BODY, MIND AND SEXUAL DYSFUNCTIONS

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Presented at Gender and Power in the New Europe, the 5th European Feminist Research Conference, August 20-24, 2003, Lund University, Sweden

Introduction

Our bodies won’t always work as we want them to. They aren’t always hard enough, soft enough or as moist as we wish they were. Vaginismus, impotence or difficulties achieving orgasm are some conditions where our bodies don’t work as we want them to when having sex. They are a few examples among others of so called sexual dysfunctions.

Sexuality, although conceived of as intimate and private, is far from individual. Rather, sexuality surrounds us. Erotic and romantic images are commonplace in everyday life. They idealize certain ways of having sexual intercourse, making some desires out to be valuable, and some expressions of excitement to be acceptable and appropriate. This however doesn’t mean that our sexualities are unequivocally and inexorably decided by those taboos, norms, rules and prohibitions that together write the story of contemporary and local sexualities, but it means that individual sexualities become meaningful, understandable and made concrete in relation to this story. Our sexualities aren’t altogether our own, but take a profound impression from the context we are living in. Social and cultural notions of sexuality are reflected in the directions, aims and shapes of our sexual desires. Sexual dysfunctions are conditions that interfere with the satisfaction of those desires. At the same time that our desires are engaged in a cultural and social production, sexual dysfunctions too are therefore socially and culturally specific conditions.

Sources and Aims of this Paper

This paper will be part of a more general analysis of the concept of sexual dysfunction, where I will examine what notion of sexuality this concept relies upon, and what views of femininity and masculinity are expressed when the concept is employed in medical treatment. The focus here however will be on the use and elaboration of body, mind and emotion in explanations of sexual dysfunctions and development of therapeutic methods thereof. While the concept of sexual dysfunction includes several distinct definitions and descriptions of different conditions, I will at this stage limit my analysis to only one of these dysfunctions: Hypoactive sexual desire disorder (hereafter: HSD). In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), this disorder is characterized as chronically or recurrently “deficient or absent desire for and fantasy about sexual activity”, if this also leads to distress or interpersonal problems.

The aim of this paper is to investigate how the notions of body or organism, and mind or psyche, as well as different notions pertaining to human emotions are 1) used in research on HSD, and 2) assumed to relate to each other in research on HSD. My analysis will focus on the works of American sex therapist Helen Singer Kaplan, who have written extensively on sexual dysfunctions and HSD in particular.1 Her writings are both theoretically and practically oriented, and relies on both reviews of previous research and her own case studies. However, as my work proceeds I hope to remedy this

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exclusive focus in my analysis, by incorporating other sources as well as other dysfunctions. I view this paper is as a first outline of my analysis, and I hope it will help me trying out some ways of identifying and analysing critical aspects of the notion of sexual dysfunction, that I can employ in the future.

From the definition in DSM-IV a few points of importance for further analysis can be made: First, the notions of desire and fantasy play important parts. However, the definition makes no attempt at clarifying neither what desire or fantasy is, nor how they are related to each other. Presumably then, the elaboration of both desire and fantasy will provide important clues to understand how body and mind are conceived of. Second, without distress or interpersonal problems, there is no sexual dysfunction. Such emotional conditions are thus presented as absolute qualifiers in the definition, but at the same time there are important ambiguities surrounding them. What, for example, counts as distress? How severe should it be to qualify? Do both (all) parts in a relation have to experience interpersonal difficulties, or is it sufficient that only one of them do? Examining these ambiguities in greater detail will, presumably, contribute to a more general appreciation of the rhetorical role of human emotional life in explanations of HSD.

Third, and thoroughly obvious, the definition is silent when it comes to what causes HSD. The point of this last comment, however, is that it enables the distinguishing of two different ways in which the distinction between organism and psyche presumably will prove important in relation to the concept of HSD. First, this distinction is crucial to the general notion of sexuality supposed by Singer Kaplan, in that she, as will be shown later on, assumes that human sexuality is composed of both biological and psychological components. Clarifying such notions as desire, fantasy and emotion will help clarifying the relation between body, mind and sexuality in general. Secondly the distinction is also fundamental when it comes to the causes of HSD, since it, as will be shown later, supposedly can be an effect of either organic or psychological causes, or in other cases a combination of both kinds of factors. In every specific case, finding out whether organic or psychological factors are at play, is therefore a crucial part of determining the aetiology of the symptoms. This differential diagnosis therefore relies heavily on what our bodies and minds are in fact assumed to consist of.

Following this, I will present some theoretical considerations and then start off my empirical analysis by a more thorough description of HSD focusing especially on the notions of desire and fantasy. At this stage I will also comment on and examine the general notion of sexuality as it appears in the works of Singer Kaplan. From there, in the next paragraph, I will examine how HSD is supposedly known, both to the symptomatic subject and to therapist. I will focus on the attention directed at emotions as a way of feeling the disorder, and on the evaluation and appraisal of psyche and organism as potential causes of HSD. In the last paragraph of this paper, I will attempt an analysis of the role and function of the different notions pertaining to body, mind and emotion, in the conceptual production of sexuality that will be encountered.

**Theoretical Considerations**

The medical and psychiatric sciences view sexuality in many ways as something to be managed, as something riddled with problems and risks to be handled, but at the same time as something that promises fulfilment and joy when it takes on allegedly healthy expressions. The relation between sexuality as a topic of speech and writing, and sexuality as part of human experience is contested. In psychiatric documents such as the aforementioned DSM-IV, sexuality figures as an objective feature of the human biological condition. But sexuality, many argue, is not “already there”; it is not a universal fact transgressing society and culture, but a part, and a result, of the many processes that go on in and constitute societies and cultures.² The management of sexuality is part of the production of both the idea of sexuality and the experience of it. The rules, taboos and, particularly in this case, therapeutic techniques governing sexuality is also shaping sexuality as it is known and felt.

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The experiences of impotence such as impotence, is dependant on a system of classifications that define the boundaries of the conceptual space known as such. The medical sciences are conditions for sexual dysfunctionality by presenting and elaborating such a system of classification. *Function* and *dysfunction* are relational concepts in that they negotiate the same conceptual space; changing the boundaries of what is conceived of as functional, also means changing the boundaries of the dysfunctional. While our cultural and social notions of sexuality presents the backdrop to the normality that dysfunctions diverge from, the medical sciences compile and explain a deviance to understand normality from. By defining, classifying and explaining sexual dysfunction, the medical sciences thus reflect and reinforce a notion of functional sexuality. While doing this with the legitimacy associated with respected claims of rationality, the research on sexual dysfunctions provides certain sexual desires, expressions and forms of sexual intercourse with an allegedly rational foundation.3

If sexuality is viewed as a cultural product rather than as a biological necessity, it makes sense to ask on what premises sexuality is built. It makes sense to refrain from asking how well an alleged description of sexuality captures its object, but to instead view description and explanation as production: if sexuality is what a certain text says it is, what then is sexuality? This puts focus on the means of production, rather than on the relation between explanation and the explained. Concepts produce sexuality, and regarding sexual dysfunctions in particular, they do it through inclusions and exclusions that ultimately contribute to the distinguishing of the abnormal from the normal.4

The distinction between normality and abnormality is conferred upon rather than derived from human conditions. It pertains to a worldview rather than to the world itself. Feminist studies of western worldviews have shown that such ways of knowing the world, often employs dualism. Nature is opposed to culture, object to subject, and passivity to activity. Such dualism in turn, display a gendered structure: while culture is associated with subjectivity and activity, and ultimately with masculinity, nature has ties to objectivity and passivity and ultimately to femininity.5 In this way, the world is known through gendered notions. Studying the conceptual production of sexuality, will therefore in the end also involve attention to these gendered politics of representation.

**Active and Hypoactive Sexuality**

The notion of hypoactive sexual desire as it takes shape in the work of Singer Kaplan6 relies on a conception of human sexuality that portrays sexuality as the interplay between two kinds of factors. On the one hand, a person’s sexuality consists of sexual impulses, of desires and urges. On the other hand, such impulses always come in to realization through a regulatory system, providing them with shape, direction and certain intensity. Sexuality, whether it is hetero- or homosexuality, hyper- or hypoactive, is a result of the generation of impulses and the control of desires.

While the monitoring, control and regulation of sexual desire are fundamental to all and any sexuality, the amount and nature of this regulation is central when it comes to differentiating between normal and abnormal sexual desire. The regulation of sexual desire can range from overly rigorous, to appropriate, to insufficient, resulting in hypoactive sexual desire disorder, normal and hyperactive sexual desire. In short, HSD is what happens when sexual desires are systematically and abnormally suppressed, and consequently fade away and vanish from a person’s experiences.

This story of sexuality and HSD is explicitly psychodynamic. Sexuality is, at least at a first glance, to desire and control, what the psychodynamic ego is to id and superego. Given this connection, it seems viable to interpret the notions of sexual impulse and system of regulation, along the lines of the distinction between organism and psyche. Although there is some validity to such an interpretation,

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there is no straightforward attribution neither of impulses to the biology a person, nor of regulation of desire to hers or his psychology. To make this image of sexuality more appropriate, closer looks at the notions of sexual impulse and desire, to begin with, and at the notion of regulatory system, are needed.

Sexual impulses do not occur entirely spontaneous, but are generally reactions. So far, sexual impulses could be seen as a result of what goes on in our physical or, as the case is with fantasies, imagined environment. The sight of other people, caressing or being caressed are examples of classical turn-ons, while a stressful workplace and the thought of our own parents naked, are classical turn-offs. However, what stimuli turn us on, and what turn us of is, in this version of sexuality, not arbitrary. There is a basis for discriminating between stimuli that activates our sexual desires and those that deactivate or keep them inactive, and this basis is biological:

Despite the fact that human sexuality has been virtually divorced from reproduction, the imprimatur of the biological imperative to reproduce and multiply still gives shape to our sexual desires.7

To be more precise, this assumed biological imperative comes into effect in the form of hormonal and chemical processes. On the hormonal level estrogen and testosterone, commonly8 referred to as sex hormones, are portrayed as the chief actors. Estrogen is depicted as the “hormone that makes females attractive to males”9, mainly because estrogen is supposed to be certainly influential in the development of female anatomy and sexual characteristics “that are attractive to males”.10 Estrogen is rendered a significant cause of sexual impulses, insofar its effects in women are considered attractive by men; it is significant to men’s psychology and perception of women's biology and anatomy. However, this perception is not entirely psychological, but, again, relies on a biological, genetic, foundation, so that we, and in this case men, “lust for partners with characteristics that favor species survival”.11

While estrogen primarily affects women, and men by proxy, testosterone affects both women and men. It is portrayed as the “libido hormone of both human males and females”12, and is supposedly necessary for the general generation of sexual desire, irrespective of how this desire is constituted; without testosterone there is no desire. The role of testosterone in the human male can also be interpreted as important in relation to the already encountered biological imperative to reproduce:

This hormone masculinizes the developing brain so that its behaviour will become appropriate to the male gender.13

It is not explicit in the text, but given the general heteronormative version of sexuality presented, it seems plausible to assume that part of what is supposedly appropriate to the male gender, is the desiring of women with characteristics that would favor the survival of the species.14

Earlier I made the claim that there is some truth to the assumption that the relation between desire and regulation corresponds to the distinction between organism and psyche, but that there were more to this relation then just that. So far, I have commented on the notion of desire, and before I will go by examining the notion of regulation closer, I will sum up the story of desire so far.

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8 But, according to Anne Fausto Sterling in Sexing the Body, mistakenly so.
14 The text leaves no clue to how testosterone affects the brains of women, or why the behaviour of women's brains won’t also become appropriate to the male gender.
In Singer Kaplan’s version of sexuality, biology is clearly important to desire and sexual impulse. To be more precise, biology provides a complex basis for desire. Hormones, and testosterone in particular, are necessary conditions for desire to occur, but hormones do not cause desire, at least not in any immediate way. Instead environmental and sometimes mental stimuli give rise to sexual desire, but to be able to do that, a certain minimal testosterone level has to be present. Stimuli produce sexual impulses through testosterone. Even though, this far, there is no causal connection between testosterone and desire, there is a direct one. Between estrogen and desire however, there is a connection that despite being indirect is portrayed as causal. In this story of sexuality, estrogen causes the stimuli that in turn cause desire: Estrogen causes the development of female anatomy and sexual characteristics that cause men to feel desire. Underneath these connections lies a biological shaping of desire as an ultimately heterosexual matter; the supposedly biological imperative to procreate serves as the reason why men get aroused by “feminine” women.

So far it can be concluded that testosterone is portrayed as needed to feel desire, that biology is assumed to shape how desire is felt, but that the immediate cause of desire does not lie within the organism, but is environmental or mental. Turning now to the notion of system of regulation, this notion has a stronger connection to psychology than to biology, even though it is not exclusively biological. Stronger than the imperative to procreate, is the, also biological, ambition to stay alive. In the presence of mortal dangers, and less harmful cousins of it such as stress and discomfort, feelings of sexual desire are downplayed, thus preparing the body for more urgent matters. It seems then that the imperative to procreate as well as the survival instinct, together constitute, or perhaps are both part of, a general biological foundation shaping how we react to our environment.

Insofar there is such a biological foundation it is a foundation that is common throughout the human species. At the same time, it is stressed that people do not react to and interact with their environment in the same way. Although there is a biology of sexual desires, there is also a significant psychology of such desires:

Superimposed on the dominant genetic theme, to lust for partners with characteristics that favor species survival, we acquire our idiosyncratic sexual desires, preferences, and fantasies as a consequence of our individual histories, learning, and experience.15

Even though biology helps us to distinguish roughly between potentially sexual stimuli and other kinds of stimuli, what we actually perceive as arousing is largely determined by a psychologically established “love-map”. A “love-map” being “a mental template of every individual’s sexueroetic fantasies and erotic practice”16 negotiate our biological heritage into specific sexualities, accompanied with individual preferences and particularities. To put this idea in the heteronormative manner characteristic of Singer Kaplan’s version of sexuality, biology predispose us to lust for penetrative sexual intercourse, but there are many ways of having such intercourse, and many activities leading up to it. If we prefer the missionary position or woman-on-top-man-on-his-back, if we like to be orally or manually stimulated in advance, if we want to do it in bed or on the kitchen table, if we just want to do it, or rather be taken to dinner first, is determined by the vast repertoire of preferences and fantasies that make up our “love-maps”.

When we fantasize about sex, we do that through our love-maps. But at the same time as fantasizing through our love-maps turns us on, fantasizing against them turns us of. Outside our love-maps, there are maps that fuel our “anti-fantasies” and counter-sexual behaviours. Through our biological constitution, mortal danger is grounds for anti-fantasies, but as well as our love-maps negotiate our biological foundations for desire into specific sexualities, the psyche negotiate our urge to survive into specific anti-fantasies. Helplessness, loss of control and feelings of being exposed are arguably what constitute experiencing mortal danger. In a sense then we experience mortal danger also in situations that are not dangerous. Talking in front of an audience, being naked in public, having too much to

handle at work are examples of situations that may give rise to such panicky feelings, even though they do not present actual or immediate threats to our biological beings. Being in such situations, in fact or in our imagination, reduce or diminish feelings of sexual desire, because they present more urgent things than sex to handle.

Together sexual fantasies and anti-fantasise constitute the psychological aspects of the regulatory system of sexual desire. When conjoined with a notion of normal sexual desire, this regulatory system supposedly ensures that we feel sexual desire when it is appropriate, and that feelings of such desire are suppressed in situations where they do not belong.

From a psychological perspective this regulatory system works through fantasies; however, fantasies are not alone in this process. As well as desire in general comes in to effect through testosterone, specific desires comes in to effect through biological and material processes. Biology and psychology works together in the production of specific sexualities and individual desires. How this cooperation actually functions is largely unknown. It seems clear enough that hormones is a needed basis for sexual desire, and that our genetic heritage provides a rough predisposition towards an undifferentiated heterosexuality, but when it comes to individual realizations of heterosexualities as well as other sexualities the mechanisms by which the psyche materializes as neurobiology and chemistry are uncharted territory:

The sex regulating apparatus of the brain is in a certain sense still a “black box”… [t]he precise neurobiological mechanism that maintain physical homeostasis and regulate our drives remain to be elucidated. Thus, current concepts of drives and motives are based largely on inferences…17

Even though these mechanisms are unknown, the assumption remains that there are distinct mechanisms to be known. Even though the relation between organism and psyche is unclear, it is assumed that there is a certain distinction between them to be known.

Knowing the Cause, Feeling the Effect

Hypoactive sexual desire disorder occurs when sexual desires do not arise when they ought to. There are two kinds of reasons this happens: psychogenic and organic. Characterized in general, psychogenic HSD is the result of the systematic employment of anti-fantasises in situations where sexual fantasies would be more appropriate, and organic HSD comes, in the same general terms, from deficient hormone production. Singer Kaplan is of course far more detailed, reviewing and discussing many deeper psychological reasons why someone would excess in anti-fantasises, and examining several medical conditions that supposedly affect sexual desire. My focus though, will be on the clues a therapist should look for, in order to find out if further examination and treatment should be of the psyche or of the organism.

One crucial issue that should be taken into account when performing this differential diagnosis is whether the dysfunction is situational or global. For example, situational HSD may occur with a certain partner but not with others, while global HSD occurs irrespectively of partner. Relying on the assumption that the psyche is more discriminating than a person’s organic constitution, that the organism could not tell one partner from the other while the psyche could, situational dysfunctions could presumably not result from organic disorders.

Although situational HSD implies a psychiatric condition, global HSD is not necessary organic. Hence, if it is concluded that the disorder is global, further steps has to be taken in order to fulfil the differential diagnosis. One such step is to examine whether the dysfunctions first appeared simultaneously with the onset of another medical condition, such as removal of the fallopian tubes and ovaries in women or testicular injuries in men, which could lead to testosterone deficiency and supposedly consequently a decrease in sexual desire. The differential diagnosis ends either when an

organic condition that account for the loss of desire is found, or when all possible organic factors are ruled out. Psychogenicity is thus established through a process of elimination; if HSD cannot be explained organically, it must be psychological. 

Not all loss of sexual desire, no matter if it is psychogenic or organic, constitutes disorders. The loss of sexual desire is not in itself sufficient grounds for such a diagnosis. It also has to be experienced as problematic by the person or persons concerned with vanishing desire. Phenomenologically speaking, in many cases sexual disorders are disorderly only insofar they yield a distressing emotional response. Emotions are what make them knowledgeable as disorders to, as in the following case, the person afflicted by them:

Sexually anorexic patients are perfectly comfortable with their lack of sexuality and claim that they do not miss sex. In clinical practice we see men and women with severe hyposexual desire states only when their lack of interest in sex has resulted in marital problems, or if their asexuality has interfered with their ability to form romantic relationships to the point where their loneliness and sense of isolation drives them to seek help.

Feelings of loneliness and isolation, as in this example, are what make the dysfunctional condition palpable. It is not the lack of desire itself that is problematic, but, as in the next example, the limits this lack put on interaction, here described by one of Singer Kaplan’s clients:

She’s a wonderful, beautiful woman, it is not her fault, she’s an excellent partner and would do anything to please me, but I just feel like a brother to her. I’m very guilty about this, I know I’m ruining her life and jeopardizing my marriage, but I just can’t help it.

In other cases, lack of sexual desire gives rise to emotional distress in the person that otherwise could be expected to be the object of desire: “[H]e went to bed in a separate room without making love to Evelyn, which hurt her very much.”

In a relationship where none of the partners wish that their relationship was (more) sexual, there is no problem in one or both of them not feeling sexual desire. Exceptionally low or high levels of sexual desire do not necessarily lead to difficulties in a relationship:

As far as I am concerned, if a person and his or her partner are content to have sex once a month or just once a year, or if both enjoy having sex twice a day, it would be inappropriate to label this behavior as a disorder or to intervene therapeutically. As long as the patient’s atypical sexual behavior does not create problems for either partner, the diagnosis of sexual desire disorder is not warranted.

Evidently, there is no straightforward relation between HSD and emotions. Neither feelings of loneliness, guilt nor hurt, are direct consequences of HSD, but come from contextualized lacks of desire. A common feature of such contexts seems to be sexual expectations. There is the expectation that a romantic relationship also should be a sexual one, that a marriage should incorporate erotic encounters, and that husband and wife should sleep together in the same room and the same bed. Such expectations are of course familiar in our cultural notions of marriage and romanticism, but what is noteworthy here is that Singer Kaplan employs such notions to distinguish between normal and potential disorderly desires. If at least one partner experiences that there are problems, such conceptions of how sex should be had, take precedence over the lacking sexual desire, and sets the norm desire should comply with.

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Desire should measure up to our conceptions of a healthy sex life; distressing emotions tell us that something is wrong, not with how we conceive of sex, but with our interest in having sex. The role of emotions in explanations of HSD, assumes that HSD and other sexual dysfunctions are abnormal, not in relation to social or cultural conventions, but in and by them selves.
A Differential Diagnosis of Conceptual Functions

To metaphorically perform a differential diagnosis on the explanations of HSD is to make an appraisal of how the notions of organism and psyche contribute to these explanations. In the following I will sum up this diagnosis around some reflections on the politics of the sexuality we have encountered.

We have seen that explanations of HSD rely on a specific conception of sexuality where both organic and psychological notions are important. Biology provides the general basis for sexual desire, while the specifics of how desire is realized in the individual person come from the constitution of hers or his psyche. However, biology is still influential even on the specifics of sexual desiring. It sets the limits for how a person’s sexuality should be constituted, even though it does not necessarily determine how it actually is constituted. In the well functioning person, the organism works as a paradigm to the psyche, so that the psyche follows from the organism. Normal sexual functioning is at hand when the psyche works with, attuned to, the organism, while abnormal sexuality occurs when the psyche obstructs and works against the organism. Emotions then are measures of how well the psyche is attuned to the organism.

The distinction between organism and psyche thus helps to establish the distinction between normality and abnormality. Normality resides within the organism, abnormality mainly within the psyche. Ultimately then, the notion of biology employed not only justifies a therapeutic practice, but also rationalize heteronormative sexual conventions. Even though this exemplifies biologism very well, it does not entail biological determinism: Our cultural notions of a healthy sex life could draw the lines that distinguish what is appropriate and acceptable differently. Leaving the heteronormative ramifications behind would not be impossible but it would be wrong.

Given the general tone struck in DSM-IV, and the tradition of discourse on sexuality in the American Psychiatric Association, it is far from surprising that sexuality here is thoroughly conflated with heterosexuality. Despite this, the particular politics of HSD actually do have some surprising and remarkable elements. In an article on male sexual dysfunctions, Annie Potts argues that conceptions of premature ejaculation (PE) as well as masculinity are centred on control.\textsuperscript{23} Masculinity symbolizes being in control, while PE is defined and explained as lack of control. Thus, PE marks a symbolic feminization of the symptomatic subject. The notion of PE expresses a devalorization of femininity – being in control, symbolizing masculinity, is definitive of normality, while femininity, symbolized by a lack of control, is pathologized and portrayed as disorderly.

In this way, I believe that Potts’ analysis shows how the notion of PE makes use of the system of gendered dualism I commented on earlier in this paper; the normality that PE is deviant from is a condition where the mind, here symbolized by control symbolizing masculinity governs the body, here symbolized by involuntary orgasmic spasm symbolizing femininity. Masculinity normally dominates femininity, and PE symbolizes a failure to establish this relation.

This vision of the relation between femininity and masculinity is criticised by the definition and explanation of HSD. It is not lack of control that marks the abnormality of HSD, but control gone too rigorous. The symbolic domination of masculinity over femininity does not constitute normality, but is conceived as disorderly. While a successful therapeutic intervention regarding PE reinstates a more familiar gender order, therapy of HSD, in a small way, works against masculine power. In the midst of all heteronormative splendour and gender stereotypes the concept of HSD is thus also in fact subversive of traditional notions of symbolic gender relations.

\textsuperscript{23} Potts, A. ”The Essence of the Hard On” I: \textit{Men and Masculinities}, 3(1): 85-103
References


