“It’s just like riding a bicycle.” This was the basic sex advice given to me by my mother 40–plus years ago, meant to reassure me that once I knew what to do, sex would always come naturally. Perhaps this analogy worked all those decades ago, but today it’s hard to even recognize the metaphoric bicycle. Concepts of normal, healthy, and ideal sexuality have expanded to include sexual activities and orientations that not so long ago were labeled deviant, sick, or perverted. In fact, the binary classification of normal and not has all but disappeared. Increasingly, people are coming for therapy, not to be “cured,” not to become “normal,” but rather to become more comfortable, confident, and capable of expressing their own sexuality.

The outliers of a group often force a reexamination of the group’s boundaries and identity. One might trace the current culture of widening sexual acceptance back to the gay rights movement. As a disorder, homosexuality has long been removed from the psychiatric and psychological lexicon. The same is now true in the court of public opinion. A recent Gallup poll shows that fully 55% of the U.S. population favor legalizing gay marriage, and that figure rises to 80% of people under the age of 30 (McCarthy, 2014). Gay marriage is currently legal in Canada and in many states in the United States. International agencies, most notably the World Health Organization (2006), have declared that sexuality is a human right, and the United Nations has essentially put the world on notice that gay rights are human rights by hosting a panel discussion regarding the practice of conversion therapy. Panelists argued that not only is conversion therapy ineffective (and therefore fraudulent), but it also violates a person’s fundamental right to sexual expression (Hausman, 2013). Conversion therapy for minors is now banned in several states (Shapiro, 2015).

Mainstream media have both mirrored and prompted this social change. In the mid–20th century same–sex relationships were virtually invisible in the popular media. Then television shows such as Queer Eye for the Straight Guy played off our stereotypes of gay men as having better taste in food, fashion, and furnishings than did the hapless heterosexual. Now television shows like the popular Modern Family show gay couples coping with many of the same issues that all couples face, including dealing with jobs and relatives and raising children. On the big screen, sympathetic portrayals of the struggles of gay men (Brokeback Mountain, Milk) and women (The Kids Are All Right) have been box office successes, attesting to their wide appeal.

Perhaps the most amazing shift in public attitude is that involving gender identity, leading Time magazine to announce that as a society we are now at the “Transgender Tipping Point” (Steinmetz, 2014). Laverne Cox, an African American transgender woman and an actress on the popular series Orange Is the New Black, graced the front cover of the June 2014 edition of the magazine. Here again we find a grass roots movement of individuals refusing to be labeled as mentally ill challenging public and
professional prejudice and stereotypes. Increasingly, young adults and teenagers are refusing labels. They do not want to be cast as male, female, gay, straight, transsexual, or bisexual. In ever-growing numbers they are embracing sexual and gender fluidity (Diamond & Butterworth, 2008). This trend is forcing college campuses to rethink the meaning of single-sex education (Padawer, 2014) and will undoubtedly require sex therapists to rethink the classifications of sexual dysfunction that are gendered defined.

If these changes make your professional head spin, it is not surprising. This is a time of unprecedented change. Technology may be the wellspring of this transformation. In essence, the Web 2.0 has shaped the way we perceive ourselves and others. Worried that you are deviant? No need to suffer in private shame: there’s bound to be a website, a chat group, or an app for that (and if not, you can always start your own). The power of knowing that you are not alone, that you are not the only one, is transformative. It alleviates much guilt and shame. People with similar fetishes, fantasies, propensities, and proclivities can meet in a virtual world or in reality. Lurking on websites allows the timid to safely explore a desired lifestyle. Learning the language, the lingo, the fashion, and the meeting places helps assuage the anxiety that might otherwise prevent someone from going to a gay bar or a BDSM (bondage, domination, sadism, masochism) house party. Online role-playing games such as World of Warcraft and Second Life allow players to explore alternate genders and try out new sex roles in the safety of their homes, while apps like grindr and tinder allow for immediate sexual connections between people who might not otherwise meet (Buhi, Blunt, Wheldon, & Bull, 2014).

What might be the final frontier in the movement toward sexual rights involves pedophilia, perhaps the most reviled of the sexual deviations. Professionals and the public are coming to understand the distinction between child molestation (a behavior and a crime) and a sexual attraction to children (proposed to be a hardwired sexual orientation) (Cantor, 2014). Here again we see the power of the Internet with online communities, such as the Virtuous Pedophile, allowing those with an attraction to children, but a commitment to abstain, to communicate with each other for support, encouragement, and ideas as to how to live in a world where you can never act on your sexual desire.

Technology has also informed individuals and couples struggling with sexual dysfunctions. Whether labeled deviant or dysfunctional, people believe that a fulfilling sex life, across their lifespan, is their right. Online chat and support groups as well as a host of sexually informative websites have alleviated the shame and isolation that many sufferers endured. However, in the arena of sexual dysfunction, sexual medicine has also exerted a strong influence. Effective pharmacologic treatment of erectile dysfunction (ED) and premature ejaculation (PE) has resulted in these two very common and distressing disorders being reinterpreted as primarily physiological, rather than purely psychological, in origin. Direct-to-consumer marketing of ED drugs has often been euphemistic (in the United States a man throwing a football through a tire or a Saudi Arabian commercial featuring a man trying to insert a plastic straw into a capped beverage). Now the ads are becoming more forthright, with Pfizer recently launching a television commercial featuring a sexy British woman speaking into the camera: The setting is perfect. But, then, erectile dysfunction happens again. You know what? Plenty of guys have this issue, not just getting an erection . . . but keeping it. In 2013 Pfizer spent over $176 million on advertising Viagra (Hiers, 2014). It is now almost impossible to watch a televised football or baseball game without a commercial interruption for one of the ED medications. Patients and physicians are now likely to ask about these dysfunctions and physicians to prescribe medication for them during routine office visits (Perelman, 2014).

Buoyed by these early successes in treating ED and PE, sexual medicine has flourished, with world-wide societies and scientific journals now devoted to the practice. But sexual medicine has little to offer women in terms of enhancing their sexual desire and pleasure. Some argue that women’s sexual pleasure, or lack thereof, is rarely a medical problem (Kaschak & Tiefer, 2002). Others counter that effective pharmacologic treatments have been unfairly hindered by regulatory pushback and political pressure groups (Perelman, 2014). Nevertheless, it is on the battlefield of women’s sexual pleasure that the turf wars are highly delineated and fiercely battled. Yet low desire continues to be the most common sexual complaint of women presenting for treatment in the United States.
(Brotto & Luria, 2014). As a society and as professionals we may be complicit in this seeming epidemic of low desire. Unless we are careful, and we have not been, it is not far to go from talking of rights to imposing obligations. Women get the message that they should feel sexual desire despite stress and often despite relationship dissatisfaction. The push to define low sexual desire in women as a physiologically based disorder may have the effect of pathologizing normal variations.

As a society we may be complicit in perpetuating myths that diminish women’s sexual desire and pleasure. Women’s sexual desire is inextricably linked to feeling desired and/or feeling desirable (Meana, 2010). Media depictions of desirable women differ greatly from how the average woman looks and feels. As if the young, thin, tanned, and toned models that grace the covers of magazines are not enough, the recent trend toward vulvar rejuvenation has meant that a woman’s genitals are no longer exempt from the scrutiny that her breasts, buttocks, and abs suffer. The cosmetic and beauty industry is thriving. It is built on women’s insecurities and the belief that if you try hard enough (gym memberships, plastic surgery, cosmetics, and clothes) you too can be beautiful and desirable, according to the fashion of the time.

The hope is that as young people eschew categorization of their sexual orientations and identities they will also redefine on a personal level what it means to be sexy and sexual. While we can help our patients confront damaging stereotypes on an individual level, we can also take to social media to make sure that more accurate sex positive messages are conveyed. We can continue to listen to people once considered sexual outliers as they challenge us to examine and reexamine our personal and professional sexual values and attitudes. In this way, the sexual revolution continues to roll.

References