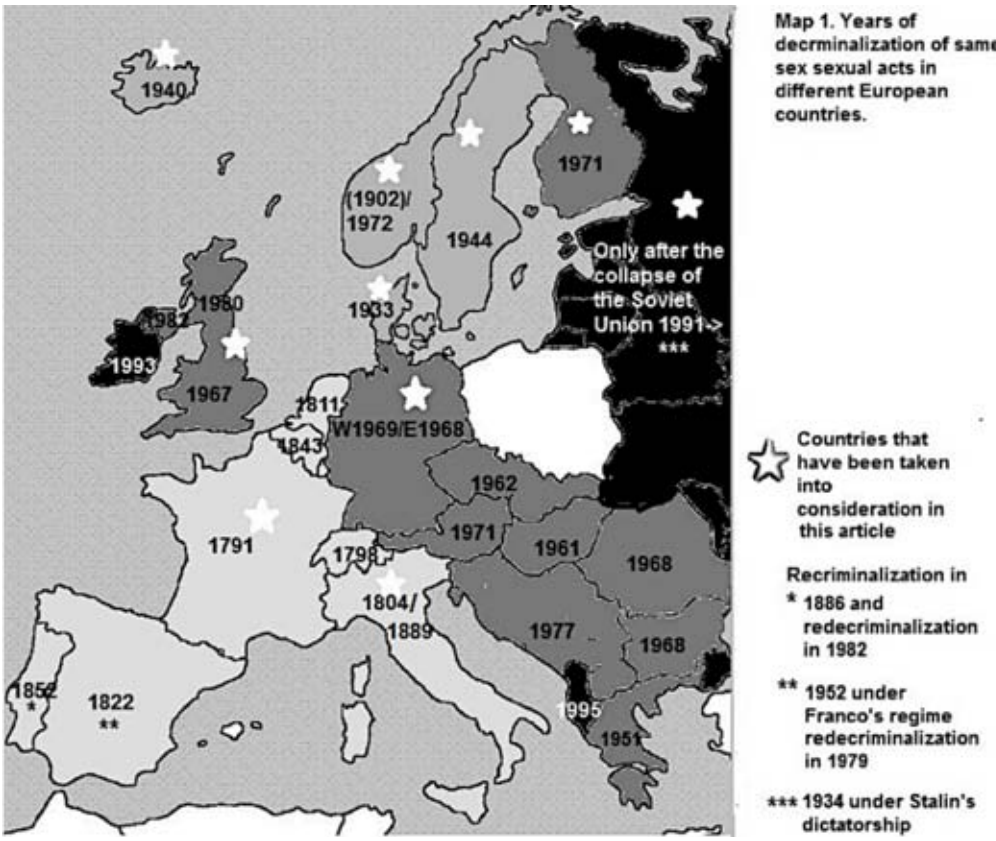
1 The article is based on my PhD-project called *Seven Queer Brothers, Stories of forbidden male same-sex relations from modernizing Finland 1894-1971*. Through seven micro historical studies the project shows how homosexuality appeared in Finnish society and how it was perceived in different decades of the 20th century. The seduction discourse explored in this article is one of the leading themes in the thesis.

2 In this article "Nordic countries" refers to Sweden, Finland, Norway, Denmark, and Iceland in comparison to "Scandinavian countries" which stands for Sweden, Norway, and Denmark.

3 Registered partnership has been possible since 2002 in Finland, whereas it was introduced to Denmark already in 1989 to Sweden in 1995.



The first criminal codes written in Europe were based on Bible, which meant that all over the Christian Europe same-sex relations were criminalized as "sodomic sins". The first main transformation regarding legal control over same-sex sexual relations took place after the Enlightenment and Napoleon's victorious wars. At the turn of the 19th century the Napoleonic penal code, called *Code Napoléon*, spread all over Western and Southern Europe[4] and as the aim of the code was to secularize the law, it lifted the general ban over biblical 'sodomic crime'.

However, at the time of the Code Napoléon same-sex sexuality had not yet gained the attention that it would after less than hundred years, when sexual deviances became to be an object of medical, psychiatric, anthropological, and criminological studies. Moreover, the dates of decriminalization do not tell much about the tolerance towards homosexuality in these countries. For instance, France and Italy had strict policies against homosexuality in the 1930s, when homosexual relations were controlled through other paragraphs (even no new laws explicitly against homosexuals were

[4] Countries that adapted Code Napoleon and therefore decriminalized same-sex sexual relations were France, Netherlands, Belgium, some cantons of Switzerland, Luxemburg, northern parts of current Italy, Spain and Portugal.

enrolled). However, the level of control over homosexuality and that of democracy have gone hand in hand in the 20th century European history.[5]

Different perceptions and discourses of homosexuality can be found behind the differing legal strategies and policies towards homosexuality. When Central and Nordic European countries started their national codification processes in the middle of the 19th century homosexuality became a figure that had to be taken into consideration in the law making process. At this point all the countries criminalized homosexual acts among men, and some also among women.[6] However, regarding the issue the group of countries split to two groups rather quickly, as from the early 20th century onwards Nordic countries started to plan decriminalization of homosexual acts and to speak about homosexual human rights, at the same time Germany went on enrolling stricter laws against such relations, and Finland and England increased the control over same-sex fornication causing an exponential peak in numbers of convictions in the both countries.[7] [8]

As we can see from the map 1, Finland does not fit to the Nordic model, but goes together with the other group. In the most of the Nordic countries, homosexual acts between consenting adults were decriminalized during the period from 1933 to 1944, whereas Finland maintained homosexual relations in the penal code until 1971.[9] Although Norway decriminalized homosexuality even later, in 1972, the Norwegian penal code's section against male homosexuality was not strict; it allowed prosecution against homosexuals only "if public interest so demanded", and actually the law was hardly ever used.[10] Therefore it has been said that, in practice, Norway was the first Nordic country to lift the general ban on homosexuality.

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5 Franco's Spain recriminalized homosexual conduct and so did Stalin in 1930s even Bolshevists' had decrminalized homosexual acts alongside the revolution in 1917. Nazi-Germany enrolled stricter rules against homosexuals in 1935 and Mussolini's Italy even not enrolling new laws persecuted homosexuals through other laws. Ex-Soviet Union countries decriminalized homosexual acts when they turned to democracy. More in BENADUSI, LORENZO. *Il nemico dell'uomo nuovo: l'omosessualità nell'esperimento totalitario fascista.* Feltrinelli, Milano 2005.

6 Countries where same-sex relations between women were criminalized were Finland, Sweden, Austria, and Greece and some cantons of Switzerland.

7 HEKMA, GERT. "Same sex relations among men in Europe 1700-1990" in *Sexual cultures in Europe. Themes in Sexuality*. Edited by Eder, Franz X et.al. Manchester University press, Manchester, 1999:94. Hekma indicates the years from 1933 to 1955.

8 MUSTOLA, KATI. "(Re)Production of Silence by Production of Limited Noise. The Social Control of Homosexuality through Criminal Court Process and Medical Surgery in the 1950's in Finland." In *Silence, Discourse and Deprivation*, edited by Sakari Hänninen, 50-58. Stakes Jyväskylä: 1994,52. The number of same-sex fornication conviction increased slowly from the 1930s onwards and reached its peak at the beginning of the 1950s, when approximately 65 people were sentenced to imprisonment every year.

9 Homosexual relations between adults were decriminalized in Nordic countries as follows: Denmark 1933, Iceland 1940, Sweden 1944, Finland1971, and Norway 1972.

10 HALSON, MARTIN SKANG. "Norway 1842-1972. When Public Interest Demands." *In Criminally Queer: Homosexuality and Criminal Law in Scandinavia, 1842-1999.* Ed. Jens Rydström and Kati Mustola. Aksant, Amsterdam 2007:91-117.

Innate and Learned Homosexualities – Different Theories on Homosexuality

Scientific discourses on homosexuality played a central role behind the legislations in the above mentioned codification processes. As it is, the late 19th century was a turning point in the history of same-sex intimacy, as it started to gain interest in different scientific fields, mainly in Germany and England. The attempts to explain homosexual relations through biology or culture, through psychopathology or physics, were all contributing to the question: What should society do with homosexuals? And further: should they be treated as mentally ill or as criminals, or should they just let live their lives as any other citizens?

Michel Foucault has stated that in the 19th century 'homosexual became a personage', 'a species', with what he wanted to emphasise the discursive change in the fields of psychiatry and sexology that gave new meanings to same-sex intimacy in the 19th century. Before the new scientific discourses, according to Foucault, same-sex intimacy was viewed as a set of physical actions, which did not set the person doing these apart in any way from others. Afterwards, however, people who practised same-sex intimacy were presented as entirely different from others, namely, as a specific group, that of homosexuals.[11] However, Foucault tends to look only suppressive power structures and neglects the fact that also people who related to same-sex relations wanted to define themselves, and in fact, the whole concept "homosexuality" was first coined by a homosexual activist.[12]

In general, there were two different discourses on the field of homosexuality discussion: there were those who considered homosexuality as an inborn and normal variant of human sexuality and those who considered it as pathology. Secondly, along with the pathology discourse, for the first time, appeared also the question of etymology. Some psychiatrists saw homosexual desire as degenerative disease, and therefore as something physical, whereas others saw it as cultural, learned in course of life, and therefore as mental illness.[13] These two differing discourses are behind the different legal developments regarding homosexuality in Europe, and therefore they are presented in this connection.

Discourses that perceived homosexuality as a normal variant of human sexuality were first pronounced by homosexual activists in the middle nineteenth century. One was a German lawyer, Karl Heinrich Urlichs, who in 1860s wrote a pamphlet series on "urnings", which name he gave for men who desired other men. For Urlichs, homosexuality was an inborn quality and therefore natural expression of sexual drive. With these writings he tried to influence the planning of the new German Criminal Code in order to lift the general ban on homosexuality from it. However, when the new German Criminal Code was enrolled in 1871, it still had a paragraph that criminalized

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11 FOUCAULT, MICHEL. *History of Sexuality. Volume 1*. (1976) Translated by Robert Hurley. Penguin 1990: 43.

12 Hungarian writer Karol Maria Kertbeny wrote about homosexual rights in Germany, and was the one who coined the word homosexuality in his pamphlets in 1869.

13 DE CECCO, JOHN P. *Gay personality and sexual labeling*. Routledge, London and New York, 1984: 2.

indecent acts between men. The most influential in the field was a German physician, Magnus Hirschfeld, who had developed the theory on third, intermediate sex that was in between male and female. The third sex would include all sexualities were feminine and masculine were mixed (transgender, intersex, bisexual). According to Hirschfeld, homosexual had "*a woman's soul in man's body*".[14] In 1897, Hirschfeld founded *The Scientific Humanitarian Committee* (Wissenschaftlich-humanitäres Komitee) of which purpose and the goal was the decriminalization of homosexuality from German penal code. The committee wanted to produce scientific research on sexuality, and more particularly on *intermediate sexes*. In addition, English psychiatrist, Havelock Ellis joined to the same group in the end of the nineteenth century. In his writing on "Sexual inversions" Ellis considered homosexuality as an inborn anomaly of some people, such as colour-blindness is, and therefore according to Ellis it is natural part of human sexuality.[15]

In 1886, a German psychiatrist Richard von Krafft-Ebing published his notorious book on sexuality, called *Psychopathia sexualis*, which moved homosexuality to pathological discourse. In his book, Krafft-Ebing used the word homosexual, which, because of the success of the book, became commonly used term for same-sex intimacy on the field of sexual studies. Krafft-Ebing saw homosexuality as a sexual perversion, which was caused by degeneration. For Krafft-Ebing, homosexuality was an inheritable disease, physical malfunction of the nervous system, which may start to flourish as a result of masturbation. Anyhow, Krafft-Ebing considered homosexuality as a disease, not sin or criminal, and it is said that he himself would have supported homosexual rights. However, he saw very much all unproductive forms of sexual behaviour as diseases. Seeing homosexuality as a pathology remained unchallenged, even the theories of Krafft-Ebing were later questioned.[16]

Albert Moll, a medical doctor and sexologist was the first who separated congenital and learned homosexuality. He talked about "contrary feeling" when referring to homosexual desire in 1891. According to Moll, homosexuality was mainly learned in life because of unhealthy sexual experiences, whereas only a small minority was born as such.[17] Sigmund Freud was strongly influenced by Moll's work. To Freud all children were 'polymorphous perverse', who when passing through their stage of latent sexuality would have homosexual desires. According to Freud, children would develop to heterosexuality through puberty if the stages of development were not disturbed. Different disturbances could anyhow develop homosexual orientation that later would be impos-

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14 BROOKEY, ROBERT ALAN. *Reinventing the male homosexual, the rhetoric and power of the gay gene*. Indiana University Press 2002:26-27. CLARKE, VICTORIA et al. *Lesbian, Gay, Bisexual, Trans and Queer Psychology, an introduction*. Cambridge University Press, 2010:7.

15 BAYER, RONALD. *Homosexuality and American psychiatry, the politics of diagnosis*. Princeton Unversity Press, 1987:21. CLARKE, 2010:8.

16 BOYD, STEPHEN BLAKE et al. *Redeeming men, religion and masculinities*. Westminster John Knox Press, 1996:108-109. CLARKE, 2010:8-9. Even decriminalized, homosexuality remained a classified disease in most of the European countries till late 20th century. Further readings: STÅHLSTRÖM, OLLI 1997. *Homoseksuaalisuuden sairausleiman loppu*. Finnqueer.net/pdf/Homoseksuaalisuuden.pdf.

17 TAMAGNE, FLORENCE. *A history of homosexuality in Europe. Berlin, London, Paris 1919-1939*. Algora, New York 2006:154.

sible to cure, and even if not been disturbed while growing up, every adult would still retain the latent remnants of their childhood's homosexual desire.[18]

These different efforts to explain same-sex intimacy at the turn of the 20th century mainly German speaking Europe would have remained marginal without their later political use, in which processes they were transformed into political purposes and into laws and policies.

Scandinavian Countries and Homosexuality as a Human Right Question

Scandinavian countries are known as leaders and pioneers regarding LGBTQ-rights in the world. At the same time these countries have presented strict moral values regarding control over prostitution for instance,[19] and therefore it can be said that it is not the overall liberality that makes these countries to stand at front regarding homosexual rights, but something else. Regarding the decriminalization of homosexual acts there was a strong idea of it as a human right question that it still keeps on being.

The demand of the decriminalization of the same-sex fornication paragraphs as a human right question gained support in Denmark at the beginning of the 20th century. In his study, Wilhelm Von Rosen shows how Denmark, which was the first country to decriminalize homosexuality in the North in 1933, had adapted the human-right attitude on homosexuality from Magnus Hirschfeld, the coincidence that was to affect the other Nordic countries, too. In Denmark, the general idea had been to criminalize human behavior only by scientific reasons, so to say, not by moral arguments. From the scientific argumentations the German sexologist Magnus Hirschfeld's idea regarding homosexuality as an innate and natural variant of human sexuality, was taken as a leading scientific argument in Danish discussion. According to the studies of Von Rosen, the Hirschfeldian theories were presented to the Danish legal authorities by Danish psychiatrist, Sophus Thalbitzer, who did not make any references to the fact that actually Hirschfeld's view to homosexuality was strongly debated in psychiatric circles.[20]

The fact that Thalbitzer's turned into Hirschfeld's argumentation had a wider significance in the North. It did not only affect to the decriminalization of homosexual acts in Denmark, but in Iceland too. Iceland decriminalized homosexual acts in its criminal law reform of 1940. The new criminal law was mostly copied from Danish criminal law, and therefore without an active debate also homosexuality was decriminalized.[21]

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18 ZILNEY, LAURA J. and ZILNEY, LISA ANNE. *Perverts and predators, the making of sexual offending laws*. Rowman & Littlefield 2009: 14,15; DE CECCO, 1984: 2; BAYER, 1987:24. CONRAD, PETER and SCHNEIDER, JOSEPH W. *Deviance and Medicalization. From Badness to Sickness*. Temple University, Philadelphia 1992:185-186.

19 Buying of sexual services is illegalized in Nordic countries, except in Finland.

20 More about Danish criminal law and homosexuality in WILHELM von ROSEN: "Denmark 1866-1976: From Sodomy to Modernity" in RYDSTÖM, JENS and MUSTOLA, KATI (ed.). *Criminally queer: Homosexuality and Criminal Law in Scandinavia 1842-1999*. Aksant, Amsterdam 2007:.61-90.

21 THORVALDSDÓTTIR, THORGERDUR. "Iceland 1869-1992: From Silence to Rainbow Revolution" in RYDSTÖM, JENS and MUSTOLA, KATI (ed.). *Criminally queer: Homosexuality and Criminal Law in Scandinavia 1842-1999.* 117-144.

In Norway, the section against homosexual acts was mild from the beginning,[22] because two important legal authorities[23] had a liberal view towards homosexuality and were familiar with the latest scientific discussions. Actually another of them advocated decriminalization already from the new 1902 criminal law, but the Parliament was not ready for this. Their influence was anyhow strong, and therefore the anti-homosexual law section allowed prosecutions only if public interest so demanded.[24] Also in Swedish decriminalization discussion of the 1930s homosexuals were viewed as victims of the society. Youngster gangs and blackmailers were seen as the criminals from whom homosexuals should be protected from. Thus in Nordic countries others than Finland the decriminalization of homosexual acts was seen as a human right question. Altogether, before the end of the Second World War Scandinavian countries had already demonstrated their will to support sexual minorities.

Finland and the Homosexual Seducer as a Social Danger

Even Berlin is remembered as the most vivid place for homosexuals in the inter-war years[25] and even Germany formed the space from which the most of the literature related to homosexuality was produced, the country never decided to decriminalize homosexual acts although the paragraph 175, that criminalized male-male sexual relations, was constantly debated.[26] When Nazis got in power they enrolled stricter laws against homosexuality in 1935. Whereas the previous criminal code had criminalized only male-male intercourse, the new law prohibited all kinds of "indecent acts" between men. Two years before the law reform also the Scientific Humanitarian Committee of Hirschfeld was closed and all the studies destroyed.

The tightened control over homosexuality was reasoned as follows: "I*t is a danger to the State, for it damages the men's character and their civic life in the most serious way, disturbs healthy family life and corrupts young male*".[27] The quotation shows that homosexuality was seen as a threat to real masculinity, to family, and to young men. The dangerousness of it was in a seduction idea. Relying on theories of Moll and Freud explained above Nazi Germany legitimized the tightened suppression over homosexual relations in Germany. Without their purpose, theories of Freud and Moll were interpreted as if without careful protection every man and especially a younger man could turn to homosexuality through homosexual seduction. In this way homosexuality formed a risk to the most important unite of the society, that of family.

Finland and Germany had strong scientific connections in the interwar period. The connections with Germany had also been strong with the political elite until the

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22 The Norwegian Criminal Code was established in 1902.

23 The authors of the criminal law proposal were Bernhard Getz and Francis Hagerup.

24 RYDSRÖM and MUSTOLA 2007:23.

25 HEKMA 1999:87. TAMAGNE, 2006.

26 Not even when a big part of the national elite was related to a homosexual scandal called *Eulenburg scandal* that was tried along the years 1907-08. More in DOMEIER, NORMAN. *Der Eulenburg-Skandal, Eine Kulturgeschichte Der Politik Des Späten Kaiserreichs*. European University Institute, Florence 2009.

27 TAMAGNE 2006:361-362.

late 1930s, when the attitudes became more skeptical. Marjatta Hietala's study over Finnish and German scientific connections shows that Finnish academy was strongly influenced by Germany, for instance the race hygiene ideology was adapted already in 1920s. Helsinki university used mainly German textbooks, one third of the professor experts came from Germany, as well as half of the invited foreign lecturers were German. The connections to Germany were especially high in medicine in which Finland absorbed Nazi-German influences.[28]

In this particular field, conceptualization of homosexuality, the scientific and political connections between Finland and Germany made Finnish medical, juridical, sociological and later common people to perceive the German perception of homosexuality as '*a danger that lurks in our society*' as Finnish tabloid magazine wrote about homosexuality in 1951.[29] Let me show next how this seduction discourse functioned in practice in Finland in the post-war period.

In juridical matters the adaption of German seduction perception was visible in textbooks of criminal law, which followed the German interpretations: firstly, any sort of indecent act between same sexes was considered "same-sex fornication" and secondly, the worries about possible homosexual seducers and of the spread of homosexuality were pronounced.[30] Finnish professor of the criminal code Brynolf Honkasalo had divided homosexuality to inborn and learned types, which affected his argumentation related to homosexuality as an object of criminal law. Honkasalo used the seduction argument when justifying the existence of the same-sex fornication paragraph in the Finnish penal code. Honkasalo wrote that the law has an important role in preventing "*homosexuals to seduce young men to homosexuality, which may cause an abnormal sexual drive in them*".[31]

The seduction discourse was entirely absent from a similar Swedish textbook. Swedish juridical experts Gösta Rylander and Erik Bendz divided homosexuality to three different types, from which two were inborn and one cultural. Regarding the cultural type of homosexuality the Swedish writers saw that in some extraordinary circumstances, as in prison, homosexual behaviour may occur as a substitute to heterosexuality. However, they said that when the conditions are normalized also the sexual activity would turn back to heterosexuality.[32] Thus, the Swedish writers connected the other two types of homosexuality to inborn types, and they did not have an idea that people may be educated to homosexuality, which idea seems to having been really strong in Finnish perception in different layers of the society. For Honkasalo, the learned type of homosexuality was more permanent, it was not a temporal stage, but once someone was introduced to it by other homosexual he would 'turn' homosexual, too.

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28 HIETALA, MARJATTA.

29 In Kalle 1951:9, 2. "yhteiskunnassa piilevä homoseksualismin vaara".

30 HONKASALO, BRYNOLF *Suomen rikosoikeus. Yleiset opit, toinen osa*. Suomalaisen lakimiesyhdistyksen julkaisuja b-sarja, 34, Helsinki, 1949:59-60.

31 HONKASALO 1949:59-60.

32 RYLANDER, GÖSTA and BENDZ, ERIK. *Rätpsykiatri, I kort framställning lämte huvuddragen av lagsstiftningen rörande psykist abnorma.* Wahlström & Widstrand, Stockholm 1947: 126-129.

The same kind of discourse is present in Finnish scandal magazines which were worryingly following the developments in 'decadent' Sweden that had legalized homosexual acts and therefore '*men had slid to this sick and abnormal trap*'[33]. Same worry increased regarding Finland: "*Public authorities warn: alarming danger*"[34] *or* "*Has Swedish disease increased in Finland*?"[35] Homosexuality was often connected to Sweden in magazine articles, because regarding the issue Sweden was the first, and actually the only, point of reference: It had legalized homosexual acts and had an active gay-life in Stockholm for instance. Moreover, Sweden had also experienced big homosexual scandals at the beginning of the 1950s, which were a lot discussed also in Finnish press.[36] In 1951 it was reported in *Helsingin Sanomat* how homosexuality was so commonplace in Sweden that a father could not go to movies with his teenage-son without people assuming them being homosexuals.[37] The journal wondered: "*could it really be so that Sweden is the stamping ground of 'homophiles' in the world?*" The wonder was real, as homosexual scandals reported in Finnish press had been foreign from Krupp's scandal (in 1902) onwards, whereas what happened in the own country was by and large unknown. This was a tradition that broke down only at the end of the 1950s.[38]

The spread of homosexuality was also discussed in other forums. For instance, Swedish and Danish homosexuals were interviewed about their lives in Copenhagen and Stockholm to a Finnish male entertainment magazine in 1951. When these homosexuals explained themselves they strongly stated that homosexuality was their inborn quality, and that homosexuality cannot be transmitted to other people. The Finnish writers of the article were anyhow against this perception.[39] Moreover, one of the leading figures behind the post-war population politics in Finland, doctor Rakel Jalas[40], also discussed the roots of homosexuality in her influential book in 1941. She

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33 JUVONEN, TUULA. *Varjoelämää ja julkisia salaisuuksia. Homoseksuaalisuuden rakentuminen soiten jälkeisessä Suomessa*. Vastapaino, Tampere, 2002:87.

34 Jallu 11/1959.

35 Kalle 1951:

36 There were at least two big homosexual scandals in Sweden in 1950s being *Kejne affair* and *Haijby affair,* which both dealt with homosexual relations of political elite. RYDSTRÖM, JENS. *Sinners and Citizens. Bestiality and Homosexuality in Sweden 1880-1950*. University of Chicago Press, Chicago 2003.

37 In *Helsingin Sanomat* 24.7.1951 with deadline "'homophile horror's' phenomena in Sweden" ("*Homofiilikauhun" ilmiöitä Ruotsissa*).

38 I find the conclusions presented by Tuula Juvonen (2006) that Finns would have consciously alienated homosexuality to Sweden because of Finns' own queer experiences in the war exenterated. Tuula Juvonen analyses in her article ("Ruotsalaistaudin kourissa. Heteromaskuliinisuuden jälleenrakentaminen 1950-luvun Suomessa." In *Kun sota on ohi*, edited by KARONEN, PETRI and TARJAMO, KERTTU. Historiallinen arkisto, 124. Suomalaisen Kirjallisuuden Seura, Helsinki, 2006: 310–341.) that the reason for alienating homosexuality outside the Finnish borders was part of the reconstruction process of Finnish hetero-masculinity. During the war men had experienced homosexual relations, which afterwards needed to be forgotten and alienated from Finnish masculinity, Juvonen says. Sweden was a good object as it was 'full of mommy's boys who did not even participate to the war' Juvonen describes the rationality behind the discourses of 'Swedish disease' JUVONEN 2006:332-333.

39 JUVONEN 2006, 326.

40 Rakel Jalas was one of the founding members of Family Federation of Finland (Väestöliitto), and was behind the biggest social political family laws. In FORSIUS, ARNO. *Rakel Jalas (1892–1955) – psykiatri sosiaali- ja väestöpolitiikan kehittäjänä*. in http://www.saunalahti.fi/arnoldus/rakjalas.html read 24.8.2012.

saw that homosexuality was learned: it was something that started from occasional relations and become to be "*a habit and necessity*". Jalas saw that the wide distribution of homosexuality was caused by ignorance, that people did not know with what they were engaging within these sexual relations. Jalas connected homosexuality to ignorance, and said that people should be warned and educated with knowledge about homosexuality, so that they would learn to avoid it.[41] The seduction explanation was also found from many court case documents where people explained their sexual past and reason for them being homosexuals.[42]

In Finland, other than in Scandinavia, homosexuality, or as in the post-war connection we should speak about *homosexualism*, was a threat to every man - like *alcoholism* - Something that may be fun, but not responsible, and what, in the end, would make one a slave of it. Exactly comparable to sober-movements of the turn of the 20th century, which tried to educate ignorant Finns about the dangers of booze, was homosexuality now needed to be educated and explained to Finns. Sex acts between men had previously been widely overlooked in Finnish agrarian communities, as well as in the first urban working class environments, in gender segregated communities in the woods and wars. However, from the late 1930s onwards and these relations became problematic, they endangered the society and its healthy growth.

The seduction discourse, even having caused an intensified policing over same-sex intimacy in many European countries, is at the same time rather *queer* as a theory, because the fear of seduction manifests also that 'heterosexual' and 'homosexual' were not clear and unchangeable categories, but flexible as any 'normal' man if not keeping one's eyes peeled, could become homosexual.

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41 JALAS, RAKEL. *Sukuelämä terveeksi*. WSOY, Porvoo 1941:73-74.

42 Quite often it appears in the court case documents that people explain them being homosexuals because they had been seduced by other homosexuals in parks, school, or military, and how after that seeking homosexual sex had become habit to these people.

Good Sex – Enhancing Wellbeing in Sexuality Education by Utilizing Stories

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Once upon a time there were…

Two persons who met some time somewhere. Their backgrounds were different, although they were both studying. They had an age difference; one of them was a little older. There had been an enormous attraction between them when they met for the first time. Things went well in many different ways on different days.

At some point after their meeting, they decided to have sex together for the first time.

It may have been immediately after the first meeting or it may have been after dating for a longer time. Different stories are told about that, too. What is common to these different stories is, however, that they both are known to have thought about their sex together, how it would feel, and what the moment would be like. They both wanted a happiness-filled moment, words suitable for the encounter. They both also knew what they would not want to hear when they were standing naked and looking each other in the eye.

At some point of the story, there came a special point where one of these two described the experience to the other one afterwards and the reason why it had felt especially good.

> *"I was touching your skin while sighs were escaping from your lips. You were lying naked on the bed giving me the freedom to touch you because you knew that you could trust me."* (Frank TC).

There were many kinds of twists in their story and also in their happy sex, and the stories have also had different endings. Just like stories in general, they change with the storyteller. Perhaps they lived happily together until the end of their lives, perhaps they had to cope with difficulties, and at some point their living together ended or maybe they only met once. This story told about one of their happy experiences.

> *"M takes hold of Kaarina, carries her with everything he has when the inevitable happens, the endless shuttle of surrendering, letting go, it is a spin and shaking that throws their liberated flesh, minds, and hearts and drops them into a velvety vacuum. There is nothing left, nothing, nothing but the flesh that has been warmed happy, a wild animal's cry into the great unknown."* (Krista).

This text deals with the possibilities of stories in sexuality education work. In training and sexuality educational processes, Nektaria ry has given several hundreds of adults and young people guidance in constructing joint stories also on matters related to sex. Stories used as a method of sexuality education make it possible to distance oneself, learn about oneself, and enhance equality. With the help of stories we can make myths and normative assumptions related to sexuality and gender visible. The ability to empathize and mentalization skills (ability to see oneself and the other person as human beings with their own desires, beliefs, and goals) are considered to be central factors in good sexual experiences, good sexuality, human relationships, and experiences of wellbeing in general. These skills can be strengthened by means of stories.

This text was originally published on the web page of Nektaria ry on the World Sexual Health Day on 4 September 2012 in Finnish. The text is based on the speech given by Susanna Ruuhilahti and Juha Kilpiä on Good Sex – enhancing wellbeing in sexuality education through stories (7 October 2012, Valkoinen Sali, Helsinki).

The citations used are extracts from the stories of the book "*Onnellisia tarinoita seksistä*" (*Happy Stories about Sex*). Although extracts are translated in English the pen names are in Finnish. The book has been produced by Nektaria ry. It consists of those people's stories who have been willing to write their stories to be read by others. The stories have been written by people aged 19 – 70. Nektaria ry sent Facebook messages asking for stories. This book is for adults. The purpose of the book is to draw attention to happy stories about sex so that we could experience happiness and joy that sex can give.

The Power of Stories – an Opportunity to Find a New Way of Thinking about Matters

> *"Guided by intuition, I had bought a lace decorated baby doll nighty. I will always remember how delighted he was when he saw me wearing it."*
> (Baby Doll)

Since the beginning of time people have told stories. Stories help us to organize our lives and make meaningful phenomena emerge both on the individual and collective levels. All stories are combined at least by the fact they have a storyteller or storytellers and listeners, readers, or viewers. A story tells about some subject and it is connected to some subject matter. A human's life is also some kind of story. We tell a story about ourselves and other people form their own kind of stories about us from their different perspectives. We experience something that we want to share for some reason. On the other hand, some matters are forgotten and will never be told. Some stories we want to keep secret without ever telling them to other people.

Utilizing the experiential aspect of stories in sexuality education provides many opportunities to deal with various themes and grow as human and sexual beings. Stories help us to learn about ourselves, our own habits, other people, the world, and our culture, as they open new views of these. Stories enable us to reflect on our own experiences as compared with other people's experiences. We can learn to understand different experiences and perceive diversity not as a threat but as an opportunity. With the help of stories we can learn about the customs, cultures and norms that we have.

"I can start a new the dance, in which I try everything I have learned. I can dance alone or with a partner – sometimes the sexual experience is thrilling…" (Reiki)

Stories provide an opportunity to perceive the reality and the versatility of sexuality and also to enhance the ability to live with this reality strengthening everyone's self-esteem and increasing self-knowledge. Stories enable sexuality educators to get information on what is going on in the minds of those who they are educating and to what kind of questions and situations they might want to have answers and help.

The Fizzing Inquiry of Nektaria ry is one example of utilizing the narrative approach in the planning of sexuality education. One of the items in the questionnaire asks young people to tell some kind of story or description of a situation in which a person of the same age could need help and support most.

These stories gave a lot of information on what was going on in young people's lives, what kind of matters they reflected on and considered challenging. Sexuality education can then be directed to finding out how educators could meet their precise needs concerning the dealing of sexuality themes. Also questions sent to young people's magazines and chat columns provide a multiple views of their world in themes related to sexuality and gender.

When a story forms the foundation for discussion on sexuality themes, no single person is concerned but the theme is distanced far enough from oneself. Then the lives and challenges of those young people who are present are not disclosed to the others in the group, which makes it possible to deal with real subjects without referring to any participant's situation. This makes it also possible to construct different solutions to the situations and reflect on what could follow from these different solutions. Stories can be adapted, changed, and worked on as required. With the help of stories we can always start the situations again and give the kind of appropriate ending to the story that we are satisfied with.

The meaningful thing in stories is not only what happens but also how it is experienced, what is thought, and what kinds of emotions arise. Stories make it possible to become open for discussion, many kinds of conclusions and thoughts, conversation, and reflection. Stories provide us with sense perceptions when imagination starts to develop images in our minds: we perceive a story also in what we see, smell, and hear.

"Until the fog is dispersed we have time to make love, caress, smell, touch, and kiss both the outside and the inside of each other." (Hertta)

The narrative imagination makes it possible that we can empathize with the characters in the story. Stories help us to notice different ways of being, which contributes to new kind of ways of being in one's own life (Kearney, 2002).

A Good Story Makes Many Feelings Possible

The storyteller requires imagination and a method for constructing stories. Also a language is needed for storytelling. Our language constructs our ideas about sexuality and sex, on the one hand enabling us to find something new and, on the other hand, telling what kind of ideas and thoughts we have about sexuality and what we do not want to make visible or what we at least want to leave outside our stories. Language

can never fully describe sexuality or sex, as part of it always remains mystical, outside concepts, because each person's sexuality is unique.

Constructing happy sex stories together with young people is usually a happy and thought provoking experience. Stories involve magical elements that appeal to us. When a story begins, we want to hear or form in our minds also the middle and the end of the story.

> *"I make you lie under me and take hold of your hands.*
> *I look at you demandingly seriously and you know*
> *what I want – Pleasure, Happiness, Ecstasy."* (Haave)

Growing and learning are always somehow related to constructing and reconstructing individual and collective stories. Humans have a need to find themselves; to know who we are and what the meaning and purpose of our lives is. When we stop and reflect on ourselves, our own values, attitudes, thoughts, and emotions, we in a way construct an inner story for ourselves. This story is born from our mental processes. When we construct stories, we interpret our own lives through narrative meanings also in relation to sexuality. When we tell our stories, we bring about social influences, share experiences, and may get social reinforcement to our thoughts. Storytelling provides space also for reflection.

Stories that can be people's descriptions of their personal experiences can help people of very different age in different life situations to see that they are not alone with their emotions and experiences. Stories open a world in which also other people experiences different things and events or things that are exactly like their own. Stories make it possible to understand wholes and stories also make it possible to break up a whole.

A good story can make us cry, laugh, want, or enjoy. The end result of a story can be that we learn something, perhaps about life or ourselves. Perhaps we find a new way of thinking about matters, a new character or attitude that we can use (Vogler, 2007).

> *"And what I learned? About myself…perhaps even the fact that I am thrilled*
> *by a ritually planned and realized desire. I learned that mutual respect is*
> *related to love. The skilful lover who follows a joint plan is allowed to cause*
> *me pain as long as I agree to it myself. I learned to say yes.*
> *I also learned to say no. I didn't want everything. I participated only in*
> *a handful of what this man knew, had tried, and was used to doing."* (Raku)

A Story Contributes to Understanding Everyone's Uniqueness and Differences

Stories provide us with a view of goodness, fairness, the good, and the allowed. This observation can make us stop and consider what the story is like that our sexuality education tells for example about sex, love, happiness, and gender. What is it that we tell young people about and why? What kind of values and truths do we forward in our stories? *If we must secure a certain kind idea of the good in the stories told, we may simultaneously lose an opportunity to understand what it is like to be someone else in a world that considers him or her a bad or wrong kind of person* (Dooley, 2007).

"Are we allowed to make love on the graveyard? Yes, we are." (Dea)

According to Dooley (2007), the most important task of stories is that they enable us to gain entry into another person's head and this other person may be someone who we dislike or despise. The purpose is not then to determine to what extent these other people are morally untrustworthy but become familiar with their world and understand their views and actions. Even the fact that we understand another person's fears may be enough to arouse sympathy. When we understand that what we call good life is only one version of it, we also understand that our moral consciousness determines to what extent we are prepared to accept the unknown. (Dooley, 2007)

> *"A real encounter with the cunt – my own or another woman's – and being absorbed in its gaze really is a holy experience."* Magdalena

Imagination Connects Us to Others and Makes Us Less Self-Centred

Imagination can be defined in many ways. Imagination is among other things an ability to bring to our minds matters that do not exist or are not present. It is also an ability to sense and be enchanted by imagined things, illusions, and stories. According to Dooley (2007), humans need the ability to imagine in order to get connected with other humans and to be less self-centred. Imagination helps us to perceive that we have different ways of living as humans within our reach. We need imagination also for expressing sexuality. *Humans have the ability to form in their minds an image of something or someone they want but do not have yet. Or then someone does not exist in the way wanted or as often as wanted. This ability starts developing soon after the birth and it remains permanent. When we long for someone, the reality of the person's absence or unattainability is an obstacle that we can strive to overcome in our memories or fantasies*. (Kontula, 2012)

> *"A long time passes before I think about the unknown person again.*
> *One day, while I am alone and caressing myself, I remember him.*
> (Atra)

According to Tolkien (2008), it is question about art in fantasy. In fantasy, it is question about an activity that is natural for humans and does not threaten our rationality or cloud our observation skills but just the other way round (Tolkien, 2008). Sexuality and fantasies related to sex have thus their important task. *Fantasies have an important task in arousing and maintaining sexual desire and in stimulating erotic dreaming. Sometimes they express a sexual need and longing, sometimes they also intensify a desire that has already been aroused or help to remain aroused until the climax. Fantasy may also be a moment's entertainment in the gray everyday life*.
(Kontula, 2012)

> *"I am stooping over your cavernous body, you are tight and full. You are full of smells and tastes. You taste like cherry and my raspberry is mixed up with it. Together we make jam that has been meant for adults, the retarded, the playful, and the toothless."* (Marja ja Terttu)

Young People, Sex, and Stories – What Makes Sex Good

When we discuss sex and create collective stories with those who are present in educational situation, we can make visible hidden myths that guide our thinking, work, and lives. Speeches and stories do not necessarily enhance wellbeing unless we pay special attention to their contents. When we talk about sex, sexuality or gender, we may also exclude some persons who are present. The sex discussed in sexuality education quite often deals only with heterosex. For example when the prevention of pregnancy and STDs are discussed, non-heterosexual people seldom get any guidance. By bringing up several ways of having sex and, at the same time, possibilities of protecting from STDs, we could enhance all people's wellbeing and sexual health. We need many kinds of stories and truths when we want to pay attention to humans' many kinds of sexual habits and differences. Also stories that are implied by us may make young people experience that they do not have space to exist in the way they are.

> *"You have stroked my scars, you have caressed with your acceptance. We have made love fast and caressed each other to heavens in a bed with sweet linen. I have looked you in the eye and dared to come while you have been watching."* (Murretut muurit)

Reflecting on what makes sex good produces a lot of discussion and also increases understanding about when so called sex is not actually sex at all, but even violence. Together with young people we can reflect on many kinds of questions if we start a dialogue with them: Is there bad sex? What would it be like? If I do not want but, however, agree, is it question about sex or something else? Can one have sex alone or with several people? At what age do people actually have sex for the first time? What is the difference between making love, fucking, sex or screwing? When does sex become sex and what makes sex good?

> *"This is a story about how even the first time of making love with a new person can feel exciting, happy, and safe at the same time."* (Yö treenikämpällä)

According to Pia Suvivuo's doctoral dissertation (2011), young people who belong to the risk group need practise in emotional skills, which is possible at least to some extent with the help of various stories. Stories enable us to get into situations which would be otherwise strange to us. At the same time our imagination develops and utilizing our imagination makes the strengthening of mentalization ability possible. Then we become able to understand different mental states that differ from our own states and we notice the existence of hopes and beliefs. We are able to predict our own and others' reactions and actions. Mentalization ability is considered one of the cornerstones of psychic wellbeing. (Larmo, 2010). According to Suvivuo's doctoral dissertation (2011), also her young interviewees had scripts related to sex according to which they acted.

By means of constructing joint stories it might be possible to show that the story that is being born has some predictive elements which enable us to conclude what kind of script is guiding the story. We could then think together how and at what point the

persons in the story could, if necessary, act according to another script in order to enhance their health and wellbeing.

> *"Then you come to my mind, you, who I loved. With you I enjoyed doing sex."* (Hiljaisuus)

When we tell stories that provide opportunities for versatility, we can create happy and good experiences and frameworks for "good sex" and ways of enjoying sex that are suitable for us. When we create stories about the experiences of good sex, we can make our readers and listeners aware of their own experiences, thoughts, and reflections. Stories encourage us to reflect on our own sexual experiences and what kind of sex we actually would like to have or would not like to have, if we wanted sex.

If one of the main tasks of sexuality education is enhancing sexual health and sexual wellbeing, it is worth paying attention among other things to the WHO's definition of sexual health before starting sexuality education. Applying the definition, sexuality education should be utilized to support and encourage young people to consider their own sexuality important and positive, worth respecting as part of self. Sex should be spoken about also as an enjoyable experience with emphasis on safety, security, and trust. According to Douglas B. Kirby (2009), we should teach young people in sexuality education to determine what they want and what they do not want and in what kind of situations and with whom. In addition, young people should learn to take a stand on what they want and do not want as well as learn skills in how to produce pleasure also to their partners. If we do not have an opportunity to reflect on matters on our own and together with others, can we learn to determine what we do not want or what we want? What if we do not have knowledge and understanding of the alternatives and possibilities? Are contraceptives and risks related to sex sufficient themes for dealing with sex? Do they enable us to learn the ethos of promoting good sexual health?

> *"The step that I hear from the staircase is strong and determined. The step tells me: I am coming and wipe your dusts away. Help, what am I actually imagining? I'm going crazy from the lack of touch. How many steps are there in fact before you come close to me and wave your whisk so that the dust in my shelll, the dust in my treasure, the dust in my garden, will be wiped away forever? I am thus going crazy."* (Pölyhuisku)

In addition to giving knowledge and information, sexuality education should also provide young people with opportunities to reflect on their sexuality, opportunities to see themselves as valued persons and worth loving so that both adults and young people could for example in sexually stimulating situations say, "Yes thank you, I want sex with you" or "No thanks, I don't want sex right now". Utilizing stories could also make it possible to get practice in coping with the disappointment caused by another person's negative answer related to sex. Stories provide space for reflecting on what happens in the situation and what the rejection actually means. After becoming rejected in a real situation, the person would perhaps be better able to deal with the feeling of disappointment and understand that the rejection can be seen also as a sign of appreciation and trust if the matters have been discussed together in advance.

"The happiest thing about sexual experiences may be the fact that there is in general an opportunity for sexual experiences together or alone or at least alone." (Nyt)

People who like themselves and other people in general are seldom guilty of forcing, discriminating or resorting to violent behaviour. People who like being in their own skin take care of themselves and recognize situations in which there could be a risk or danger. On the other hand, it is possible and permissible to seek help, advice, and support, if everything does not work out in the way one would have hoped. Many young people are prepared and willing to discuss and reflect on matters together with adults, but do we adults have the ability and skills in talking about sexuality and gender so that we really promote sexual health?

Good Sex Experiences are Important

Studies show that good sex predicts happiness. For example in the international study *A Cross-National Study of Subjective Sexual Well-Being Among Older Women and Men: Findings from the Global Study of Sexual Attitudes and Behaviors* (2006), which investigated middle-aged and older women's and men's subjective experiences of their sexual wellbeing, sexual wellbeing was predicted by physical and psychic health, human relationships, and sex. These results remained the same irrespective of cultural differences. According to the study, both men's and women's sexual wellbeing correlated with the experiences of happiness.

When we discuss sexuality and happy sex with young people, we may be able to enhance wellbeing and decrease adults' sexual problems in the future. Sexuality that is experienced to be good enhances mental health, happiness, and wellbeing and contributes to success in human relationships and a good experience of self. Successful sexuality education may have positive influences also on the sexual wellbeing of the elderly.

In accordance with the ethos of health education, from the perspective of sexuality education, sex should be examined in multiple ways and paying attention to promoting wellbeing. According to Lasse Kannas (2007), health education as a school subject should inspire (motivate to receive information and make it become part of one's own life), promote change towards better health and wellbeing, civilize (i.e. provide relevant and up-to-date knowledge) and support young people's mental health at the same time.

Positive points of view are required in sexuality and human relationship education also in other countries than Finland. For example in the publication *Enhancing Sexual Wellbeing in Scotland – A Sexual Health and Relationships Strategy*, school staffs are encouraged to reflect on their own attitudes, challenge their assumptions, and enhance wellbeing for example by tackling bullying related to sexuality and gender at schools. Therefore also professionals' supplementary training is required, the kind of training that makes it possible to reflect on self, own attitudes, values, and ways of providing guidance in matters related to sexuality and gender. Stories can be used to promote processing and reflection also in adults. Stories help to face also our own pain spots when it is possible to distance ourselves from them and look at them from a secure distance.

"However, it is important to me that both of us feel desired and loved in just the way we are." (Kultapossu)

It is possible that even well-meaning and purposeful sexuality education may cause anxiety and feelings of shame and guilt in young people if their wishes, needs, and everyday lives are not taken into consideration. In their education, young people may have to face situations in which they are not yet prepared to deal with the themes discussed. Some young people may also have to face an experience of being different or "wrong kind", because they do not recognize themselves in the examples given of young people or adults. The media also keep presenting us similar views of femininity, masculinity, sexiness, and sex. The young people who are left outside the normative news, research results, textbook contents, and various catalogues may be overwhelmed by the experience of being strange or abnormal.

However, we cannot blame only the media for the pictures and speeches that strengthen stereotypes. At least to some extent it depends on us educators what kind of ideas of sexuality, sex, and young people we forward. The media should be made to contribute to promoting sexual wellbeing. Many kinds of campaigns could be arranged to promote and convey positive messages instead of frightening and sensation-seeking messages. In collaboration with the media, it would be possible to break many taboos and challenge for example heteronormativity.

"The feeling when I want to get even closer to another person than the physical and spiritual connection can make possible. Then I have the experience of being tied to my partner completely in that moment." (Anna aikaa)

What Kind of Story Do We Convey on Sex?

A Canadian study (Kleinpatz et al. 2009) investigated what makes sex excellent. In the same study, they found out that sexual therapists rather concentrated on negative aspects than positive matters when they were interviewed about good sex. The other interviewees, who were not professionals in sexology, spoke about their own splendid sexual experiences and paid attention mainly to positive aspects. It is good to reflect on what kind of story we carry with us. If sex is a technical matter to us, does it affect the way we speak about sex and how does it influence our own sex? Or if we professionals believe that, during a sexual encounter, our partners are thinking about how lovely we are but we are thinking about cooking, repairing a car or for example jogging, can we then even open the door to a different kind of sex in our discussion with young people?

"After a month Salmari would surprise everybody with the secret that she was already carrying happily inside her." (MiuMarilla)

According to the Canadian study (Kleinpatz et al. 2009), great sex had very little to do with physiological activities. However, sexuality education and guidance is to quite a great extent focused on the physiological aspects, risks, and problems related to sex while the social, psychic, and spiritual dimensions are not paid much attention to. Why is so little attention paid to good sex that is known to affect our wellbeing?

According to the study of Kleinpatz and his colleagues, great sex is related to own emotions and thoughts, how capable and valuable we consider ourselves to be and how we see ourselves.

> *"My hand is longing for the roundness of your pelvis, it is longing for your stomach and your thin public hair, the moisture and warmth, your softness and your opening up. I am longing for that smell. I love it, no, I am longing for it. We have decided to avoid speaking about love and here I am standing under the window of my café that is wet from rain with my trousers tight, so hard that I have to try to seek a better position and I make a mixture of longing, love and desire. I hate this when my clear thoughts become complex."* (Juurihoito)

Stories and opportunities to reflect on life and alternative solutions to problems support the strengthening of inner factors. Then young people can express their emotions and thoughts more freely. They can cope with difficult situations in which they have to make decisions, as they are able to give reasons for their choices. Trust, a secure attitude to them themselves and the world as well as the belief in their own capabilities increase when they experience that they are valuable human beings. It becomes then more meaningful to respect also the other people's limits. Sexuality education should not forget humans' freedom and responsibility, which are related to every choice that we make in our lives, and reflection on how we could live with the different choices and consequences.

> *"I didn't feel that penetration, but that organ was really awesome, special."* (Peppi)

In sexuality education sessions with young people arranged by Nektaria ry, we have discussed what makes sex good. Young people have told that the important things are: trust, safety, right time and place, suitable partner, chemistry between the partners, pleasure, desire, passion, both wanting sex and being prepared for it, being equal and able to discuss matters openly. When we examine sex through those qualifiers, we find quickly and easily also the points where actions or activities can hurt the other one. Also young people's answers tell that they have lots of prerequisites for experiencing great sex (cf. Kontula's article in this work).

> *"This is literally safe sex. Our wedding day is in a month."* (Ruby)

To Sum Up

The stories we tell reflect the world we live in. The world, sexuality, and sex are revealed to us in stories in the way we see them, hope them to be, and how we would like things to change. *As far as stories and the passion felt for them are concerned, we can state that adults are not very different from children*. (Kovalainen, 2009)

The purpose of Nektaria ry in collecting and publishing happy sex stories was to draw attention to the importance of speaking about happy sex in addition to the other themes in sexuality. *With the help of stories we can remind each other where we have come from and join together to determine where we are going* (Benjamin, 2006).

I am flesh when you look at me. I am star dust and gentleness.
No one touches me in the way you do.
You make my cheeks dark red, every blood vessel visible, my face look greedy.
I don't have a similar need to be filled and get empty with anyone else.

According to Tolkien (2008), the most important task of stories is to help us to find, escape, and comfort ourselves. Finding means for example getting a new point of view or some long-lost matter back. Tolkien explains that escaping satisfies the humankind's deepest desire, the desire to escape death, while comforting is related to the happy endings of stories.

In his book, *When I still remember,* André Brink (2004) regards the stories of A Thousand and One Nights as the most marvelous guide to love. In his opinion these stories show how it is possible to tame an angry revengeful king who hates women to become a creative and loving person. Stories increased the king's understanding of the worlds, versatility, and miracles related to life as well as him himself. The stories of A Thousand and One Nights are like an endless number of alternatives in different life situations. Brink sees a story telling young girl encountering death while she is telling her stories to her king. Brink understands that the stories of A Thousand and One Nights are a gigantic, versatile, and amazing allegory of love and making love.

Isn't lovemaking a kind of storytelling? – Our bodies tell even the most intimate stories about themselves to each other. (Brink, 2004).

Lovemaking is thus a story. It has a beginning, middle, and ending that are told and heard. Lovemaking has a storyteller and a listener – at the moment of lovemaking we are both of these and perhaps even both at the same time. When lovemaking is thought to be storytelling, it is possible to get rid of control, surrender ourselves to be carried by a stream, become immersed in the situation, the moment, the other person, and the joint rhythm in order to enjoy the journey to pleasure. The connection that is born then forms a story, a mystery, which can never be fully described by words.

"Our eyes meet. You know that I was thinking about you. You are touching my hand and awaken my expectations. I would like to get home already."
(Alku)

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Expanded Sexual Response in The Human Female:

The Mechanisms of Expanded Orgasms in Women

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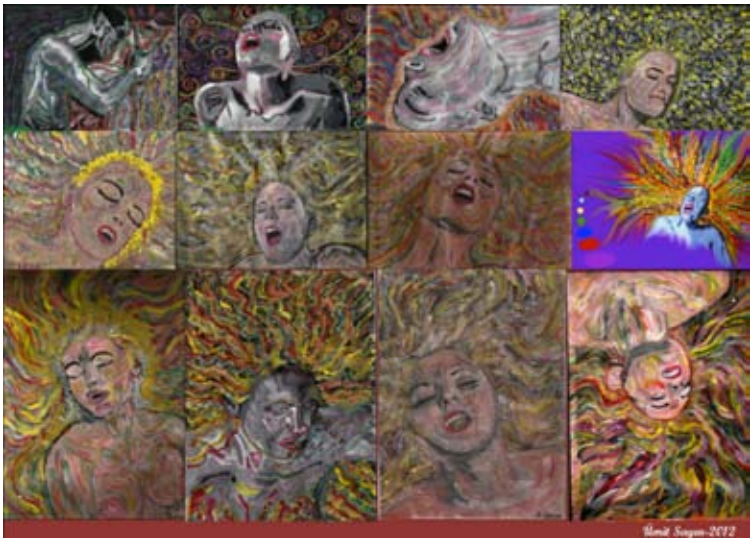


Note: Paintings are made by Dr. Ümit Sayın to depict altered states of consciousness in ESR.

Introduction

The medical literature has mostly been interested in and focused on the pathologies of human sexual behavior. Not much research and investigation have ever been done on the limits and extents of human female's sexual potentials, such as **Expanded Sexual Response (ESR)**. Ancient Eastern literature is full of incidences and descriptions of elevated and enhanced levels of orgasmic response and sexual pleasure of women, utilizing many different techniques centuries ago, such as Tantrist and Taoist Love Making in India and China (Vatsyayana, 1883; Chang 1977, 1983; Schwartz, 1999; Chia 2002, 2005; Mumford, 2005; Michaels 2008). Recent publications and books in the West after 1990's point out that female sexual response can be enhanced and expanded to certain levels (Rhodes, 1991; Schwartz, 1999; Bodansky, 2000; Taylor, 2002; Zdrok, 2004; Sayin, 1993, 2010, 2011, 2012). Such results have also been reported by Masters & Johnson (1966) and Hartman & Fithian (1972). William Masters and Virginia Johnson, reported a female's sustained and long orgasms lasting for 43 seconds, coining the episode as ***status orgasmus*** in their famous book "*Human Sexual Response*" (Masters & Johnson, 1966). William Hartman and Mariyln Fithian, also reported the highest recorded orgasm number in the human female as *134 orgasms* per hour. Since then, many occurrences about the extremes of female orgasmic response, up to *200 orgasms* per hour or more, have been reported (Sayin, 1993, 2010, 2011, 2012). No physiological or psychological disorders of these high orgasmic women were ever re-

ported. This kind of elevated number of orgasms may occur in mania, mood disorders, bipolar disorders, persistent genital arousal syndrome, hypersexuality, nymphomania, hyperthyroid function disorders, temporal lobe epilepsy, parkinsonism treated with L-DOPA, following brain trauma etc. (Sayin, 2010, 2011, 2012). However, it is also known that many women without any of these disorders may exert very high orgasmic patterns, which is not investigated by modern science and medicine thoroughly yet!

In 1991 Brauers designed a method named as "***ESO Ecstasy Program***" by which prolonged, sustained and long lasting orgasms could be attained by women, such as orgasms lasting for more than an hour (Rhodes, 1991). In 2000, Patricia Taylor reported expanded orgasm patterns of 22 women in her PhD thesis and defined the term "**Expanded Orgasm**" in the human female (Fisher, 1974, 1977; Taylor, 2000, 2002). In Patricia Taylor's research group, "*Altered States of Consciousness*" (**ASC**) patterns were also defined during expanded orgasms and **ESR**. In Taylor's study, the expanded orgasm (EO) or **ESR** (Expanded Sexual Response) duration was 0.2 to 60 minutes and even more in some particular cases in 22 female subjects (a total of 44 subjects or 22 couples) (Taylor, 2000). Taylor had classified her cases into four dimensions as *physical, mental, emotional and spiritual*. Taylor's cases described a deep experience of **ASC** such as, more pleasure; deep relaxation; heightened sensations; increased energy; temporary pain relief; energy expanding out of body; deep relaxing abdominal breathing; increased clarity and creativity; acceptance of the self and others; extra sensory perception; ecstasy; mystical experience; divine feelings; increased awareness of the body; mind connection and integration; psycho-spiritual birth and death experience; loss of illusion of spatial separation; loss of spatial dimensions, loss of sense of time; personal boundaries dissolving and merging with the divine; cosmic emptiness and void; sharing with the partner; compassion; sense of fulfillment etc. (Taylor, 2000).

Mah & Binik's study also opened a typical discussion on such altered mood states during female orgasms (Mah, 2001, 2002, 2005, 2010; King, 2010). King, Mah & Binik categorized subjective feelings of female orgasms in 10 dimensions as building sensations, flooding sensations, flushing sensations, shooting sensations, throbbing sensations, general spasms, pleasurable satisfaction, relaxation, emotional intimacy, and ecstasy (King 2010). However, in Mah & Binik's studies there was no classification of women in terms of the properties of orgasmic response, such as clitoral, vaginal, blended and/or **ESR**.

Expanded Sexual Response: Preliminary Definitions

We have recently defined **Expanded Sexual Response** (**ESR**) in various scientific meetings and papers after an international ongoing survey, which is still continuing (Sayin, 2010, 2011, 2012).

ESR has been defined as: "*being able to attain long lasting and/or prolonged and/or multiple and/or sustained orgasms and/or status orgasmus that lasted longer and more intense than the classical orgasm patterns defined in the literature*". In the Eastern, Chinese, Indian and Tantric literature similar enhanced orgasmic experiences of females have been reported as well as some Western reports of the last decades.

Our survey research has pointed out that some women who claim to have **ESR** (**ESR**-women) had some main characteristics compared to the women who don't have **ESR** (None-**ESR**, **NESR**-women); **ESR**-women had at least five or more of the following characteristics of their sexual response:

1) The **ESR** women experienced vaginal, clitoral and blended orgasms, as de scribed by Ladas et al. (Ladas, 1982).
2) The **ESR** women experienced multiple orgasms in most of their sexual activities.
3) The **ESR** women were able to attain long lasting and/or prolonged and/ or multiple and/or sustained orgasms and/or status orgasmus that lasted longer than the classical single orgasm and/or multiple orgasm patterns defined in the literature.
4) The **ESR** women claimed to have strong pelvic floor muscles (PFM) compared to **NESR** women.
5) The libido of **ESR** women was very high compared to **NESR** women.
6) **ESR** women described a phenomenon called G-Spot orgasms.
7) **ESR** women described sensitive erogenous zones in their genitalia other than clitoris.
8) **ESR** women masturbated more frequently compared to NESR women.
9) **ESR** women had erotic fantasies more frequently than the NESR women.
10) **ESR** women admitted to have a form of *altered states of consciousness* during some of their prolonged orgasms and/or status orgasmus.

Other definitions we have presented include as:

Single Female Orgasm: Clitoral or vaginal orgasms. Clitoral orgasm is mediated by pudental nerve, vaginal orgasm is mediated by pelvic nerve. It has long been debated that some vaginal orgasms are triggered by Grafenberg's Spot (G-Spot) (Ladas, Whipple, Perry G-Spot, 1982). Clitoral orgasm is generally perceived in a local genital area, as bursting; 80 to 90% of women have experienced it. Vaginal orgasms are said to be more satisfactory and more radiating occurring in 30 to 35% of the female population according to Hite and Cosmo Reports (Hite, 1974; Wolfe, 1982).

Multiple Orgasms: Multiple orgasms can be either clitoral or vaginal or induced by both. There is a successive train of orgasms, generally increasing in amplitude and intensity gradually.

Blended Orgasms: Blended orgasms can be mediated by the orgasm triggering mechanism of both clitoris and spots of vaginal origin (**DVZ**: such as G-Spot, A-Spot, O-Spot, PFM or Cervix). A blended orgasm is much more intense than a clitoral or vaginal orgasm alone. Both pudental and pelvic nerves mediate the triggering of blended orgasm. Blended orgasms are much more satisfactory and they are multiple orgasms. (Ladas, Whipple, Perry, the G-Spot, 1982; Komisaruk, Beyer-Flores, Whipple, The Science of Orgasm, 2006).

Definition of Status Orgasmus: *Status orgasmus* is the continuous form of blended orgasms and/or clitoral/vaginal orgasms that last for starting from 1 minute to 10-15 minutes (or more). During *status orgasmus* a continuous orgasmic state is experienced and very few women are believed to achieve *status orgasmus* state. *Status orgasmus* can be seen in vaginal and clitoral orgasms, however mostly it is seen as an expanded/extended form of blended orgasms, in which both clitoral and vaginal orgasm reflexes are triggered at the same time. Similar orgasmic states and full body orgasms are also defined

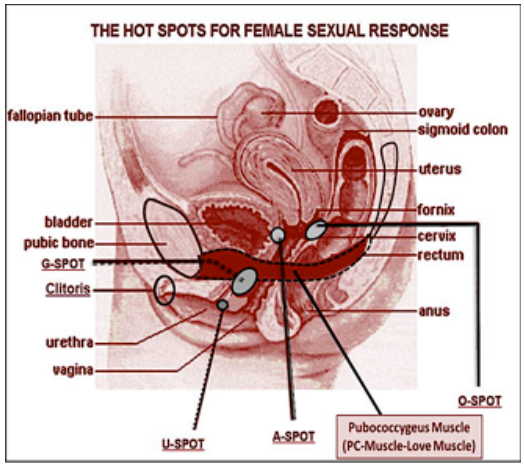
in Tantric literature. The duration may change from woman to woman. *Status orgasmus* was first defined by Masters & Johnson as lasting for 43 seconds in a woman in 1966. Today it is estimated that *status orgasmus* continues for 1 to 2 minutes, while it may last for 10 to 15 minutes, a prolonged and extended orgasmic state which ends by a giant orgasm (Big-O) that gives a big relief and satisfaction at the end. In most of the *status orgasmus* experiences there is usually a refractory period of 10 to 15 minutes. The number of minor orgasms in a *status orgasmus* may exceed from 5-10 to 20-30 (some women claim that this quantity goes up to around 50). In *status orgasmus* it is thought that pudental, pelvic, hypogastric and vagal nerves mediate the triggering mechanism at the
same time.

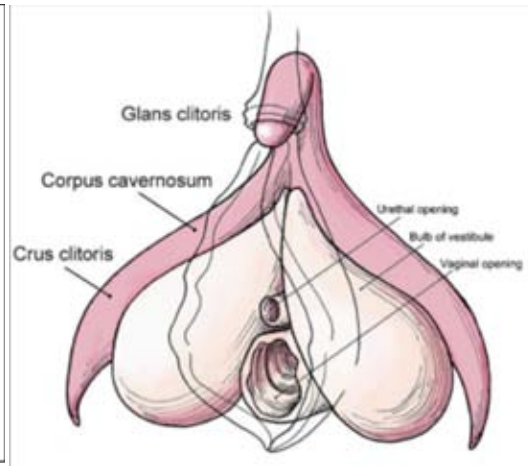
The Basic Principals of Developing ESR in the Human Female

According to our international survey results, some women who practice Tantric exercises, Yoga, Kabbazah (Sahajoli, Pompoir) exercises, and some women with very high libido and excessive sexual behavior pattern can develop **ESR** (Sayin, 2012). **Actually, ESR is a prolonged and multiple orgasm pattern which is triggered by more than one orgasm reflex and orgasm pathway at the same time; this can be both pudental and pelvic nerves mediated orgasm reflexes or a combined orgasm reflex of pudental, pelvic, hypogastric and vagus nerves.**

We have concluded that the basic constituents of ESR as;

1) **ESR** women should have experienced multiple clitoral orgasms, multiple vaginal orgasms and blended orgasms various times separately during their sexual encounters.
2) **ESR** women should have an enhanced masturbation pattern.
3) **ESR** women should have a developed, elevated and extraordinary arousal and fantasy pattern.
4) **ESR** women should have a very high libido.
5) **ESR** women should have very powerful PC muscles, such that they should squeeze the Kegel Perineometer with a pressure of more than 18-20 milibars and should sustain to continue squeezing Kegel Perineometer for more than 5 seconds.
6) **ESR** women should have the consciousness of different erogenous orgasm triggering zones in their genitals other than clitoris, such as G-Spot, A-Spot, Cervix, O-Spot, and Pelvic Floor Muscle (PFM) group etc., coined as Deep **Vaginal Erogenous Zones (DVZ)**.
7) **ESR** women should be using some sex toys and sexual novelties, innovations, such as powerful vibrators for more than 3 to 5 years of their sexual life.
8) ESR women should have experienced sexuality with very experienced and knowledgeable partners who can maintain sexual intercourse for more than 30 minutes or more in more than 50% of their sexual encounters.





THE CLITORAL COMPLEX

In our preliminary study in 198 women some of **DVZ** were identified by ESR (N=35) and NESR women (N=163). These preliminary findings of the pilot study were presented in NACS-2012-Helsinki Meeting.

G-SPOT: The localization of **G-spot** is at the anterior vaginal wall, 2.5-4 cm inside, under the mid uretral length. In our series 63 out of 198 women admitted to be aware of their G-Spots. 55 of them (27.7%) were positive that they had experienced G-Spot orgasms. 25 of these women were ESR-women.

A-SPOT: ***A-Spot*** is at the anterior wall of vagina, 2-3.5 cm below anterior fornix, under the bladder. 21 women (10.6%) admitted to be aware of such an erogenous zone. 13 of them were ESR-women.

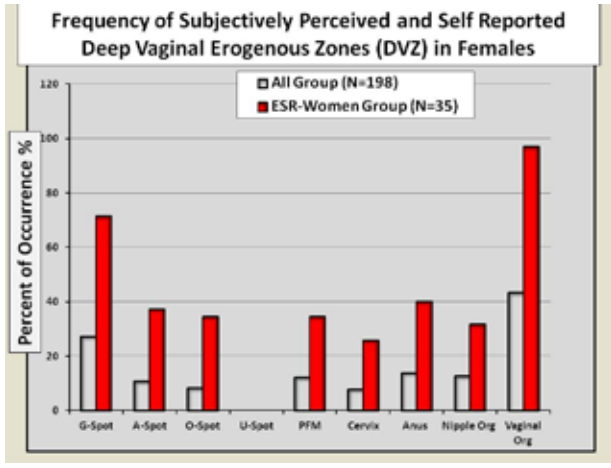
O-SPOT: ***O-Spot*** is between the posterior vaginal wall and the rectum, 2-4 cm below posterior fornix. 16 women (8%) replied that they have a sensitive area at this part of their genitalia. 12 of them were ESR-women.

U-SPOT: No ***U-Spot*** has been detected in the survey.

Cervix: ***Cervix*** is the collum (neck) of uterus. 15 women (7.5%) replied that their cervix is sensitive and may trigger an orgasm. 9 of them were ESR-women.

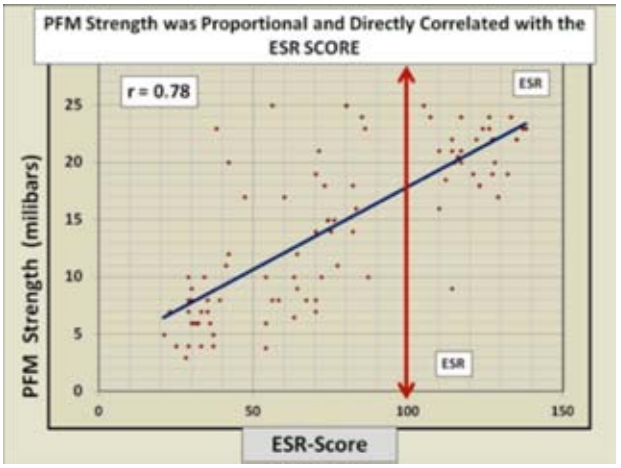
PFM: ***PFM*** are the muscle network between pubis and coccyx. 24 women (12.1%) told that activation of PFM was effective for the development of an orgasm. 12 of them were ESR women.

Most of the **ESR women** admitted that they may have such erogenous zones, which may take part in the development of orgasm, other than glans clitoris.



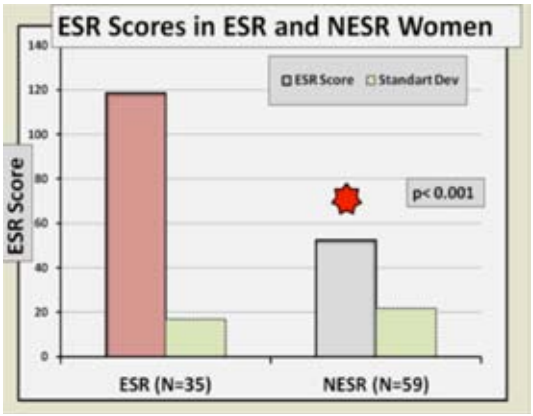
Pelvic Floor Muscles (PFM, PC-Muscles, Love Muscles)

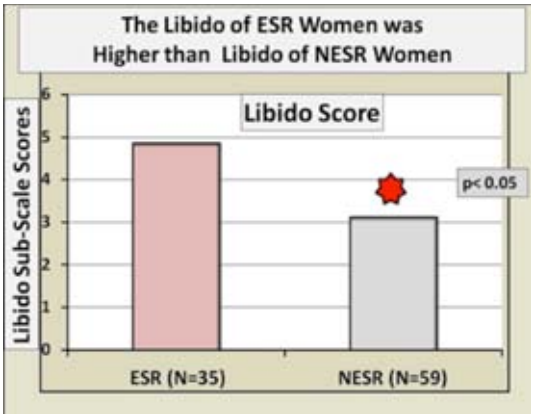
The importance of **Pelvic Floor Muscles (PFM)** has been reported by many researchers (Ladas, 1982). In our pilot study we could measure the **PFM** strengths of women in a minority of the group studied in **ESR** (N=35) and **NESR** (N=59) women by using a Kegel Perineometer. There was a statistically significant correlation between the **ESR** scores and the strengths of **PFM**.

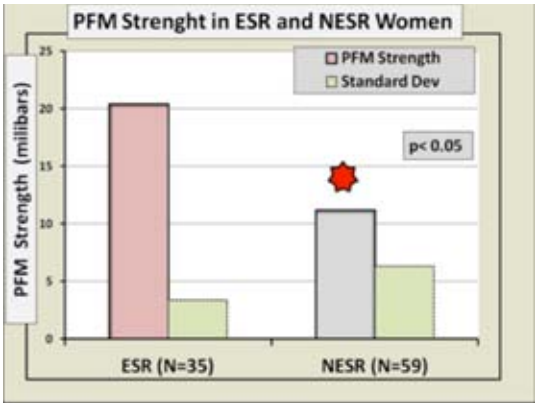


Also **PFM** strengths were significantly higher in **ESR** women compared to **NESR** women, as well as the **ESR scores**. Although **NOT established strictly and statistically YET**, our preliminary data points out the proposal that a score higher than 100 out of 150 of **ESR Score** can be coined as **ESR**, while a 0-6 likert scale was used for each of the 25 questions.

This pilot study's preliminary findings were presented in IASR-2012-Lisbon and NACS-2012-Helsinki Meetings.

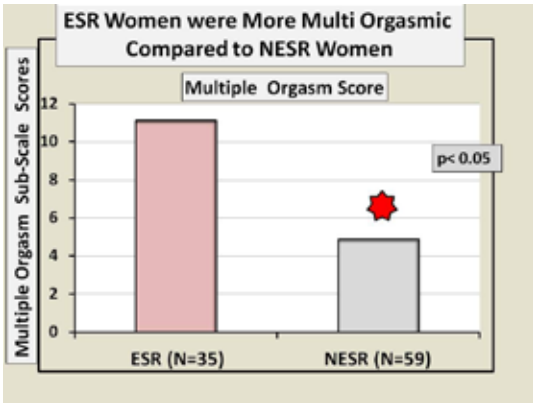


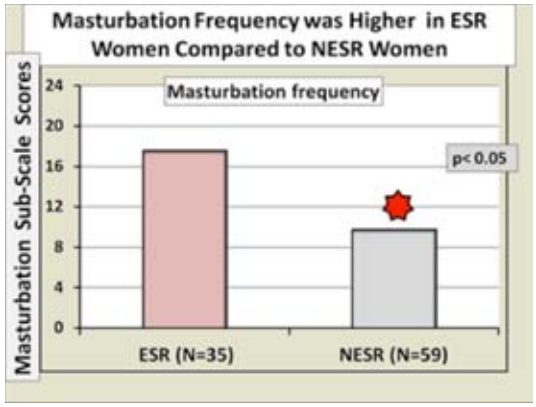




Multiple Orgasm, Libido, Masturbation Sub Scale Scores were Significantly Different in ESR Women Compared to NESR Women

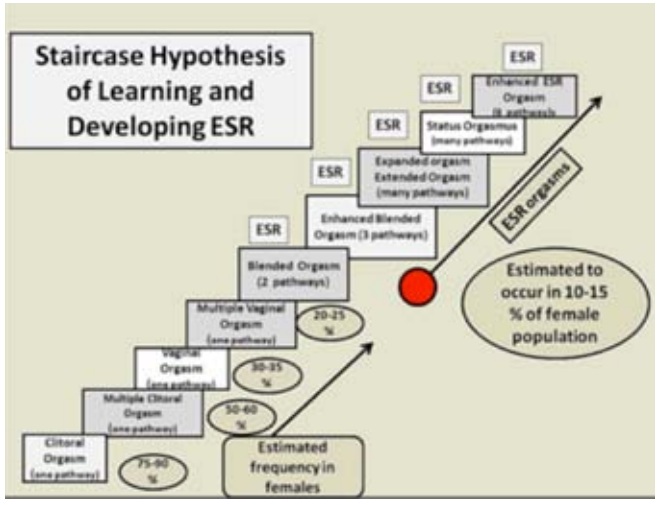
The libido of ESR women was higher compared to NESR women. ESR women fantasized and masturbated more frequently compared to NESR women. ESR women also had more multiple orgasms than NESR women.





Mechanisms of ESR Phenomenon

Actually, **ESR** is a blended orgasm, which is triggered by two or more nerve pathways which form different arches of orgasm reflexes. **ESR** is a learned behavior and reflex, which may follow the occurrence of clitoral orgasm reflex, mediated by pudental nerve. A staircase hypothesis is such that, first clitoral orgasm reflex is attained. Then multiple clitoral orgasm reflexes are established; 75 to 85% of female population can learn this reflex during early ages. After this step, vaginal and multiple vaginal orgasm reflexes, which are mediated by pelvic nerve, are learned. The frequency of vaginal orgasms in the Western society is 30-34% of the female population, while multiple vaginal orgasms are experienced in nearly 20-25% of the female population. The next step is learning blended orgasms and **ESR** occurring by the triggering of both pudental and pelvic nerves, as well as hypogastric and Vagus nerves, as reported by Komisaruk and Whipple (Komisaruk, Beyer-Flores, Whipple, The Science of Orgasm, 2006). Our survey and other estimations points out that, today only a proportion of 10-15% of the female population can attain **ESR** and such enhanced-expanded orgasms. Learning and developing **ESR** in a woman, who has the eight constituents listed above may take 3 to 5 years or more, if she is experiencing sexuality with experienced and knowledgeable partners and using vibrators and other sex toys for attaining multiple clitoral, vaginal and blended orgasms.



To measure the **ESR** phenomenon in women, we have developed a preliminary **ESR** Scale and **ESR** Score, a questionnaire of 25 items. This scale was a combination of ***SAYIN-ESR-PFM-KEGEL scale*** and ***SAYIN-ESR-Status Orgasmus-Scale***. Our preliminary results point out that, there is direct correlation of ESR-Scores and strength of pelvic floor muscles (PFM), the masturbation frequency, elevated and enhanced orgasmic response ($r > 0.7$) (Sayin, 2011). It is concluded that, the more

powerful the strength of the PFM, the stronger the intensity, duration and pleasure of the orgasmic pattern in ESR-women. Also our research pointed out that "***orgasm screams***", which increase the strength of PFM by means of elevating intra-abdominal pressure, enhance the orgasmic pattern and orgasmic pleasure in many women (Sayin, 2012). Our extensive survey and research on **ESR** is still continuing.

A Special Method to Induce Expanded ESR Orgasms in Women: Four Spot Method

In the women who have developed **ESR**, an effective method is described to induce prolonged orgasms:

Stimulation of ***G-spot*** (*coitus, manual, electrical or vibe*), **Deep Vaginal Erogenous Zones (DVZ)** (*coitus, vibe, electrical, or manual*), ***glans clitoris*** (*cunnilingus, manual, vibe, or electrical*), ***clitoral complex*** (*coitus, vibe, electrical, or manual*), ***anus*** (*coitus, vibe, or manual*), ***nipples*** (*mostly manual, or vibe*) and ***the BRAIN*** (*fantasies, learned sexual behavior patterns*). **AT THE SAME TIME**, may start to induce blended orgasms in a minority of women after certain numbers of trials, by means of triggering more than one orgasm reflex pathways. The vibration frequency of effective vibes differs from spot to spot (60-200 Hz); also, vibe frequency may be variable in different women. For coitus, a male partner should be maintaining intercourse for more than 30 minutes. For oral sex, a continuous stimulation more than 20-30 minutes should be maintained (Sayin, 2012). **In Four Spot Method**, male partner uses his left hand's second and third fingers to stimulate the G-Spot upward, fourth finger of the left hand is used to stimulate anus. The head is in between the legs of the woman to perform cunnilingus, which should be continued for at least 30 to 40 minutes, with up and down continuous movements of the tongue (1-3 Hz). The right hand should be stimulating the left nipple of the women. Thus anus, G-Spot, glans clitoris, nipples are stimulated at the same time until she reaches a series of orgasms, which may last for more than 2-5 minutes. In between these stimulations, rotating probe and vibrating vibes can be used to stimulate the deep vaginal erogenous zones (DVZ) (Sayin, 2012, ESR: Ultra Orgasm in Women).

The Neurological and Neurochemical Basis of ESR

The neurological, psychological and neurochemical mechanisms of emerging of **ASC** during an **EO** and an **ESR** are not investigated and explained thoroughly yet. The main mechanisms of **ASC** can be correlated with the abruptly released neurotransmitters in certain parts of the brain and the activation and/or deactivation of different parts of the brain.

It is reported that during a single orgasm developing by masturbation or by intercourse, *dopamine* (Stahl, 2001; Brown, 2007; Passie, 2005; Kruger, 2002, 2005, 2006), prolactin (Passie, 2005; Kruger, 2002, 2005, 2006), oxytocin (Stahl, 2001; Argiolas, 2003; Passie, 2005; Krüger, 2002, 2005, 2006), *melanocortin* (Brown, 2007), *serotonin* (Stahl, 2001; Brown, 2007) *norepinephrine* (Stahl 2001) *and endogenous opioid peptides* (Argiolas, 2003) are released and involved in the mechanisms of orgasmic and post orgasmic mind states. Acute dopamine release is a pleasure inducing factor during the female orgasm (Stahl, 2001; Brown, 2007, Kruger 2002, 2005, 2006). It is well documented in the literature that dopamine, serotonin, norepinephrine, endog-

enous opioid peptides induce changes in the mood and consciousness. The extraordinary subjective feelings during female orgasm can be caused by the abrupt robust changes in the neurotransmitter concentrations at the synaptic clefts at certain parts of the brain, mainly in the sensory cortex and limbic system. Namely, the powerful and longer the orgasmic state, the considerable and substantial, the alterations will be.

The intensity of an orgasm, and/or expanded orgasm or **ASC** induced by **ESR** may also be correlated with the activation and deactivation of certain areas of the brain. Komisaruk's research group, who have been doing fMRI studies during female orgasm, recently found heightened activation in the prefrontal cortex (PFC) during female climax - something not seen in the previous studies of female orgasm (Komisaruk, 2004, 2005, 2011). Surprisingly, this was also the case in the individuals who can achieve orgasm by thought alone, a recently defined case of '*brain orgasms*'. With fantasy and self-referential imagery often reported as being part of the sexual experience, Komisaruk et. al. investigated if the PFC might be playing a key role in creating a physiological response from imagination alone. According to Komisaruk, female orgasm is also a different form of consciousness (Sukel, 2011).

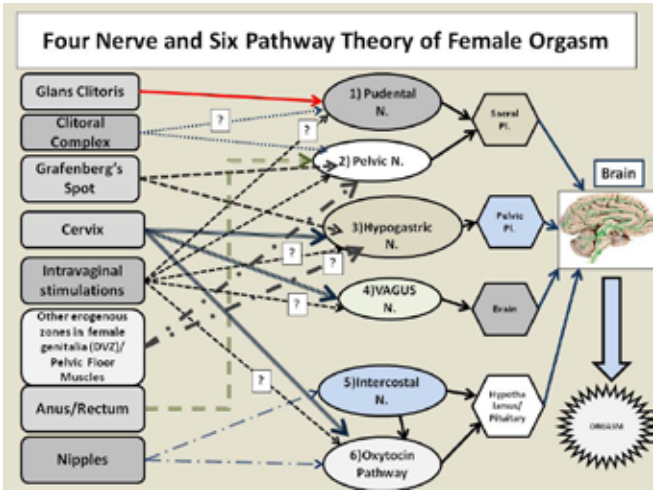
Georgiadis, performed similar experiments in which they found that the some brain regions "*switched off*" during orgasm. Specifically, they saw significant deactivation in an area of the PFC called the left orbitofrontal cortex (OFC) (Sukel, 2011). Giorgiadis found that during sexual stimulation and arousal, left (L) inferior parietal lobule and L postcentral gyrus were activated in both men and women; however right (R) amygdala, R and L fusiform gyrus, R middle temporal gyrus, L inferior temporal gyrus were deactivated. During orgasm, L cerebellar vermis of anterior lobe were activated in both men and women, while R gyrus rectus, L inferior frontal gyrus, L middle frontal gyrus, L superior frontal gyrus, L medial frontal gyrus, L inferior frontal gyrus L middle frontal gyrus were deactivated in both sexes. In females R insula was more activated than males during orgasm (Giorgiasis, 2009). Giorgiadis also reported that regional cerebral blood flow (rCBF) increased in the left secondary and right somatosensory cortex during arousal by means of clitoral stimulation. During clitoral orgasms however rCBF was decreased in the neo cortex, particularly in the left lateral orbitofrontal cortex, inferior temporal gyrus and anterior temporal lobe. Giorgiadis found that orgasm related increases of rCBF occurred in the deep cerebellar nuclei, right caudate nucleus (Giorgiadis, 2006).

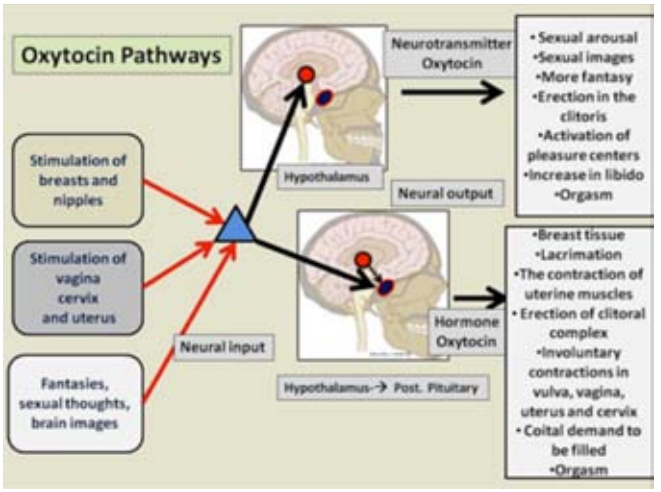
Komisaruk et. al. reported that clitoral, vaginal and cervical stimulation differentially activated the regions of the sensory cortex (Komisaruk, 2011). Komisaruk & Whipple also reported some orgasms of none-genital origin, coining the term "*brain orgasms*", where there was no genital stimulation, orgasm might occur in some women (Komisaruk, 1998). Vagal nerve involvement in the development of female orgasms was also reported, defining that vagus nerve innervating uterus and cervix, supplying a by-pass pathway distant from the plexuses related with spinal cord (Komisaruk, 2003, 2004). Komisaruk and Whipple reported that during a female orgasm induced by vaginal-cervical stimulation, hypothalamic paraventricular nucleus (where oxytocin is released), amygdala, hippocampus, pre-optic area, basal ganglia, cerebellum, anterior cingulate, lower brain stem and insular-parietal-frontal cortices were activated in the female brain (Komisaruk, 2005). It is hypothesized that pudental, pelvic, hypogastric and vagus nerves are involved in the development of female orgasm and also in the occurrence of ESR and expanded orgasms (Komisaruk, 1998, 2003, 2004, 2005, 2006, 2011; Sayin, 2010, 2011, 2012).

Most probably, primarily *dopaminergic and oxytocinergic* pathways may be involved in the alterations of mood and subjective feelings of pleasure as the studies cited above point out. Acute releases of dopamine, oxytocin, norepinephrine, endogenous opioids and prolactin may be responsible of some of the mood changes, elevated pleasure levels and **ASC** patterns during prolonged orgasms and **ESR**.

Four Nerve-Six Pathway Theory of Female Orgasm

In most of the studies of fMRI, MR and PET, investigating female orgasms, single stimulus from only one locus is studied, as it is mostly the glans clitoris. However today we know that female orgasm develops through different pathways and the stimulations of different loci (Komisaruk, 2006). For the explanation of prolonged, enhanced and expanded orgasms, "*the blended orgasm theory*" seems to be the most plausible one (Ladas, 1982). It is also reported that female orgasms can develop through the stimulation of nipples and hence through intercostals nerves-(T2-T5 vertebrae, particularly T4)-hypothalamus-pituitary-oxytocin pathway (Komisaruk, 2006; Magon, 2011; Sayin, 2012). Oxytocin has an effect as a neurotransmitter in the brain and it is also released from the pituitary to the bloodstream (Argiolas, 2003); thus forming a double fold pathway system. Also the stimulation of **DVZ** (clitoral complex, cervix, G-Spot, A-Spot, O-Spot, PFM, anus) may activate pudental nerve mediated orgasm reflex partially and pelvic, hypogastric, vagus nerve mediated orgasm reflexes directly, thus supplying more pleasure input into the brain. In **ESR** women the pleasure input into the brain and the number of activated orgasm reflex pathways are enhanced and increased. A mathematical and neurophysiological computer model would prove that in **ESR** women there is much more pleasure input into the brain and brain pleasure centers.





Besides pudental, pelvic, hypogastric and vagus nerve pathways, the two oxytocin pathways may also contribute to the development of female orgasms, forming a four nerve-six pathway module for the explanation of female orgasmic response (Sayin, 2012).

We hypothesize that during ESR orgasms, multiple pathways and cerebral centers contribute to development of prolonged female orgasms. When multiple pathways are involved, a lot of dif-

ferent cerebral loci and immense changes in many neurotransmitter systems may take part in the development of female orgasms acutely, thus inducing an extraordinary orgasm patterns, also inducing altered states of consciousness in some ESR women.

In the literature it has been shown that the following loci alone may trigger female orgasm (Komisaruk, 2006; Sayin, 1993, 2010, 2011, 2012):

- Glans clitoris (in nearly 75 to 85% of women)
- Clitoral complex (in nearly 30 to 40% of women)
- Grafenberg's spot (in nearly 20 to 30% of women)
- Vaginal intercourse (in nearly 30 to 35% of women)
- Pelvic floor muscles (frequency unknown)
- A-Spot (frequency unknown, but estimated to be very few)
- O-Spot (frequency unknown, but estimated to be very few)
- Cervix (frequency unknown, but estimated to be very few)
- Nipples (frequency unknown, but estimated to be very few)
- Ear lobes (frequency unknown, but estimated to be very few)
- Anal stimulation (frequency unknown, but estimated to be very few)

These loci carry sexual arousal impulses of pressure, vibration, heat-cold, pain, touch, etc. to five nerves (pudental, pelvic, hypogastric, vagus, and intercostal) which form a six separate pathway system. If there are six pathway systems in the female body that contribute to the triggering of an orgasm or expanded orgasms; then, there can be **63 distinct orgasm patterns** in females.

What is Different in ESR Women Compared to NESR Women?

A minority of human females experience **Expanded Sexual Response (ESR)**; however, **ESR** is a learned and developed phenomenon. Our estimation today is that only 10-15% of woman population can experience **ESR** orgasms (the actual number can be even lower!), however this number and proportion may increase by means of education, learning, Tantra workshops, developing PC-Muscles (**PFM**), training, increasing interests in sexuality. In some ESR women there may be some anatomical and physiological differences in the individual genital system and/or in the neurophysiological systems and individual psychology, as well as hormonal system. It is our estimation is that the *growth hormone* (GH), *oxytocin, testosterone, DHEA, thyroid hormones* (T3 and T4), *estrogen and progesterone levels* in the bloodstream and the cerebrospinal fluids of these **ESR women** may be altered or elevated for some (there is no substantial data). However we know that some of the sexual responses are altered in **ESR** women:

1) They have the ability to be aroused more easily.
2) They have a heightened and elevated libido.
3) They are very conscious and responsive of **G-Spot, DVZ** and other erogenous zones other than **glans clitoris**. Their sexual stimuli arousal thresholds are de creased in response to vibrators (50-200 Hz), coitus, oral sex, manual stimula tion and/or other methods such as fondling, touching, labial stimuli.
4) They spend more time in sexual issues and matters.
5) They have more fantasies and more tendency to have sexual variations, from soft variations to extreme paraphilia and/or BDSM. Many hyper-active women we interviewed had many different fantasy patterns from soft to wild and extreme, although they never experienced any of them.

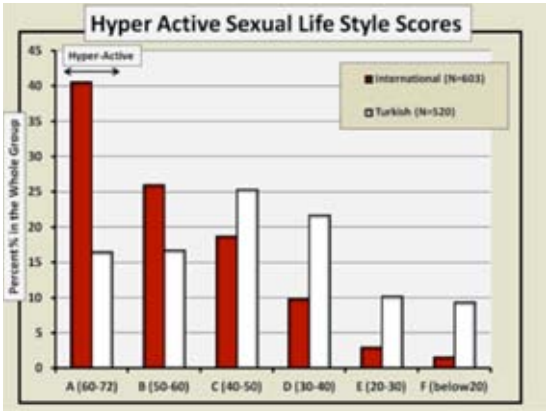
6) They generally use sex toys and vibrators.
7) They masturbate more frequently even in the presence of a partner. Their mas turbation frequency increases when they don't have a partner.
8) Their sexual-brain and sexual-psychology is more developed and responsive. Some may experience "**brain orgasms**" just by fantasizing and using **PFM**.
9) They are less inhibited, more provocative and promiscuous. They are very permissive and liberated. Their mind is more open to sexual matters and novelties.
10) They are more experienced in sex, having more partners and longer sexual relations. However partner number is not an issue, as many of them pointed out. The quality of the relationship and of sex is more important than the quantity. They are **NOT** women in search of new partners every night, for one night stands, however they prefer long term and satisfactory relationships.
11) Their imagination, IQ and EQ (emotional intelligence) seem to be higher and more developed. They prefer to be in deeper and soul-mate type relations with men rather than superficial ones.
12) **ESR** women seem to be less believers in terms of traditional religious practices compared to **NESR** women, while they have little or none, cultural and religious dogmas.
13) Some **ESR** women report to have ejaculation during orgasm like male, a phenomenon which had been reported by Ladas, Perry and Whipple (Ladas, 1982).
14) **ESR** women experience Altered States of Consciousness (**ASC**) during prolonged orgasm more frequently than **NESR** women. The number of variation of different subjective feelings and **ASC** of **ESR** women during different forms of orgasms and prolonged **ESR** orgasms is much higher compared to **NESR** women (Taylor, 2000; Sayin, 2011; King, 2010).
15) **ESR** women have happier, content, satisfactory sex life styles compared to **NESR** women. No **ESR** women goes to a clinical psychologist or psychiatrist for any sexual dysfunction complaint, so that is why the existence of **ESR** phenomenon and **ESR** women have not been pinpointed and discussed in the medical literature and psychiatry literature much.
16) **ESR** women may experience very long, multiple, prolonged and sustained orgasm patterns and also a phenomenon called *status orgasmus*, which may last from 1-2 minutes to 10-15 minutes or more (Sayin, 2010, 2011, 2012; Taylor, 2002; Schwartz, 1999).

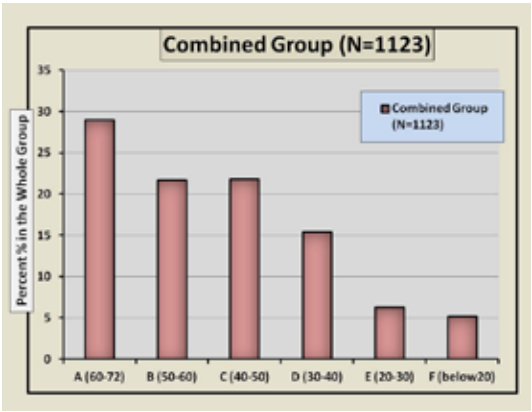
Some Aspects for DSM-V-2013 HDSI Criteria Related with ESR Phenomenon

The findings of some international surveys of Winters et al. (Winters, 2010) and ours (Kocatürk and Sayin, 2012), have shown that from 21.5 to 29% of women may have a hyper-active sexual life style on the globe. This ratio is variable from society to society, from country to country, even from city to city.

Even though the selection of the study groups above can be questioned and criticized, it was obvious that *some women with sexually hyper-active life styles exist on the globe.* In our study, the ratio of women who got the highest scores, which gave a clue about hyper active sex life styles, between 60-72 (group A) were 40.6% internationally (N=605) and 16.5% nationally (Turkish, N=520); combined ratio of the highest

scores (group A) of the whole group studied (N=1123) was 29%. Group A (scores between 60-72) was depicting the most hyper active sexual life styles, while group F (below 20) was the lowest sex life score. It would be too biased to claim that most of these women had some psychological disorders or pathologies such as, bipolar disorder, persistent genital arousal syndrome, being sexually compulsive etc. If **HDSI criteria** of DSM-V were applied to these women, 21.5 to 29% of them would also get high scores in **HDSI** of DSM-V, to be misdiagnosed as **hypersexual disorder (HD)**. This data was presented in NACS-2011-Oslo (partially) and IASR-2012-Lisbon Meetings.





Also, in **HDSI** criteria more than 9 orgasms a week, will be regarded as a sign of hypersexual disorder (Kafka, 2010), which is a very poor scientific conclusion, because 67.6% of American women experience multiple orgasms, and 65.9% of American women experience 2 to 5 orgasms occasionally, while 19.3% of American women experience 5-11 (or more) orgasms generally, during one love making session (Wolfe, 1982). Also 7.9% of American women have sexual intercourse everyday, 35.6% of them make love 3-5 times a week (Wolfe, 1982). A mathematical model would prove that nearly 30-35% of American women are experiencing more than 9 orgasms a week.

The sexual tendencies and sexual life styles of global women and Turkish women were totally different, Turkish women getting an average of lower scores would mean that scales and scores for sexuality may vary from society to society. *Turkish women seem to have a less active, less satisfactory, less liberated, less permissive and less happy sexual life styles compared to the women globally!* (Kocatürk, 2011, 2012, İstanbul Report-2012) A woman who is accepted to have a hyper active sex life style in Turkey, would be regarded as a normal and below average woman in USA or Scandinavia. Thus without performing the global surveys which would give the average sex life styles and tendencies (e.g. Orgasm number in one week, fantasy duration, masturbation frequency, multiple orgasm capability) in each society, efforts to derive "***universal scores and scales***", such as **HDSI** of **DSM-V**, are beyond the limits of ***sanity, pure logical thinking*** and ***scientific reasoning***.

Although defined recently, a phenomenon coined as **Expanded Sexual Response (ESR)** exists in the human female. **ESR** is believed to be experienced by a minority of women, while approximately, estimated 10-15% of global women can learn and develop **ESR**. The **ESR-women**, most of whom are psychologically very normal and having no psychiatric problems, can easily be misdiagnosed as **HD**, if the **HDSI criteria** of

DSM-V is legalized. Such orgasmic responses of females are well known and published in some Eastern cultures, India, Tantric cultures and China for many centuries.

Moser, criticizes HDSI criteria as (Moser, 2011) "... *In summary, the proposed Hypersexual Disorder diagnosis is based upon faulty and inconsistent logic, imprecise criteria, historical inaccuracies, and poorly conceived constructs. Inexplicably, the empirical basis required for adding a new diagnosis to the DSM is lacking. Using Kafka's own analysis and research, the proposed diagnostic criteria for Hypersexual Disorder have not met his own description of the disorder or defined a new disorder. Hypersexual Disorder is another failed attempt at defining this phenomenon and obviously not ready for inclusion in DSM-V. This proposal is another example of the quasi-scientific muddled thinking that has characterized this concept historically….*" We totally agree with Dr. Charles Moser. More research should be performed on female sexual behavior to determine the "*normals and limits*" of women, before deriving certain pathological conclusions, such as **HD**, depending on ambiguous scales or inventories. Psychiatric associations or similar foundations, - as once the Church did!- should not take such vanguarding roles to police the limits and boundaries of private and sexual lives of women, of whose sexual potentials are not YET unraveled, unveiled and revealed totally!

Conclusion

ESR induced orgasms have been defined recently in the medical literature (Taylor, 2000; King, 2010; Sayin, 1993, 2003, 2010, 2011, 2012). More emphasis should be given to an extended and further research on ESR and ESR induced prolonged female orgasms to understand the neuroanatomical, neurochemical and psychological mechanisms of ESR to unveil female orgasmic response. The researchers on sexology are welcome to join the ongoing ESR research, we are continuing to investigate.

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