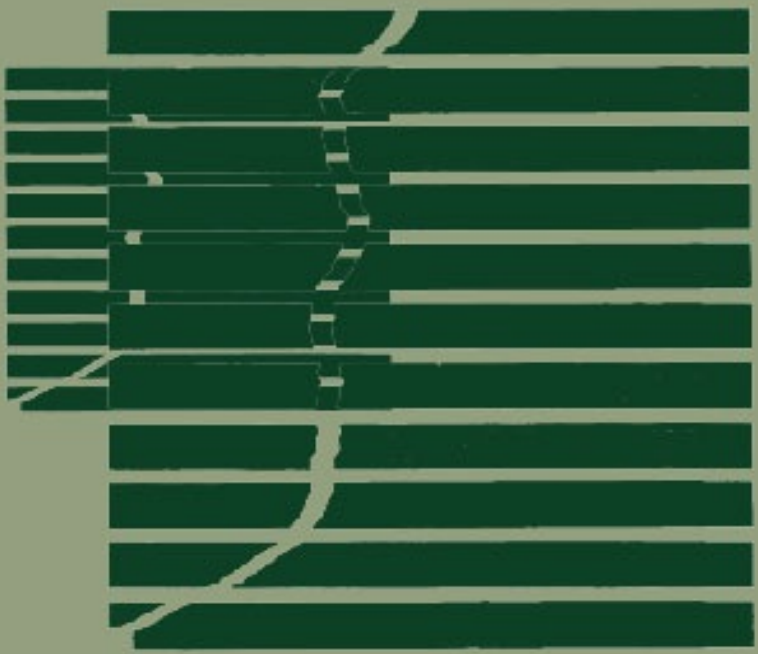
Counseling Men about Sexuality



Jeffrey C. Fracher
Michael S. Kimmel

Hard Issues and Soft Spots:

Counseling Men About Sexuality

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Table of Contents

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Nothing shows more clearly the extent to which modern society has atomized itself than the isolation in sexual ignorance which exists among us . . . . Many cultures, the most primitive and the most complex, have entertained sexual fears of an irrational sort, but probably our culture is unique in strictly isolating the individual in the fears that society has devised. (Trilling, 1954)

Sam is a 28-year-old white, single factory worker. He lives alone in a two-family home that he owns, and attends night school at a community college.[2] The third of six sons in a blue-collar, Eastern European Catholic family, Sam is a conscientious, hard-working, and responsible man with very traditional values. He describes himself as a sexual late-bloomer, having begun dating only after graduation from an all-male Catholic high school. Although strong and handsome, he has always lacked confidence with women, and describes himself as male peer-oriented, actively involved in sports, and spending much of his leisure time with "the boys."

Prior to his first sexual intercourse, two years ago at age 26, Sam had fabricated stories to tell his friends so as not to appear inadequate. He felt a great deal of shame and embarrassment that his public presentation of his sexual exploits had no basis in reality. His limited sexual knowledge caused him great anxiety and difficulty, especially since the woman with whom he was involved had had previous sexual encounters. Upon completion of intercourse, she reported that he "came too fast"(i.e., less than one minute, or after several thrusts), a statement that he reported, "hit me between the eyes." His second attempt at intercourse was no more successful, despite his use of a condom to reduce sensation, and he subsequently broke off this relationship because of the shame and embarrassment about his sexual incompetence, and the fear that word would leak out to his friends. He subsequently developed a secondary pattern of sexual avoidance, and when he first came to treatment, indicating that he was "not a real man because I can't satisfy a woman," he had not had sex for two years, and was reluctant to resume dating until his premature ejaculation was vastly improved.

Joe is a 34-year-old CPA who has been married for three years. The youngest of five children and

the only male in a middle-class Irish-American family, Joe feels his father had high expectations for him, and exhibited only neutrality or criticism. Joe was without a male role model who conveyed that it was OK to fail. In fact, he portrayed men as strong, competent, without feelings, and without problems or failings, and believes he can never live up to the image his father had for him. Consequently, Joe is terrified that failure to please a woman sexually may result in criticism that will challenge his masculinity; he will not be a "real man." Anticipating this criticism from his wife, his sexual interest is reduced.

When first seen in therapy, Joe evidenced a total lack of sexual interest in his wife, but a high degree of sexual interest involving sexual fantasies, pornography, and masturbation. He said "lust is an obsession with me," indicating a high sex drive when sex is anonymous, and though he felt sexually inadequate with his wife, he felt sexually potent with women he devalues, such as prostitutes. He could not understand his almost total lack of sexual interest in his wife.

Bill is a 52-year-old engineer, who has been married for 25 years. From a white, middle-class Protestant background, he has one grown child, and initially came to treatment upon referral from a urologist. He had seen numerous physicians after experiencing erectile dysfunction three years ago, and has actively sought a physical explanation for it.

Bill's wife, Ann, was quite vocal about her disappointment in his failure to perform sexually. Bill had always been the sexual initiator, and Ann had come to expect that he should be in charge. Both believed that the only "real sex" is intercourse with an erect penis. Ann frequently commented that she felt "emotionally empty" without intercourse, thereby adding to his sense of inadequacy. The loss of his capacity for erection, Bill told the therapist, meant that he had lost his masculinity, and he worried openly about displeasing Ann and her possibly leaving him.

His fear of lost masculinity spilled over into his job performance, and he became depressed and withdrew from social activities. Bill was unaware that as an older man, he required more direct penile stimulation for an erection, since he had never required it in the past, and was unable to ask for it from Ann. He felt that a "real man never has to ask his wife for anything sexually," and should be able to perform without her help. The pattern of erectile dysfunction was part of a broader pattern of inability to

tolerate failure, and he had begun to lose self-confidence since his masculinity was almost entirely predicated upon erectile functioning. "Nothing else matters," he confided, if his masculinity (evidenced by a functional erection) was not present. Everything was suddenly on the line— his self-worth, his marriage, and his career—if he proved unable to correct his problem.

Sam, Joe, and Bill manifest the three most common sexual complaints of men seeking therapy. But underlying premature ejaculation, inhibited sexual desire, and erectile dysfunction is a common thread, binding these and other sexual problems together. Each fears that his sexual problem damages his sense of masculinity, makes him less of a "real man." In a sense, we might say that all three men "suffer" from masculinity.

This chapter will explore how gender becomes one of the key organizing principles of male sexuality, informing and structuring men's sexual experiences. It will discuss how both gender and sexuality are socially constructed, and how therapeutic strategies to help men deal with sexual problems can raise issues of gender identity. This is especially important, of course, since so many therapeutic interventions rely on a diagnostic model that is simultaneously overly individualistic (in that it locates the source of the problem entirely within the individual) and trans-historical (in that it assumes that all cultures exhibit similar patterns at all times). The chapter combines a comparative and historical understanding of how both gender and sexuality are socially constructed with a psychoanalytic understanding of the transformative possibilities contained within the therapeutic relationship. This combination will lead us to discuss both social and therapeutic interventions that might facilitate healthier sexual expression for men.

The Social Construction of Sexuality and Masculinity

Sexuality is socially constructed, a learned set of both behaviors and cognitive interpretations of those behaviors. Sexuality is less the product of biological drives than of a socialization process, and this socialization process is specific to any culture at any particular time. This means that "social roles are not vehicles for the expression of sexual impulse but that sexuality becomes a vehicle for expressing the needs of social roles" (Gagnon & Simon, 1973, p. 45). *That* we are sexual is determined by a biological imperative toward reproduction, but *how* we are sexual—where, when, how often, with whom, and why

—has to do with cultural learning, with meanings transmitted in a cultural setting. Sexuality varies from culture to culture; it changes in any one culture over time; it changes over the course of each of our lives. Sexual beings are made and not born; we make ourselves into sexual beings within a cultural framework. While it may appear counterintuitive, this perspective suggests that the elusive quality commonly called "desire" is actually a relatively unimportant part of sexual conduct. As Gagnon and Simon argue (1973, p. 103), "the availability of sexual partners, their ages, their incomes, their point in the economic process, their time commitments . . . shape their sexual careers far more than the minor influence of sexual desire." Sexuality is learned in roughly the same way as anything else is learned in our culture. As Gagnon writes (1977, p. 2):

> In any given society, at any given moment, people become sexual in the same way as they become everything else. Without much reflection, they pick up directions from their social environment. They acquire and assemble meanings, skills and values from the people around them. Their critical choices are often made by going along and drifting. People learn when they are quite young a few of the things that they are expected to be, and continue slowly to accumulate a belief in who they are and ought to be through the rest of childhood, adolescence, and adulthood. Sexual conduct is learned in the same ways and through the same processes; it is acquired and assembled in human interaction, judged and performed in specific cultural and historical worlds.

If sexuality is socially constructed, perhaps the most significant element of the construction—the foundation upon which we construct our sexuality—is gender. For men, the notion of masculinity, the cultural definition of manhood, serves as the primary building block of sexuality. It is through our understanding of masculinity that we construct a sexuality, and it is through our sexualities that we confirm the successful construction of our gender identity. Gender informs sexuality; sexuality confirms gender. Thus men have much at stake when they confront a sexual problem: They risk their self-image as men.

Like sexuality, gender in general, and masculinity in particular, is socially constructed; that is, what we understand to be masculine varies from culture to culture, over historical time within any one culture, and over the course of any one person's life within any culture. What we consider masculine or feminine in our culture is also not the result of some biological imperative, not some religious requirement, but a socially organized mode of behavior. What is masculine is not set in stone, but historically fluid. The pioneering research on gender by anthropologist Margaret Mead (1934) and others has specified how widely the cultural requirements of masculinity—what it takes to be a "real man" in any particular culture—vary. And these gender categories also shift in any one culture over time. Who would suggest,

for example, that what was prescribed among upper-class Frenchmen in the eighteenth century—rare silk stockings and red patent leather high heels, prolific amounts of perfume and facial powder, powdered wigs and very long hair, and a rather precious preoccupation with love poems, dainty furniture, and roses—resembles our contemporary version of masculinity?

The assertion of the social construction of sexuality and gender leads naturally to two related questions. First, we need to specify precisely the dimensions of masculinity within contemporary American culture. How is masculinity organized as a normative set of behaviors and attitudes? Second, we need to specify precisely the ways in which this socially constructed gender identity informs male sexual development. How is masculinity expressed through sexuality?

Brannon and David's (1976, p. 12) summary of the normative structure of contemporary American masculinity is relevant here. Masculinity requires the avoidance and repudiation of all behaviors that are even remotely associated with femininity ("no sissy stuff); this requires a ceaseless patrolling of one's boundaries, an incessant surveillance of one's performances to ensure that one is sufficiently male. Men must be "big wheels" since success and status are key determinants of masculinity, and they must be "sturdy oaks," exuding a manly air of self-confidence, toughness, and self-reliance, as well as reliability. Men must "give 'em hell," presenting an aura of aggression and daring, and attitude of constantly "going for it."

The normative organization of masculinity has been verified empirically (see Thompson & Pleck, 1986) and has obviously important implications for male sexuality. In a sense, sexuality is the location of the enactment of masculinity; sexuality allows the expression of masculinity. Male sexual socialization informs men that sexuality is the proving ground of adequate gender identity, and provides the script that men will adopt, with individual modification, as the foundation for sexual activity.

In a sense, when we examine the normative sexuality that is constructed from the typical organization of masculinity, it is not so much sexual problems that are of interest, but the problematization of "normal" sexuality, understanding perhaps the pathological elements within normal sexual functioning. This allows us to bridge the chasm between men who experience sexual dysfunction and those who, ostensibly, do not, and explore how men array themselves along a

continuum of sexual expressions. Because masculinity provides the basic framework of sexual organization, and because masculinity requires adherence to certain rules that may retard or constrain emotional expression, we might fruitfully explore how even "normal" male sexuality evidences specific pathological symptoms, so that men who present exaggerated versions of these symptoms in therapy may better perceive their problems in a larger, sociological context of gender relations in contemporary society.[3]

The social construction of male sexuality raises a crucial theoretical issue. In the past, both social science research and clinical practice were informed by a model of discrete dichotomies. Categories for analysis implied a dualistic worldview in which a phenomenon was classified as either X or Y. Thus one was either male or female, heterosexual or homosexual, normal or pathological. Since the pioneering studies of Alfred Kinsey and his associates (see Kinsey, Pomeroy, & Martin, 1948; Kinsey & Gebhard, 1954), however, this traditional model of mutually exclusive dichotomous variables has given way to a model of a continuum of behaviors along which individuals array themselves. The continuum model allows individuals to reposition themselves at different moments in the life course, and it allows the researcher or clinician a point of entry into a relationship with the behaviors being discussed. The people we study and the people we counsel are less some curious "other" and more a variation on a set of behaviors that we ourselves embody as well. The articulation of the continuum model also requires that the level of analysis of any behavior include a social analysis of the context for behavior and the social construction of definitions of normality. It thus permits a truly *social* psychology.

The Male Sexual Script

Male sexual socialization teaches young men that sex is secret, morally wrong, and pleasurable. The association of sexual pleasure with feelings of guilt and shame is articulated early in the young boy's development, and reinforced throughout the life course by family, school, religion, and media images of sexuality. Young males are instructed, in locker rooms and playgrounds, to detach their emotions from sexual expression. In early masturbatory experience, the logic of detachment accommodates the twin demands of sexual pleasuring and guilt and shame. Later, detachment serves the "healthy" heterosexual male by permitting delay of orgasm in order to please his sexual partner, and serves the "healthy" homosexual male by permitting numerous sexual partners without cluttering up the scene with

unpleasant emotional connection. (We will return to an exploration of the similarities between heterosexual and homosexual male sexuality below.)

Detachment requires a self-objectification, a distancing from one's self, and the development of a "secret sexual self' that performs sexual acts according to culturally derived scripts (Gagnon & Simon, 1973, p. 64). That men use the language of work as metaphors for sexual conduct—"getting the job done," "performing well," "achieving orgasm"—illustrates more than a passing interest in turning everything into a job whose performance can be evaluated; it reinforces detachment so that the body becomes a sexual machine, a performer instead of an authentic actor. The penis is transformed from an organ of sexual pleasure into a "tool," an instrument by which the performance is carried out, a thing, separate from the self. Many men report that they have conversations with their penises, and often cajole, plead with, or demand that they become and remain erect without orgasmic release. The penis can become the man's enemy, ready to engage in the most shameful conspiracy possible: performance failure. Is it any wonder that "performance anxiety" is a normative experience for male sexual behavior?

Men's earliest forays into sexuality, especially masturbation, are the first location of sexual anxiety. Masturbation teaches young men that sexuality is about the detachment of emotions from sex, that sex is important in itself. Second, men learn that sex is something covert, to be hidden; that is, men learn to privatize sexual experience, without skills to share the experience. And masturbation also teaches men that sexuality is phallocentric, that the penis is the center of the sexual universe. Finally, the tools of masturbation, especially sexual fantasy, teach men to objectify the self, to separate the self from the body, to focus on parts of bodies and not whole beings, often to speak of one's self in the third person.

Adolescent sexual socialization reinforces these behavioral demands that govern male sexuality. Passivity is absolutely forbidden, and the young male must attempt to escalate the sexual element at all times. To do otherwise is to avoid "giving 'em hell" and expose potential feminine behaviors. This constant pressure for escalation derives from the phallocentric component to male sexuality—"it only counts if I put it in," a student told one of us. Since normative heterosexuality assigns to men the role of "doer" and women the role of "gate-keeper," determining the level of sexual experience appropriate to any specific situation, this relentless pressure to escalate prevents either the male or the female from experiencing the sexual pleasure of any point along the continuum. No sooner does he "arrive" at a

particular sexual experience—touching her breast, for example, than he begins strategizing the ways in which he can escalate, go further. To do less would expose him as less than manly. The female instantly must determine the limits of the encounter and devise the logistics that will prevent escalation if those limits have been reached. Since both male and female maintain a persistent orientation to the future (how to escalate and how to prevent escalation), neither can experience the pleasure of the points en route to full sexual intercourse. In fact, what men learn is that intercourse is the appropriate end-point of any sexual encounter, and that only intercourse "counts" in the tabulation of sexual encounters.

Since the focus is entirely phallocentric and intercourse is the goal to be achieved in adolescent sexual encounters, the stakes regarding sexual performance are extremely high, and consequently so is the anxiety about performance failure. Big wheels and sturdy oaks do not experience sexual dysfunction.

This continuum of male sexual dysfunction—ranging from what we might call the "normatively operative dysfunctional" to the cases of extreme distress of men who present themselves for therapeutic intervention—is reinforced in adult heterosexual relations as well. How do men maintain the sexual distancing and objectification that they perceive is required for healthy functioning? American comedian Woody Allen described, in his night-club routines, a rather typical male strategy. After describing himself as "a stud," Allen comments:

> While making love, in an effort [pause] to prolong [pause] the moment of ecstasy, I think of baseball players. All right, now you know. So the two of us are making love violently, and she's digging it, so I figure I better start thinking of baseball players pretty quickly. So I figure it's one out, and the Giants are up. Mays lines a single to right. He takes second on a wild pitch. Now she's digging her nails into my neck. I decide to pinch-hit for McCovey. [pause for laughter] Alou pops out. Haller singles, Mays takes third. Now I've got a first and third situation. Two outs and the Giants are behind by one run. I don't know whether to squeeze or to steal, [pause for laughter] She's been in the shower for ten minutes already, [pause] I can't tell you anymore, this is too personal, [pause] The Giants won.[4]

Readers may be struck by several themes—the imputation of violence, how her pleasure leads to his decision to think of baseball players, the requirement of victory in the baseball game, and the sexual innuendo contained within the baseball language—but the text provides a startlingly honest revelation of male sexual distancing. Here is a device that is so successful at delaying ejaculation that the narrator is rendered utterly unaware of his partner. "She's been in the shower for ten minutes already," Allen remarks, as if he's just noticed.

Much of peer sexual socialization consists of the conveying of these strategic actions that the male can perform to make himself a more adequate sexual partner. Men are often told to think of sports, work, or some other nonsexual event, or to repeat multiplication tables or mathematical formulas in order to avoid premature ejaculation. It's as if sexual adequacy could be measured by time elapsed between penetration and orgasm, and the sexual experience itself is transformed into an endurance test in which pleasure, if present at all, is almost accidental.

The contemporary male sexual script—the normative construction of sexuality—provides a continuum along which men array themselves for the script's enactment. The script contains dicta for sexual distancing, objectification, phallocentrism, a pressure to become and remain erect without ejaculation for as long as possible, all of which serve as indicators of masculinity as well as sexual potency. Adequate sexual functioning is seen as the proof of masculinity, so sexual problems will inevitably damage male gender identity. This is what makes treatment of sexual disorders a treatment of gender-identity issues.

Although this chapter has concentrated on sexual disorders for heterosexual men, this is not for analytic reasons, or from a sense of how these problems might manifest differently for gay men. Quite the contrary, in fact. Since gender identity is the key variable in understanding sexual behaviors, we would argue that heterosexual and homosexual men have more in common in regard to their sexuality than they evidence differences. This is especially true since 1969, when the Stonewall riots in New York and the subsequent emergence of the gay liberation movement led to the possibility for gay men to recover and repair their "damaged" sense of masculinity. Earlier gay men had been seen as "failed men," but the emergence of the gay male "clone" particularly has dispelled that notion. In the nation's gay "ghettos," gay men often enact a hyper-masculine ethic, complete with its attendant sexual scripting of distancing, phallocentrism, objectification, and separation of emotion from physical sensation. Another reason that heterosexual and homosexual men exhibit similar gender-based sexual behaviors is that all boys are subject to an anticipatory socialization toward heterosexuality, regardless of their eventual sexual preference. There is no anticipatory socialization toward homosexuality in this culture, so male gender socialization will be enacted with both male and female sexual partners. Finally, we have not focused on gay men as a specific group because to do so would require the marginalization of gay men as a group separate from the normative script of male sexuality. Both gay and straight men are men first, and both

have "male sex."

Therapeutic interventions

Our analysis of the social context of men's sexual problems makes it essential that therapeutic strategies remain aware of a context larger than simple symptom remission. Treatment must also challenge the myths, assumptions, and expectations that create the dysfunctional context for male sexual behavior (see Kaplan, 1974, 1983; LoPiccolo & LoPiccolo, 1978; Tollison & Adams, 1979).

Men seeking treatment for sexual difficulties will most often present with a symptom such as erectile failure, premature ejaculation, or inhibited desire. However, the *response* to this symptom, such as anxiety, depression, or low self-esteem is usually what brings the man into treatment, and this response derives from the man's relationship to an ideal vision of masculinity. The construction of this masculine ideal therefore needs to be addressed since it often creates the imperative command—to be in a constant state of potential sexual arousal, to achieve and maintain perfectly potent erections on command, and to delay ejaculation for a long time—which results in the performance anxiety that creates the symptom in the first place.

Sex therapy exercises, such as those developed by William Masters and Virginia Johnson and others, are usually effective only when the social context of gender ideals has also been addressed. This is accomplished by exploring and challenging the myths of male sexuality, modeling by the therapist of a different version of masculinity, giving permission to the patient to fail, and self-disclosure by the therapist of the doubts, fears of inadequacy, and other anxieties that all men experience. These will significantly reduce the isolation that the patient may experience, the fear that he is the only man who experiences such sexually-linked problems. These methods may be used to reorient men's assumptions about what constitutes masculinity, even though the therapist will be unable to change the entire social edifice that has been constructed upon these gender assumptions. Both the cognitive as well as the physical script must be addressed in treating sexual dysfunction; the cognitive script is perhaps the more important.

Recall these specific examples drawn from case materials. Sam's sexual performance was charged

with anxiety and shame regarding both female partners and male peers. He was adamant that no one know he was seeking therapy, and went to great lengths to assure that confidentiality be preserved. He revealed significant embarrassment and shame with the therapist in early sessions, which subsided once the condition was normalized by the therapist.

Sam had grown up with exaggerated expectations of male sexual performance—that men must perform sexually on cue and never experience any sexual difficulty—that were consistent with the social milieu in which he was raised. He held women on a pedestal and believed that a man must please a woman or risk losing her. The stakes were thus quite high. Sam was also terrified of appearing "unmanly" with women, which resulted in a high degree of performance anxiety, which in turn prompted the premature ejaculation. The cycle of anxiety and failure finally brought Sam to treatment. Finally, Sam was detached from his own sexuality, his own body both sexually and emotionally. His objectification of his penis made it impossible for him to monitor impending ejaculation, and he was therefore unable to moderate the intensity of sensation prior to the point of ejaculatory inevitability. This common pattern among men who experience premature ejaculation suggests that such a response comes not from hypersensitivity but rather an atrophied sensitivity, based on objectification of the phallus.

Sam's treatment consisted of permission from another man—the therapist—to experience this problem and the attempt by the therapist to normalize the situation and reframe it as a problem any man might encounter. The problem was redefined as a sign of virility rather than an indication of its absence; Sam came to understand his sexual drive as quite high, which led to high levels of excitement that he had not yet learned to control. The therapist presented suggestions to control ejaculation that helped him moderate the intensity of arousal in order to better control his ejaculation. The important work, however, challenged the myths and cognitive script that Sam maintained regarding his sexuality. The attention given to his sexual performance, what he demanded of himself and what he believed women demanded of him, helped him reorient his sexuality into a less performance-oriented style.

Joe, the 34-year-old CPA, experienced low sexual desire with his wife though he masturbated regularly. Masturbatory fantasies involving images of women wanting him, finding him highly desirable, populated his fantasy world. When his self-esteem was low, as when he lost his job, for example, his sexual fantasies increased markedly. These fantasies of prowess with devalued women restored, he felt,

his worth as a man. Interest in pornography included a script in which women were passive and men in control, very unlike the situation he perceives with his wife. He complained that he is caught in a vicious cycle, since without sexual interest in his wife he's not a "real man," and if he's not a "real man" then he has no sexual desire for her. He suggested that if he could only master a masculine challenge that was not sexual, such as finding another job or another competitive situation, he believed his sexual interest in his wife would increase. He felt he needed the mastery of a masculine challenge to confirm his sense of self as a man, which would then find further confirmation in the sexual arena. This adds an empirical confirmation of Gagnon and Simon's argument (1973) that genital sexuality contains many nonsexual motives, including the desire for achievement, power, and peer approval. Joe came to therapy with a great deal of shame at having to be there, and was especially ashamed at having to tell another man about his failures as a man. He was greatly relieved by the therapist's understanding, self-disclosure, and nonjudgmental stance, which enhanced the therapist's credibility and Joe's commitment to treatment.

One cognitive script that Joe challenged in counseling was his embrace of the "madonna/ whore" ideology. In this formulation, any woman worth having (the madonna—mother or wife) was perceived as both asexual and as sexually rejecting of him, since his failures rendered him less of a real man. A "whore," on the other hand, would be both sexually available and interested in him, so she is consequently devalued and avoided. He could be sexual with her because the stakes are so low. This reinforces the cultural equation between sexual pleasure and cultural guilt and shame, since Joe would only want to be sexual with those who would not want to be sexual with him. This common motif in male sexual socialization frequently emerges in descriptions of "good girls" and "bad girls" in high school.

Joe's therapy included individual short-term counseling with the goal of helping him see the relationship between his self-esteem and his inhibited sexual desire. Traditional masculine definitions of success were the sole basis for Joe's self-esteem, and these were challenged in the context of a supportive therapeutic environment. The failure of childhood male role models was contrasted with new role models who provide permission to fail, helping Joe view sexuality as noncompetitive and non-achievement-oriented activity. Joe began to experience a return of sexual desire for his wife, as he became less phallocentric and more able to see sex as a vehicle for expressing intimacy and caring rather than a performance for an objectified self and other.

Bill, the 52-year-old married engineer, presented with erectile failure, which is part of a larger pattern of intolerance of failure in himself. The failure of his penis to function properly symbolized to him the ultimate collapse of his manhood. Not surprisingly, he had searched for physiological etiologies before seeking psychological counseling, and had been referred by an urologist. It is estimated that less than 50% of all men who present themselves for penile implant surgery have a physiological basis for their problem; if so, the percentage of all men who experience erectile disorders whose etiology is physiological is less than 5%. Yet the pressure to salvage a sense of masculinity that might be damaged by a psychological problem leads thousands of men to request surgical prosthesis every year (see, for example, Tiefer, 1986).

Bill and his wife, Ann, confronted in therapy the myths of male sexuality that they embraced, including such dicta as "a real man always wants sex," " the only real sex is intercourse," and "the man must always be in charge of sex" (see Zilbergeld, 1978). The therapist gave Bill permission to fail by telling him that all men at some time experience erectile dysfunction. Further, Bill was counseled that the real problem is not the erectile failure, but his reaction to this event. Exercises were assigned in which Bill obtained an erection through manual stimulation and then purposely lost the erection to desensitize himself to his terrible fear of failure. This helped him overcome the "what if" fear of losing the erection. Bill was counseled to "slow down" his sexual activity, and to focus on the sensations rather than the physical response, both of which were designed to further remove the performance aspects from his sexual activity. Finally, the therapist helped Bill and Ann redefine the notion of masculinity by stating that "a real man is strong enough to take risks, eschew stereotypes, to ask for what he needs sexually from a partner, and, most of all, to tolerate failure."

As Bill and Ann's cognitive script changed, his ability to function sexually improved. Though Bill still does not get full erections on a consistent basis, this fact is no longer catastrophic for him. He and Ann now have a broader script both physically and cognitively, which allows them to have other sexual play and the shared intimacy that it provides.

As one can see from these case studies, several themes run consistently through therapeutic strategies in counseling men about sexual problems, and many of these themes also relate directly to issues of social analysis as well as clinical practice. For example, the therapeutic environment must be

experienced as supportive, and care must be taken so that the therapist not appear too threatening or too "successful" to the patient. The gender of the therapist with the male patient will raise different issues at this point. A male therapist can empathize with the patient, and greatly reduce his sense of isolation, while a female therapist can provide positive reactions to fears of masculine inadequacy, and thereby provide a positive experience with a woman they may translate to nontherapeutic situations.

Second, the presenting symptom should be "normalized," that is, it should be cast within the wider frame of male socialization to sexuality. It is not so much that the patient is "bad," "wrong," or "abnormal" but that he has experienced some of the contradictory demands of masculinity in ways that have become dysfunctional for his sexual experiences. It is often crucial to help the patient realize that he is not the only man who experiences these problems, and that these problems are only problems seen from within a certain construct of masculinity.

In this way, the therapist can help the patient to dissociate sexuality from his sense of masculinity, to break the facile identification between sexual performance and masculinity. Masculinity can be confirmed by more than erectile capacity, constant sexual interest, and a long duration of intercourse; in fact, as we have argued, normal male sexuality often requires the dissociation of emotional intimacy and connectedness for adequate sexual functioning. Raising the level of analysis from the treatment of individual symptoms to a social construction of gender and sexuality does not mean abandoning the treatment of the presenting symptoms, but rather retaining their embeddedness in the social context from which they emerge. Counseling men about sexuality involves, along with individualized treatment, the redefinition of what it means to be a man in contemporary American society. Therapeutic treatments pitched at both the social and the individual levels can help men become more expressive lovers and friends and fathers, as well as more "functional" sexual partners. That a man's most important sexual organ is his mind is as true today as ever.

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Notes

1 Authors' Note: This chapter represents a full collaboration, and our names appear in alphabetical order for convenience. Critical reactions from John Gagnon, Murray Scher, and Mark Stevens have been very helpful.

2 The names of the individual patients have been changed.

3 To assert a pathological element to what is culturally defined as "normal" is a contentious argument. But such an argument derives logically from assertions about the social construction of gender and sexuality. Perhaps an analogy would prove helpful. One might also argue that given the cultural definition of femininity in our culture, especially the normative prescriptions for how women are supposed to look to be most attractive, all women manifest a problematic relationship to food. Even the most "normal" woman, having been socialized in a culture stressing unnatural thinness, will experience some pathological symptoms around eating. This assertion will surely shed a very different light on the treatment of women presenting eating disorders, such as bulimia or anorexia nervosa. Instead of treating them in their difference from other women, by contextualizing their symptoms within the larger frame of the construction of femininity in American culture, they can be seen as exaggerating an already culturally prescribed problematic relationship to eating. This position has the additional benefit, as it would in the treatment of male sexual disorders, of resisting the temptation to "blame the victim" for her or his acting out an exaggerated version of a traditional script.

4 Woody Allen, *the Nightclub Years*, United Artists Records (1971). Used by permission.