Sexual dysfunction in gay men and lesbians

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Abstract
Sexual dysfunction can occur in gay men and lesbians, as it does in heterosexual men and women. However, the rates of sexual dysfunction are not clear as there has been very little research into the prevalence and aetiology of sexual dysfunction in gay men and lesbians. There is no evidence to suggest that the diagnosis or management of such cases is fundamentally different from sexual dysfunction presenting in heterosexuals, though some additional factors need to be remembered. The focus here is on those factors that are distinct for gay men and lesbians, such as intrapsychic conflicts which arise when an individual has difficulty negotiating a transition point in their lifecycle (e.g. leaving home for the first time, retirement). For gay men and lesbians, in addition to the usual transition points in their lifecycle, there may also be issues related to the private development and identity development and 'coming out'. The couples may be at different stages of coming out, which may place additional pressures on them. In this contribution we aim to review the literature and identify some of the special factors that the therapist may find helpful in the assessment and management of sexual dysfunction in gay men and lesbians.

Keywords aetiology; bisexuals; gays; lesbians; management; sexual dysfunction

Sexual dysfunction can occur in gay men and lesbians; however, there has been very little research into the prevalence of sexual dysfunction in these groups. There is no evidence to suggest that the diagnosis or management of such cases is fundamentally different from sexual dysfunction presenting in heterosexuals, though additional factors need to be remembered.

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In this contribution we aim to review the literature and identify some of the special factors that the therapist may find helpful in the assessment and management of sexual dysfunction in gay men and lesbians. We do not propose to discuss issues that are common to gay men, lesbians and heterosexual patients as these are discussed elsewhere, or to discuss sexual deviation and paraphilias, but will focus on those factors that are distinct for gay men and lesbians. These special factors are shown in Table 1.

Prevalence

One of the rare studies of prevalence demonstrated among 200 gay men attending a seminar that 97.5% reported sexual dysfunction over their lifetimes and 52.5% reported current concerns regarding sexual dysfunction.[1] Bhugra and Wright provide an overview of some of the issues.[2]

It can be argued that definitions of sexual dysfunction in international classificatory systems are largely heterosexist because the focus is on pair penile-vaginal penetration and there are no equivalent terms for penile-anal penetration. Some of these issues need to be borne in mind while reviewing the literature.

Bisexual individuals may have additional difficulties in that problems may be present with one gender but not the other.

Aetiological factors

Gay men

Organic causation: in addition to the usual organic (physical) causes of sexual dysfunction there is some evidence that alcohol 'plays a more substantial role at the core of the gay and lesbian community'.[3] In addition, Kiltzman and colleagues report a substantial association between attending dance clubs and the use of 3,4-methylenedioxymethamphetamine (MDMA, or 'ecstasy').[4] Given the strong links between alcohol and sexual dysfunction

Special factors for gay men and lesbians

General factors	External homophobia
	Institutional heterosexism
	Internalized homophobia
	High frequency of sexual partners
	Language in therapy
	Sex roles
Therapist factors	Personal attitudes
	Previous experiences
	Religious views
	Cultural notions
	Over-compensating for feared prejudice
Patient factors	Sex rules
	Couple vs. individual
	Sexual health
	Comorbid substance misuse
	Gender and sex roles
	Coming out stages
	Relationship stages

Table 1

and MDMA and sexual dysfunction, a careful assessment of substance use is indicated.[5] It should be remembered that harmful substance use may be socially reinforced and regarded as normal by clients, therefore the therapist needs to be careful not to damage the therapeutic alliance by taking a strong stance against intake of harmful substances. Sexual dysfunction may also be the first symptom of an occult vascular or endocrine disease arising from substance misuse.

With the recent increase in sexually transmitted diseases (STDs)[6–8] and the link between substance use and unsafe sex,[9] the clinician should consider the possible contribution of a STD, particularly in patients who may practise unsafe sex.[10] The experience of an STD can cause substantial distress and contribute to the onset of a sexual dysfunction that persists long after the STD is treated. Persisting physical symptoms in the absence of an organic cause, on the other hand, should alert the clinician to the possibility of a health anxiety.

Intrapsychic conflict: sexual dysfunction can develop as a result of intrapsychic conflicts, which commonly arise when an individual has difficulty negotiating a transition point in their lifecycle (e.g. leaving home for the first time, retirement). For gay men and lesbians, in addition to the usual transition points in their lifecycle, there may also be issues related to the private development and expression of their sexual identity, public expression of this sexual identity ('coming out') and the development of an alternative value system and raison d'être, especially if they have been excluded from mainstream heterosexual life. Issues related to homophobic bullying or other abuse in childhood, and low self-esteem, may be submerged in the tempest of the 'coming out' process, only to re-emerge at later points of psychological stress. It should be noted that this process is ongoing and cannot be completed once and for all; for example, starting a new job will involve a whole new 'coming out process' to work colleagues, at a time when the individual is likely to feel more vulnerable. Therefore, sexual dysfunction can arise from unexpected psychological sources that the individual may disregard (e.g. coming out at work in a new job after having lived an openly gay or lesbian lifestyle for 30 years).

Interpersonal conflict: for couples in general, difficulties in the relationship are probably the most common cause of sexual difficulties and gay couples are no exception to this. Whereas heterosexual couples are repeatedly exposed to a variety of emotionally congruent relationship stereotypes throughout their development, it is currently uncommon for gay men and lesbians to have had such an experience. Indeed, the usual message depicted is one of instability, infidelity and hopelessness. As a result, gay couples must co-create their own relationship framework, roles, narrative and rules. Civil partnership may produce additional stress on individuals. While the pre-existence of fewer rules and boundaries allows flexibility and creativity, this process places a greater strain on communication skills and self-knowledge. For example, it is not uncommon for gay male couples to have an 'open' relationship where other sexual partners are enjoyed individually or by the couple together. The couple may have explicit rules about what is permitted. The process of either explicitly or implicitly negotiating the nature (including the degree of permeability) of this sexual/emotional boundary is a challenge to gay couples and can be a helpful area for therapeutic work, particularly if this has become a sticking point in the relationship. Therapists should not assume that either the existing or a 'traditional' solution is satisfactory for both partners, as issues of physical safety, sexual health, jealousy, guilt and intimacy require resolution. Conversely, the couple's adoption of an open or semi-open relationship may be an adaptation to pre-existing sexual difficulties, and resolution of these difficulties may require re-negotiation of the sexual/emotional boundary round the relationship. The communication and intimacy skills required to find a satisfactory resolution (even if that results in a continuation of a closed relationship) are important in themselves, both for the broader wellbeing of the couple and for future discussions about the boundary. For these reasons sexual dysfunction should not be addressed in isolation from the couple relationship or, for the single patient, their wider psychosexual context.

Sociocultural factors: cultural homophobia and heterosexism are expressed through legal restrictions, institutionalized homophobia, religious prohibitions and family intolerance. These will influence not only the development of identity but also the process of coming out, and will increase internalized homophobia.[11] While heterosexual relationships are actively recognized and supported by the state, the reaction to gay relationships ranges from active persecution to formal recognition as 'civil partnerships' (e.g. UK) or marriages (Denmark and Netherlands). Even in societies where gay relationships are formally recognized and homophobia is prohibited, homophobia can still occur at all levels of society (from state level down to the local microculture). Within a given context, there can be a substantial variation in an individual's experience of homophobia, and therapists will need to explore both the experience and impact of support and hostility on both the individuals and their relationships.

Lesbians

Among lesbians, lack of intimacy and power imbalances in relationships have been postulated to contribute to sexual dysfunction. Sexual dysfunction is said to be rare because ability to achieve orgasm and sexual satisfaction appears to be quite high among lesbians.[12] Primary and secondary anorgasmia may be seen. Sexual desire disorders are not uncommon. Desire difficulties may be related to power imbalance, guilt or lack of romantic stimuli.[13]

Assessment

In addition to the usual assessment process (offered to heterosexual patients) the assessor will need to explore the factors outlined above. There are two potential errors that therapists need to avoid.

- Firstly, inappropriately pathologizing the relationship, aspects of the relationship or sexual practices. This is most likely with therapists who may take a personal moral position against gay relationships. It would be unethical for such individuals to offer assessment or treatment for psychosexual difficulties to gay men or lesbians.
- Secondly, the normalization of dysfunction as overcompensation for feared prejudice may occur. In general, by keeping an open mind and using a collaborative approach, it will become

