Sexual Problems in Gay Men: An Overview of Empirical Research

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This article summarizes the findings and theoretical perspectives of 19 empirical studies of sexual problems in gay men. In order to understand these problems better, various differences between male homosexual and heterosexual functioning are discussed first. The studies included differ widely in terms of the issues explored, the populations studied, and the way data have been collected. In a few studies, researchers generally have looked at the prevalence and experience of sexual problems. In other studies, researchers have focused on the etiology and treatment of specific problems, such as sexual desire disorders, sexual aversion, excitement and arousal problems, orgasm disorders, sexual pain disorders and sexual compulsivity. Overall it is surprising how little is known about these problems in gay men. This is also true, however, for same-sex sexuality in general. Suggestions are made for studies that will enable us to obtain a better understanding of sexual problems in gay men.

Key words: gay men, sexual problems.

Sexuality is the essential factor that distinguishes homosexual from heterosexual people. That being so, it is surprising that for a long time little was known about same-sex sexuality. Which sexual behaviors do people engage in, with which relative frequency, and how is this affected by relational, social, and cultural factors? How are sexual activities related to homosexual self-understanding and identity? How does the sexual dimension of homosexual relationships evolve? Which factors affect the expression and experience of same-sex sexuality? What kind of sexual problems do gay men experience? A review of the literature only offers partial and preliminary answers to such questions.

The AIDS epidemic has brought a dramatic change in this respect, at least regarding male same-sex sexuality. Because sexual behavior is a major route of HIV transmission, and gay men constitute a major risk group in industrialized countries, a vast number of studies have been conducted. Because the potential of HIV transmission dictated the way in which sexuality could be addressed in these studies, the research has

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been focused almost exclusively on safe versus unsafe sexual practices. The dominant aim of such studies was to identify factors related to protected and unprotected anal sex, which could subsequently be addressed by prevention efforts. The AIDS epidemic also fostered new interest in sexual problems in homosexual men, although this was limited mostly to dysfunctions in men with HIV infection.

In this article, we deal with one specific aspect of gay male sexuality. We bring together the theoretical perspectives and empirical findings from various studies about sexual problems in men with same-sex sexual practices. Because this has never been systematically assessed, we will not address the treatment of sexual problems in gay men here.

The literature dealing with sexual problems in gay men is rather young. Although Masters and Johnson (1966) announced in 1966 their plan to work on sexual problems in homosexual men, it took until 1979 before they specifically addressed the issue (Masters & Johnson, 1979). Until the late 70s, the focus was not on gay men's sexual problems but on changing their sexual orientation. This is illustrated by the fact that in one of the classic works about sexual dysfunction, attention to the topic of homosexuality was focused primarily on the role of masturbation in changing one's sexual orientation (Caird & Wincze, 1977). In her standard work on sexual desire disorders, Kaplan (1979) addressed homosexuality exclusively from a psychopathological perspective. In general books about sexual disorders, it has been common practice regarding gay men to focus on issues other than actual sexual disorders, such as identity development and internalized homophobia. In psychotherapy books addressing gay and lesbian issues, sexual problems have rarely been discussed (e.g., Davis & Neal, 1996; for an exception see Coleman, 1987).

Even though this article is about sexual problems in gay men, we will start with a comparison of male same-sex sexuality with heterosexual sexuality. We do this because we want to make clear that, although it often occurs, it is not justified to study homosexual sexual problems from a heterosexual perspective. Male sexual functioning is usually implicitly considered to be heterosexual functioning (Boyle, 1993). The current version of the Diagnostic and Statistical Manual (DSM-IV, American Psychiatric Association, 1994) does not list sexual problems specific to gay men. Various authors claim that gay and heterosexual men have similar types of sexual dysfunctions and that only the prevalence differs (Bhugra & Wright, 1995; McWhirter & Mattison, 1978). When Masters and Johnson's sexual response cycle is adopted as a starting point for studying sexual problems, it is understandable that authors reach this conclusion. From a purely physiological perspective,
male homosexual sexual functioning might not differ from male heterosexual sexual functioning (Masters & Johnson, 1979). However, central to the heterosexual perspective on dysfunctions is vaginal coitus. Because this is not what homosexual men practice, a different perspective is needed. Furthermore, from a psychosocial and cultural perspective, there are several differences that need to be highlighted before a meaningful understanding of sexual problems in homosexual men is possible.

After having discussed how sexual problems in homosexual men have been studied, we will subsequently present an overview of what is known about these problems in terms of prevalence and etiology. In doing so, we will make a distinction between the authors’ ideas and impressions, and what actually has been found in empirical research. After having evaluated the current knowledge about sexual problems in gay men, we will attempt to identify why so little is known about sexual problems in gay men, and we will highlight issues that warrant further exploration.

A note on terminology—up to this point, we have used words or terms such as gay, homosexual, and same-sex sexuality as if they have the same meaning. However, these words can not be used interchangeably. The word gay requires a self-consciousness and a presentation towards others as having a homosexual orientation (Donovan, 1992). Not all same-sex sexuality is expressed in such a context, neither in non-Western nor in Western cultures (see Doll et al., 1992; Herdt, 1990). As far as we have been able to discern, same-sex sexual problems have exclusively been studied in self-identified gay men: that is, men who practice same-sex sexuality, have a homosexual orientation, and perceive themselves as gay or in such a way that they distinguish themselves from heterosexual men (an exception are those case studies in which latent-homosexuality has been identified as a cause of sexual dysfunction in heterosexual men; see for instance Gutstadt, 1976). It should be realized, though, that even when we talk about gay men, a broad variety of lifestyles are included. In this article, we will not specifically address bisexual men because we assume that sexual problems in gay men and bisexual men are not necessarily identical nor have the same etiology.

**Differences Between Gay and Heterosexual Male Sexuality**

Gay male sexuality differs from heterosexual male sexuality in a variety of ways, especially if one looks beyond physiological aspects and adopts a biopsychosocial perspective, according to which sexual behavior is influenced by a variety of factors from different domains (cf.,
O'Donohue & Geer, 1993). It is important to take these differences into account if one wants to understand gay men's sexual problems. Documenting these differences does not imply that there are no similarities. Blumstein and Schwartz (1983) found a relationship in gay, as well as heterosexual, couples between emotional expressiveness and sexual initiative taking. In gay couples, they found the emotionally more expressive partner to be more often the initiator of sex. In heterosexual couples, they found that the more emotionally expressive a partner is, the more he or she initiates sex. In both homosexual and heterosexual couples, the most powerful partner in the relationship usually does the refusing of sex. Equality in sexual initiation and refusal correlates with a happier sex life in both gay and heterosexual couples.

There are differences, however, between homosexual and heterosexual sexuality on physical and psychological levels. Although it is unclear to what extent their findings can be generalized beyond their laboratory, Masters and Johnson (1979) found major differences between heterosexual and homosexual couples in the way the sexual response pattern develops in the interaction between two partners. They observed that homosexual couples take more time for each other and each other's feelings of pleasure, place less emphasis on rushing towards orgasm, and focus less on simultaneous orgasm. Although from a physiological perspective the actual sexual response develops similarly, the fact that it is brought about by a stigmatized source—the same instead of the other gender (Keating & Over, 1990)—is likely to have various psychological consequences.

From a physical perspective, the sexual acts that can be practiced by two men are almost identical to those that can be practiced by a man and a woman. A major exception is of course vaginal intercourse, which is central to at least male heterosexual functioning. As a consequence, gay male sexuality can not result in offspring, and gay men's sexuality is not affected by the fear of potential pregnancy (Leigh, 1989). A further difference is that all roles and positions in the same-sex sexual encounter can be completely reversed. This is not the case in heterosexual sexuality. Consequently, practices as performing fellatio on each other are reserved to same-sex male couples. Although gay men relatively more often practice anal intercourse than heterosexual men and women (Haynes, 1994), it does not function as a substitute for vaginal intercourse. Noncoital sexuality, such as oral sex, is more frequent in homosexual interactions (Blumstein & Schwartz, 1983; Laumann, Gagnon, Michael, & Michaels, 1994).

The physical differences between homosexual and heterosexual sexuality are likely to have consequences on a psychological level. Further-
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more, because sexual roles and positions have power related symbolic meanings, their reciprocity in gay men's sexuality creates extra challenges. Whereas in heterosexual interactions sexual positions are limited by the gender of the partners, these positions have to be negotiated in same-sex sexual interactions. Other differences on a psychological level result from the gendered nature of sexual expression and the omnipresence and dominance of the heterosexual script. The stigma attached to homosexuality further affects gay men's sexuality on a psychological level. We will now discuss these issues more extensively.

The gendered nature of heterosexual sexual behavior has been documented in a vast body of literature (e.g., see reviews by Oliver & Hyde, 1993, and Baumeister, 2000). Central to these differences is men and women's orientation towards sexuality, with men usually being more performance and pleasure oriented and women being more expressive and oriented toward relationships and intimacy (Hendrick & Hendrick, 1985; Regan & Berscheid, 1996). These differences in perspective might create obstacles in heterosexual interactions. The shared perspective should enhance the sexual interactions of gay males (Masters & Johnson, 1979). The fact that two people of the same sex interact with each other affects the interaction in various other ways. Because specific roles, such as penetrating and being penetrated, carry symbolic meanings in terms of dominance and submission, gay men may find reciprocation important. Only having the receptive role might induce worries about appearing submissive. The image that homosexual partners have specific roles in sexual interactions is not confirmed by existing data (De Zwart, Van Kerkhof, & Sandfort, 1998). The fact that anal sex can bring up sensitive issues of dominance and reciprocation might contribute to the lower prevalence of anal sex compared to oral sex (Blumstein & Schwartz, 1983). The specific features of the male gender role might also impose challenges if two men want to convert a sexual bond into an intimate bond and develop a long-term relationship, for instance, as traditionally feminine qualities, such as of taking care of the relationship, are likely not to be present.

Differences between sexuality in homosexual and heterosexual relationships that have been found in empirical research are usually perceived to be a result of the gender-related differences in sexuality and the absence of a need for gay men to adjust to women's sexual values. Such differences have been described extensively by Blumstein and Schwartz (1983). In their study, they found gay couples to more often approve of sex without love, to be more open about sex outside their relationship, to think more often that being monogamous is not important, to actually be less often monogamous, and to have higher number of outside partners then married
or cohabiting heterosexual couples and lesbian couples have. The lower value attached by gay men to “fidelity” has been found in other studies as well (see Hendrick & Hendrick, 1985; Kurdek, 1991; Leigh, 1989). Leigh demonstrated that next to gender differences there are several orientation differences regarding reasons for “having sex.” Homosexual men rated reproduction, emotional closeness, and pleasing one’s partner as less important than heterosexual men did. Reasons for not having sex differed as well. Leigh found that heterosexual men attached more importance to the fear of pregnancy and dislike of contraception than did gay men, whereas fear of AIDS was higher in homosexual men. Both homosexual and heterosexual men rated conquest and relief of sexual tension more highly than did homosexual and heterosexual women.

Most of these findings are in line with the stereotypical image of gay sexuality as promiscuous and practiced in relatively short-lasting relationships. Blumstein and Schwartz (1983) even wrote “If a gay man is monogamous, he is such a rare phenomenon, he may have difficulty making himself believed” (p. 269). Regardless of the period under consideration, gay men usually have more sexual partners than heterosexual men. Laumann et al. (1994) found 42.8 versus 16.5 partners since age 18 in homosexual and heterosexual men respectively (95% CI respectively, 13.7-19.4 and 12.4-73.1). In various European countries the same differences have been found (Leridon, Van Zessen, & Hubert, 1998). These findings suggest that sexual desire and arousability are stronger in gay men than in heterosexual men; there are, however, to our knowledge, no data that support this. This image is balanced by authors who stress gay people’s capacity of maintaining long-lasting relationships (Peplau, 1991). In people’s statement about this issue, it is unclear what reflects the actual situation and what is influenced by ideological motives to make gay relationships seem more respectable. Findings from a large-scale, representative sample of Dutch men (N = 5,686) show that gay men in steady relationships have more frequent sexual contacts outside of the relationship but that the differences are not as large as the stereotypical image suggests (Sandfort, 1997). Compared to 4.9% of the heterosexual men, 24.4% of the homosexual men had had sex with another partner in the preceding half year, whereas in various convenience samples, the latter percentage ranged from 50% to 73%. Sandfort also showed gay men to be less frequently involved in steady relationships than heterosexual men, and the relationships of gay men also had a shorter mean duration than those of the heterosexual men (respectively, 7.8 and 9.7 years). It is possible that as a consequence of the AIDS epidemic and the growing social recognition of gay relationships, gay steady relationships are becoming more frequent. Furthermore, the findings of
this study suggest the importance of the subculture in which men participate: Gay men living in a city with a strongly developed gay culture had more positive attitudes towards extrarelational sex than gay men living outside such areas. Likewise, Adler, Hendrick, and Hendrick (1986) found the gay men they studied in New York to have a less altruistic and more selfish lovestyle, with more concern for the self rather than the partner, than gay men in their Texas sample.

Heterosexual men and women receive support for negotiating their differences from the heterosexual script. This script is a cognitive schema which helps people to decide how to act, what to feel, what to expect from the partner, and how to understand the partners behavior in sexual interactions (Gagnon & Simon, 1973). As there are scripts for different kinds of interactions, the sexual script makes sexual interactions come about and develop further. People acquire this script from early on in their lives. Parents and peers reinforce acquisition of this script. The script is presented to people in various cultural expressions. This heterosexual script with its gender-based rules does not work for gay men (Rose, 1996). Having incorporated elements of the heterosexual script might actually create problems in gay men's sexual interactions. Because the heterosexual script attributes responsibility for taking sexual initiatives to men—making initiating into a symbol of maleness—this potentially induces problems in situations where both partners are male (Blumstein & Schwartz, 1983). Although the growing openness about homosexuality might have improved the situation, sexual scripts are less readily available for gay men. As a consequence it is harder for them to know how to interact with a partner and what they should expect in sexual interactions. Lacking a clear sexual script might, however, also promote gay men to explore sexual possibilities. This might also make them more vulnerable for sexual abuse, as suggested by the fact that gay men report more sexually abusive experiences than heterosexual men do (D'Augelli, 1996).

Differences between the male homosexual and heterosexual experience may also result from the stigmatized status of homosexuality. This stigma affects gay men's sexuality in a variety of ways. One of the tasks gay men have to accomplish during their coming out is to process negative attitudes towards homosexuality, which, because they are raised in a heterosexual environment, they themselves have acquired as well. Not all gay men succeed in doing this to the same extent, leaving them with various levels of what is called internalized homophobia (Shidlo, 1994). This internalized homophobia is likely to interfere with partner selection and relationship formation, as well as sexual functioning (Meyer & Dean, 1998). On the other hand, the fact that gay men, as part of their
coming out process, have to challenge heterosexual assumptions and attitudes about sexuality might explain why their attitudes towards sexuality are often found to be more liberal than heterosexual men’s attitudes (Adler et al., 1986; Crowden & Koch, 1995). The stigmatized nature of homosexuality contributes to the lack of social and institutional support for gay relationships, making it more difficult to establish and maintain these relationships (Kurdek, 1991). The relative scarcity of potential partners also makes it more difficult for gay men than for heterosexuals to find a partner for intimate relationships.

Differences between gay and heterosexual male sexuality seem basic as far as the physical level is concerned. The way gay men express and experience their homosexuality will be affected by changes in gender roles, as well as the growing acceptance of homosexuality (Sandfort, 1998; Van den Akker, Halman, & de Moor, 1994). Such a change might be apparent from the way in which Saghir and Robins (1973) described homosexual sexuality in 1973: “Soon after seeking and meeting a potential partner, he embarks on a sexual contact that usually ends the relationship immediately afterwards. Frequently, he does not know the name of his sexual partner and often does not care to know or to give him his own name” (p. 63). Although it is not clear to what extent this research-based description of homosexuality reflected the day’s objective reality or was colored by a biased perspective, this description would no longer be considered accurate. That gay men do have long-lasting relationships has since then been found in various studies (Kurdek, 1988). The increasing acceptance of homosexuality, as well as the legal recognition that is established in some countries, quite likely contribute to gay men’s opportunities to develop and maintain long-term relationships.

**How Sexual Problems in Gay Men Have Been Studied**

For this review we have identified empirical studies addressing gay men’s sexual problems by searching Psychlit and Medline with the search terms “gay” or “homosex*” combined with sexual dysfunction(s); sex therapy or counseling; sexual dissatisfaction, problems, or concerns; sexual disorder(s); sexual pain; sexual addiction or compulsivity. The period covered was 1966-2000. Although these searches resulted in a long list of references, only 19 of these references concerned actual empirical studies (Table 1). As has been concluded in other reviews of the literature, empirical research regarding sexual problems in gay men is indeed scarce (Behrendt & George, 1995; Bhugra & Wright, 1995; Coleman & Reece, 1988; Coleman & Rosser, 1996; Coleman, Rosser, & Strapko, 1992; Dunkle, 1994; George & Behrendt, 1987; Gordon, 1986; Nichols, 1989; Reece, 1988).
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<td>McWhirter &amp; Mattison (1978)</td>
<td>Treatment of gay male couples with sexual problems</td>
<td>Description and analysis of experiences as therapists</td>
<td>Clinical</td>
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<td>Masters &amp; Johnson (1979)</td>
<td>Treatment of gay male couples with sexual problems</td>
<td>Description and analysis of experiences as therapists</td>
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<td>Reece (1981-1982)</td>
<td>Group treatment of individual gay men and self-reported change in follow-up</td>
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<td>Everaerd et al. (1982)</td>
<td>Evaluation of group treatment</td>
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<td>Paff (1985)</td>
<td>Description of sexual dysfunctions and treatment</td>
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<td>Gellman (1986)</td>
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<td>Wilensky &amp; Myers (1987)</td>
<td>Etiological variables and treatment methods retarded ejaculation</td>
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<td>Shaw (1990)</td>
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<td>Catalan (1993)</td>
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<td>Jones, Klimes, &amp; Catalan (1994)</td>
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<td>Garippa &amp; Sanders (1997)</td>
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<tr>
<td>Rosser et al. (1997)</td>
<td>Prevalence of sexual problems</td>
<td>Survey</td>
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<td>Rosser et al. (1998)</td>
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<td>Survey</td>
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<td>Catalan &amp; Meadows (2000)</td>
<td>Description of sexual problems in HIV positive men, treatment and outcome</td>
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a "Clinical" implies that the group studied consists of people who had sought professional help to solve sexual problems. "Nonclinical" may include individuals who were seen for other therapeutic reasons. Groups consist of homosexual men unless indicated otherwise.
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The studies reviewed here are from both before and after the onset of the AIDS epidemic. This is to some extent problematic, because it is unclear whether findings from earlier studies are still applicable. At this specific moment of time, same-sex sexuality can not be understood without taking the impact of the AIDS epidemic into account. On the other hand, AIDS does not completely determine the expression and experience of male same-sex sexuality. Given the limited number of studies, we decided to include them all.

The studies identified differ widely in terms of the issues explored, the populations studied, and the way data have been collected. Most studies (11 out of 19) are based on the treatment of either one specific sexual problem or a range of problems, usually given by the investigators of the study to be either gay couples or individual gay men. Included in these articles is information about the sexual problems treated, the background of these problems, the treatment given, and the outcomes. In a few cases these outcomes have actually been measured, although not necessarily in terms of the problems treated but in more general terms.

The number of people or "cases" in these 11 treatment-based studies ranges from 1 to 57. One study on the treatment of sexual problems in gay men was based on information collected among 10 psychotherapists who, in total, had seen an estimated number of 500 gay men with sexual problems of whom approximately half were in steady relationships (Paff, 1985). Most of the treatment studies focused exclusively on gay men. In two studies gay men are part of the sample, but conclusions about the gay men involved can not be separated from the data (Everaerd et al., 1982; Shaw, 1990). In addition to a description of the treatment given, in one study a comparison was also made on various background variables with a group of gay men with general and no sexual problems (Quadland, 1985). In none of these studies were the sexual problems reported actually measured, with the consequence that the reader is dependent upon what clients have presented to the therapists and the therapists' interpretations of these complaints. The etiological factors contributing to the sexual problems discussed in these studies have also not been systematically assessed and are only available from the clinical interpretation of the therapist involved. In addition to the described 11 studies, there is one additional study in which psychological factors associated with erectile disorders in gay men were measured and compared with such factors in heterosexual men with erectile disorders (Shires & Miller, 1998); in this study, however, there was no report on the treatment of these problems.

The remaining seven studies contained reports on sexual problems in more general samples of gay men. These men did not participate in the
study because they had been looking for help to solve their sexual problems. In one of these studies, sexual problems were studied as one of various other aspects of homosexual life in a large sample of White and Black gay men (Bell & Weinberg, 1978). Gellman (1986) also used a general sample of gay men and focused on the prevalence of sexual problems and whether or not they were experienced as such by the respondents. Rosser and his colleagues (Rosser, Metz, Bockting, & Buroker, 1997; Rosser, Short, Thurmes, & Coleman, 1998) studied sexual problems in gay men who participated in a 2-day psychoeducational sexual health workshop; these men were recruited via various psychosocial services and announcements in the gay community. In three studies sexual problems in HIV-positive gay men were investigated. In two of these, the prevalence of sexual dysfunctions as a consequence of the HIV infection was assessed (Jones, Klimes, & Catalan, 1994; Tindall, Forde, Goldstein, Ross, & Cooper, 1994); the latter study also included HIV-negative men as well as HIV-negative and HIV-positive men with haemophilia. In the third study, psychosexual problems in HIV-positive gay men were also addressed, but like Gellman (1986), Dupras and Morisset (1993) also looked at whether the person involved experienced the dysfunction as a problem.

The 19 studies vary in terms of the kind of sexual problems assessed. A few studies are focused on one or two specific kinds of sexual problems (erectile dysfunction, retarded and inhibited ejaculation, and anal pain), whereas other studies include a broader range. Gellman (1986) only discussed the occurrence of sexual problems in general, and he compared three groups of men: nondysfunctional men, dysfunctional men who experienced their dysfunction as problematic, and dysfunctional gay men who did not do so.

What could come up as sexual problems in these studies depended predominantly on the way in which data were collected. In studies in which written questionnaires were used, researchers decided, a priori, the issue of what constitutes a sexual problem. When existing scales were used, they were usually designed using a heterosexual frame of reference. What a sexual problem was, in most treatment studies, depended on the kind of problem presented by the gay subjects, in combination with what was seen and interpreted as such by the clinician. Because an in-depth study of what gay men experience as sexual problems has not yet been carried out, it is likely that studies seldom have covered the full range of potential sexual problems gay men encounter.

In exploring sexual problems in gay men, most investigators adopted the human (hetero)sexual response cycle (Kaplan, 1979) and looked at problems related to desire, arousal, and orgasm. In addition to these
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specific sexual dysfunctions, Reece (1981-1982) also looked at the occurrence of generalized anxiety in sexual situations and awkwardness while behaving sexually. Bell and Weinberg (1978) applied a broader definition of sexual problems and also looked at other problems, such as finding a suitable partner, lack of frequency, concerns about not being sexually adequate, and maintaining affection for one's sexual partner. Bell and Weinberg also independently asked their subjects to what extent these problems concerned them.

The focus on heterosexual, vaginal intercourse in discussing sexual problems explains why pain related to intercourse was predominantly seen as a sexual problem that women might have. Problems related to anal intercourse have remained unexplored. Even though Masters and Johnson (1970) acknowledged in a clinical note their awareness of anal intercourse as a common sexual practice in gay men, they did not address problems related to anal intercourse in their study focusing on homosexual functioning (Masters & Johnson, 1979). Although various others have stated that difficulties in enjoying desired anal erotic stimulation should be seen as a specific sexual dysfunction (Morin, 1981; Reece, 1981-1982), it was 1998 before problems related to practicing anal sex were empirically studied (Rosser et al., 1998).

In studies measuring the prevalence of sexual problems, there is a difference in how these problems were assessed and in the criteria applied for categorizing subjects as having sexual problems. Criteria vary in terms of duration and frequency of symptoms, and subjective distress. In some studies, just reporting a decrease in sexual interest or potency is sufficient to classifying a person as having a sexual dysfunction. References to the reliability and validity of measurements instruments used are not reported. In the various treatment studies, the reader is dependent upon the clinical expertise of the therapists; these studies do not contain any information about the criteria used to identify specific sexual problems. In none of the studies were standards for classifying sexual problems according to the DSM-IV (American Psychiatric Association, 1994) applied. As a consequence, there is little agreement among studies and findings from the various studies can only be provisionally integrated.

Overview of Observed Sexual Problems in Gay Men

In our attempts to integrate the findings from the various studies, we were dependent upon those problems identified and studied by the researchers. Most of this research focused on problems associated with the sexual response cycle, including sexual desire disorder, sexual aversion, problems related to sexual excitement and arousal, and orgasm
disorders. Sexual problems that have been studied separately from the sexual response cycle are painful anal intercourse and sexual compulsion or addiction. Findings related to these various problems will subsequently be discussed. We start the overview of findings with outcomes of general studies.

Prevalence of Sexual Problems

Because of their relatively large and diverse sample, Bell and Weinberg's study (1978) is one of the few in which an indication of the relative prevalence of various sexual problems in gay men is given. They assessed 10 sexual problems, each problem with a single question. Because these problems are not defined and only abbreviated descriptions of each problem are presented, it is not clear what the presented data actually represent.

The problem reported most frequently by the respondents was "partner's failure to respond to sexual requests." Eighty-one percent of their White subjects and 73% of their Black subjects reported having this problem. The second most frequently mentioned problem (76% of the White gay men; 63% of the Black gay men) was "finding a suitable partner." Over 50% of the respondents said that almost all the problems studied played a role in their sexual life. The other problems, in order of their decreasing prevalence were, "responding to partner's sexual requests," "lack of frequency," "difficulty in getting or maintaining an erection," "lack of orgasm on part of partner," "maintaining affection for sexual partner," "coming' too fast," "concern that you are not sexually adequate," and "lack of orgasm." Although many respondents reported having the various problems (only a yes-no answer was possible), most respondents seldom considered these to be very much of a problem in their sexual lives.

Even though Bell and Weinberg's (1978) sample is diverse, it is not clear to what extent it reflects the diversity of the gay population. As a consequence, these findings can not be generalized to the total gay population. Furthermore, because the data reported by Bell and Weinberg were collected in the 1970s, before the onset of the AIDS epidemic, it is not clear whether the same type and range of sexual problems would be found today.

Correlates of General Sexual Problems

In his nonclinical study among 140 homosexual males, Gellman (1986), using the Sexual Function and Dysfunction Scale based on Kaplan's model of sexual dysfunction, found that 43% of the respondents could be classified as having a sexual dysfunction. Of these 60
men, 35% experienced the sexual dysfunction as problematic. Having a sexual dysfunction and experiencing it as problematic was positively related to a lesser acceptance of one's homosexuality and a relatively slower adoption of a positive gay identity. The same respondents also had more psychological symptoms, experienced more mood disturbances, and were less satisfied in their overall sexual relationships. Contrary to what was expected, respondents with dysfunctions did not have less accurate information about sexuality and were not less androgynous in their sex-role identities. Individuals who had a dysfunction but did not experience it as problematic were also less accepting of their own homosexuality and experienced more guilt and obsessive-compulsive symptoms than did the group without any dysfunction.

Dupras and Morisset (1993) applied the same design as Gellman (1986) in a study among HIV-positive gay men. They found that men who experienced their dysfunction as problematic differed from the two other groups, the functional and the nonproblematic dysfunctional, in a variety of ways. The dysfunctional individuals experienced more fear of sexual relations and more sexual depression than the nondysfunctional and the nonproblematic dysfunctional groups. Furthermore, this group was less sexually assertive and had a lower degree of positive esteem about their sexuality. The nonproblematic respondents had a lower sexual motivation than the functional and problematic dysfunctional ones.

**Sexual Desire Disorders**

In the few non-AIDS related studies addressing sexual desire, low or hypoactive sexual desire was observed in only a limited number of the gay men with sexual problems (5% to 25%). In comparing lifetime with current prevalence, Rosser et al. (1997) observed a three times higher rate in both therapy clients and other gay men (respectively, 49% and 16% of 277 gay men). In HIV infected men, loss of sexual interest (or enjoyment) was a more frequently observed problem (Catalan & Meadows, 2000; Dupras & Morisset, 1993; Tindall et al., 1994). Based on their clinical experience, George and Behrendt (1987) suggested that low sexual desire was the most common kind of sexual dysfunction among their gay male clients. They added, however, that people rarely complained about this themselves and that the problem was more likely to be identified by the partner. Coleman and Reece (1988) suggested that actual cases of low sexual desire might be less prevalent than cases of sexual desire discrepancies.

Low sexual desire is attributed to a variety of intra- and interpersonal causes. The therapists who were studied by Paff (1985) observed an association with depression as the presenting problem,
which was often noted in combination with alcoholism. Other reasons cited commonly by Paff’s respondents were self-directed homophobia, interpersonal problems, gender identity confusion, sex negative attitudes and values, and lack of adequate sex information. In some instances, a low sex drive was interpreted as a defense against rejection or having to perform. These potential causes were also mentioned by George and Behrendt (1987), who further suggested that the origin of low sexual desire frequently lies in a traumatic experience early in life arising out of religious, social, and family taboos against homosexuality, as well as in one’s own homophobia. Additionally, the few cases of low desire observed by McWhirter and Mattison (1978) were seen as a consequence of severe problems with communication between partners accompanied by difficulties regarding their sexual orientation. In their extensive discussion of low sexual desire in gay men, Coleman and Reece (1988) saw low sexual desire also related to various identity and intimacy dysfunctions. Paff (1985) suggested that in intimate relationships a low sex drive might develop when partners get more familiar with each other and are no longer as sexually interested in each other as in the beginning of the relationship. In a sample of HIV-infected patients, Dupras and Morisset (1993) observed that low desire coincided with a more negative perception of one’s sexuality, manifested by feelings of apprehension, depression, and self-depreciation.

Sexual Aversion

Although sexual aversion has been observed in gay men (Masters & Johnson, 1979), the available data suggest that sexual aversion is a rarely occurring problem (McWhirter & Mattison, 1980). As suggested by George and Behrendt (1987) fear of HIV infection and AIDS might cause phobic reactions to sex.

Aversion toward specific sexual practices, especially anal sex, is observed more frequently (McWhirter & Mattison, 1978). This specifically creates a problem if there is a discrepancy between partners on the enjoyment versus aversion of anal sex. An aversion to anally penetrate or to being penetrated, observed by a few authors, might be a consequence of the symbolic meaning of authority and submission associated with these practices (Reece, 1981-1982). Paff (1985) suggested that being penetrated might also be considered as “feminine” and consequently elicit aversion, a consequence of the common error of confusing gender identity with sexual object choice. George and Behrendt (1987) suggested that one of the factors that might induce sexual aversion in many gay men is the unconscious anger and resent-
ment against men in general, often resulting from unresolved issues with their fathers.

**Excitement and Arousal**

This category includes problems with getting or maintaining an erection. Although four kinds of erectile problems are usually distinguished—primary or secondary, depending on whether the disorder has always been present or started later in life, and global or situational, depending on whether they are generally present or only in specific circumstances—this is seldom specified in the literature dealing with gay men's sexual problems. Masters and Johnson (1979) were one of the exceptions. They classified the majority (86%) of the erectile disorders as secondary. Dupras and Morisset (1993) found that among HIV-positive gay men situational erectile disorders were more common than primary or secondary dysfunctions.

Erectile disorders have been frequently described in other studies as well. McWhirter and Mattison (1978) noted erectile problems in a quarter of their patients, and Reece (1981-1982) reported that over 80% of his patients had such problems. The therapists surveyed by Paff (1985) reported erectile disorders in 20% to 90% of their patients, resulting in an overall prevalence of 50% of 500 gay male patients. More than half of the respondents in Bell and Weinberg's (1978) nonclinical sample also reported at least sometimes having a problem to get or maintain an erection; very few of their respondents, however, reported being bothered by this very often. In their mixed sample of clinical and nonclinical respondents, Rosser et al. (1997) asked about getting and maintaining an erection separately and found current and lifetime prevalences for both problems to be in the same range. Of their sample of 197 respondents, 13% reported difficulty getting an erection as a current problem, and 40% as a problem they had had at least once in their life (for difficulty maintaining an erection the percentages were respectively 15% and 46%). In studies among gay men with HIV or AIDS, erectile problems have been frequently observed as well (Catalan & Meadows, 2000; Dupras & Morisset, 1993; Jones et al., 1994; Tindall et al., 1994).

A variety of causes for erectile dysfunctions in gay men have been mentioned in the literature. Paff (1985) attributed a major role to performance anxiety, closely tied to an individual's masculine identification. The increased emphasis in the gay world on being macho (Levine, 1979; Paff, 1985) might have promoted the stress on performance and induced the anxiety that one is unable to perform. According to Paff, erectile dysfunction is also commonly found in intimate gay relationships, where it can express a variety of conflicts between the partners, as well as fear of
intimacy or fear of rejection. For the individual, erectile disorders might be a consequence of self-directed homophobia. In the Paff study, drug and alcohol use was also mentioned by the therapists as a cause. Less frequently cited reasons were the client's extreme focus on the other, obsession about what others think, and lack of caring for the self. Organic causes were found only in one percent of the cases described by Paff.

Garippa and Sanders (1997) presented a case study of a patient who had difficulty maintaining an erection in the presence of his partner and who was also unable to achieve an orgasm with manual or oral stimulation from his partner. They reported as immediate causes of the problem the client's excessive self-observation, obsessive thoughts, performance anxiety, and fear of failure, as well as his vigorous stimulation and high frequency of masturbation. Contributing factors included his inability to get lost in the moment sexually, his fear of losing his partner, and unrealistically high expectations of himself. The deeper causes seemed related to his feelings of guilt about, and anger with, his parents' nonacceptance of his homosexuality.

Further insights into the etiology of erectile disorders in gay men come from a study by Shires and Miller (1998), who compared homosexual and heterosexual men experiencing erectile difficulties in a number of affective and cognitive variables associated with erectile difficulties. Results indicate that the homosexual group was more affected by HIV anxiety, internalized homophobia, and intimacy issues. Heterosexual men were more likely to be affected by performance anxiety, and showed higher levels of general anxiety and depression, and lower levels of self-esteem than their homosexual counterparts.

Disorders of Orgasm

Disorders in the orgasm phase of the sexual response cycle, premature ejaculation, and delayed or inhibited ejaculation have been observed in several studies. Based on their practice, Masters and Johnson (1979) concluded that premature ejaculation was very rare in gay men. Other researchers have mentioned prevalences ranging from 16% to 25% in their clinical samples (McWhirter & Mattison, 1978; Paff, 1985; Reece, 1981-1982). In Rosser et al.'s (1997) mixed sample, 19% of the gay men reported premature ejaculation as a current problem, and 44% of the men reported having experienced it at least once in their life. In the nonclinical sample of Bell and Weinberg (1978), more than 50% reported to have the problem of "coming too fast" at least to some extent; about 6% of the men reported having this problem "very much." In studies among gay men with HIV or AIDS, premature ejaculation is rarely mentioned as a problem (Jones et al., 1994).
Delayed or inhibited orgasm is observed in studies among gay men with sexual problems, with prevalences of 5% to 48% (McWhirter & Mattison, 1978; Reece, 1981-1982). In Rosser et al.'s (1997) sample, delayed or inhibited ejaculation is reported by 16% as a current problem and by 39% as a problem that they have had at least once in their life. Bell and Weinberg (1978) observed the problem in their nonclinical sample in somewhat less than half their participants; less than 3% of them, however, reported to have the problem “very much.” In studies among gay men with HIV or AIDS, delayed or inhibited ejaculation is mentioned somewhat more frequently than premature ejaculation (Catalan & Meadows, 2000; Jones et al., 1994; Tindall et al., 1994).

Paff (1985) offered a general cause for premature ejaculation, which he saw as the result of early sex conditioning, where the boy learned to ignore preorgasmic sensations, because of a felt pressure to ejaculate quickly so as not to be caught while masturbating. It would also be associated with negative attitudes toward sexuality. Paff did not specify why this would be so.

Various general factors are mentioned that would play a role in delayed ejaculation. Paff (1985) suggested that, in addition to various physical factors (such as a high sensation threshold or lack of adequate stimulation), a learned denial of sensation, performance anxiety, a lack of trust in others, or intrapsychic conflict involving obsessive-compulsive neurosis or a passive-aggressive personality may be involved. Other authors (McWhirter & Mattison, 1980; Wilensky & Myers, 1987) observed a higher degree of psychopathology in patients with delayed ejaculation. Wilensky and Myers (1987) especially found high rates of guilt-proneness and low ego strength. They also observed a relationship with body image problems, especially in adolescence, resulting in lack of inner sense of attractiveness or desirability. Catalan (1993) observed negative cognitions regarding sexual performance and anxiety associated with genital touching and self-stimulation in three case reports of anorgasmia in gay men. George and Behrendt (1987) noted sexually aggressive fantasies in gay men with delayed ejaculation. Associated with such fantasies was the fear that they might try to live out these aggressive fantasies. To live out their fantasies would be unacceptable because that would imply being out of control.

Some authors mentioned specific factors related to homosexuality in the etiology of retarded or inhibited ejaculation (George & Behrendt, 1987; Reece, 1981-1982). The first factor is the belief men might have that homosexuality is wrong or a lack of acceptance or conflicts about one's homosexual identity. Ejaculating with a male partner might prove to men that intimate relationships with other men are possible, and
force them to acknowledge that they are gay themselves. Withholding ejaculation from another man might allow some of these men to maintain the illusion of having a heterosexual identity. Conflict about one's homosexuality might reinforce another factor: difficulties in getting close to and being intimate with another man. Reece (1981-1982) suggested that not being manly, competitive, or defensive, and fear of being vulnerable to another man, might be partly responsible for blocking the sexual response.

In patients with HIV infection, delayed ejaculation is understood as a consequence of a concern about putting one's partner at risk of infection. These concerns would interfere with their sexual response in such a way that ejaculation is unlikely to happen. Such concerns were not only present when unsafe sex was practiced but also when safer sex was practiced (Jones et al., 1994). Jones et al. noticed a higher prevalence of delayed ejaculation in their sample of HIV positive men than the prevalence among men in general (respectively, 38% versus 3%-6%).

**Sexual Pain Disorders**

As has been mentioned, pain during sexual interactions has primarily been studied as a heterosexual phenomenon. Rosser et al. (1997) were the first to assess the prevalence of painful anal sex in gay men. In their study, 16% of their subjects reported painful receptive anal sex as a current problem, whereas 61% reported having had the problem at least once in their life. Painful insertive anal sex was reported by 3% of the subjects as a current problem and by 14% as a lifetime problem. In a second study, Rosser et al. (1998) looked at the issue more extensively. They examined the frequency and duration of painful same-sex anal intercourse in a sample of 277 men who had engaged in, or attempted, anal intercourse during their lifetime. They concluded that pain in anal intercourse is normally distributed among the male homosexual population. The results also make clear that only for a few men is anal intercourse not necessarily painful: 25% of those who have participated in anal intercourse reported no-to-extremely mild pain. Sixty-three percent reported occasionally-to-fairly-frequent pain of mild-to-moderate severity. It is not clear to what extent these levels of reported pain during anal intercourse contribute to or are considered a self-evident part of sexual pleasure or whether it is experienced as something to be avoided. Twelve percent of the respondents reported recurrent to persistent severe pain, too painful to continue the act.

The main factors that contributed to painful anal sex are, according to Rosser et al. (1998), internalized homophobia and psychophysiological factors. According to Everaerd, Laan, and Spiering (2000), the anal
sphincter contractions are a normal part of the defensive reflexes and should be taken as a sign of anxiety or fear of pain. These anal sphincter contractions may cause, in addition to inadequate lubrication of the anal meatus, mechanical friction resulting in genital pain for the man with the insertive role in anal sex (see also Agnew, 1985).

Sexual Compulsivity or Addiction

Sexual compulsivity is usually defined as a lack of control over one's sexual behavior or an inability to reduce one's number of different sexual partners (Quadland, 1985). There are almost no data about the prevalence of this phenomenon. Rosser et al. (1997) only found one gay man in their sample of 147 who reported having this problem. People seem to seek treatment for this problem out of fear of AIDS and dissatisfaction with their sexual, social, or relational life (Quadland, 1985). In comparison to noncompulsive men, Quadland found that men who are sexually compulsive differ primarily in terms of the frequency and type of their behavior. They seemed to have sex in public places, to combine the use of alcohol and drugs with sex, and to have casual sex more frequently. Men who are sexually compulsive also felt less loving and less relaxed prior to sex than did controls. In some men sexual compulsivity might be a phase in the process of coming out to oneself. Amico (1997) reported that many of his clients with some type of compulsive sexual behavior were struggling with their identity, which contributed to relapse issues with chemicals, as well as unwelcome sexual acting out practices. It seems that men who are sexually compulsive more often have histories of childhood sexual abuse than men who are not sexually compulsive (Carnes, 1989).

Discussion

Reviewing the available empirical studies examining sexual problems in gay men, it is surprising how little is known, and the quality of what is known has serious limitations. In this section we will discuss the quality of the available studies and explore potential reasons for why our knowledge is so limited. We will conclude with suggestions for future research.

Evaluation of Available Studies and Current Knowledge

In this paper we integrated findings from a variety of studies dealing with sexual problems in gay men. The basis for doing so is, however, rather weak because the way in which sexual problems were conceptualized and assessed varies greatly among the studies. The populations studied differ as well, including mixed homosexual and heterosexual samples, gay men with reported sexual problems, more general gay
samples and homosexual men with HIV infection (sometimes mixed with other HIV-positive people). The basis for classifying men as homosexual is seldom specified and is likely to vary across studies.

The individual studies can be criticized for a variety of reasons. One is that the quality of the assessment procedures is rarely reported. Some authors have adopted measurement scales from other studies that did not necessarily look at gay men, without checking whether these scales were appropriate for the population studied. Content-wise, it is not clear what the substance of the reported problems was, nor the impact upon people's lives; most authors only reported on the presence of specific problems, seldom on their magnitude in terms of severity and duration. Furthermore, the causes reported for the various sexual problems, seldom empirically tested, are not specific. Based on the available data, it is also not clear why a specific cause would lead to problems in one gay man and not in another. A substantial part of the knowledge of sexual problems in gay men is based on case studies or studies with small and restricted samples.

That little is known about sexual problems in gay men is not so surprising, given the limited understanding of sexual problems in general (O'Donohue & Geer, 1993; O'Donohue, Swingen, Dopke, & Regev, 1999). The lack of a theoretically based system to classify sexual problems in gay men makes it understandable that researchers adopted a heterosexual model for their initial studies. Boyle (1993) criticized basing knowledge of homosexual sexual problems on the model of heterosexual functioning. The existing nomenclature and theory, she argued, are based on assumptions that do not apply to homosexual sex. The model of sex as a relationship of (male) dominance and (female) submission does not fit in same-sex sexuality. Boyle further reasoned that another assumption, that penis-vagina intercourse as the only correct way to have sexual intercourse, also does not apply to homosexual sex. One might of course question whether the criticized model even fits heterosexual people. Even though Morin discussed problems related to anal sex in 1981 (Morin, 1981), it was not until 1998 that these problems were seriously studied (Rosser et al., 1998). The other side of this criticism of the adoption of the heterosexual model is the lack of a well-developed theoretical perspective on male-male sexuality, which also takes into account its sociohistorical context, including the changing status of homosexuality in society, the impact of the gay community on the subcultural meaning of sexuality, and the presence of HIV/AIDS (cf. Bohan, 1996 & Nichols, 1989).

Why Do We Know So Little?

One of the reasons why very little is known about sexual problems in gay men is that much of the research attention has been focused on safe
and unsafe sex. The threat of AIDS specifically within the gay community warranted a research endeavour focused on understanding the dynamics of sexual risk taking behavior. Another reason might be that from a societal perspective sexual problems in gay men is a less compelling issue. In absolute sense gay sexual problems are less prevalent. Therapists are infrequently confronted with them. It is unclear whether problems are also less frequent in relative sense. Sexual problems in gay men might also be less frequently experienced or articulated as such. The centrality of sexuality in the gay community (Blumstein & Schwartz, 1983; Levine, 1979; Nichols, 1989), understood by Bohan (1996) as a reaction against previously unquestioned denigration of homosexuality, might induce the irrational belief that being homosexual is synonymous with always being able to sexually perform. For gay men, having sexual problems might be more embarrassing and difficult to admit to oneself and others. This could result in less help-seeking behavior. It might also be unclear for gay men where to find help. It could be that among gay men there is greater willingness to just accept problems because an alternative partner is more difficult to find. It is also true that it is easier for gay men to deny and to hide sexual problems (McCarthy, 1992). This is more difficult in heterosexual sex, where performing the vaginal coitus is standard practice. Gay men can more easily hide functional problems by taking a passive role in sexual encounters or by focusing on the partner's experience. The fact that fewer gay men, compared to heterosexual men, are involved in a steady relationship, where in the end it would be harder to deny the problem, also contributes to a lower salience (cf MacDonald, 1998). It is interesting to note that when gay men came in more contact with the helping professions as a consequence of AIDS, their sexual problems became more frequently recognized as well.

Future Directions

Various types of studies are needed to get a better understanding of sexual problems in gay men. Two main areas deserve further attention. First, epidemiological studies are needed, which assess the prevalence of sexual problems and risk factors. Such studies should include an identification of factors that determine whether dysfunctions are experienced as problematic. Secondly, there is a need for studies in which the treatment of sexual problems in gay men is systematically evaluated. A better understanding of what causes and perpetuates sexual problems in gay men would contribute to the sexuality literature in general. In conducting these studies, distinctions have to be made between problems of individual gay men and problems experienced by gay couples.
Comparisons with heterosexual males might shed further light on what is specific for gay men's sexuality.

Future research on sexual problems in gay men, whether it focuses on prevalence, origin, or treatment of such problems, would greatly benefit from the development of research instruments that assess gay men's sexual functioning. Such instruments should be based on an in-depth study of sexual problems experienced by gay men and an understanding of the various factors that affect the expression and experience of gay men's sexuality. Such a theoretical perspective should look at gay men's sexual socialization processes; sexual knowledge; sexual expectations in terms of intimacy, lust, and recreation; symbolic meanings attributed to sexual acts in terms of dominance and submission, as well as in terms of masculinity and femininity; sexual self-efficacy and skills; and normative aspects. A major part of such a theoretical perspective would need to focus on gender role and sexual identity development. Gender role issues play a role in the sexual functioning of heterosexual men (Morris, 1998; Pleck, Sonenstein, & Ku, 1993). Gender role issues might be more important or affect sexual functioning in a different way in gay men. The reasons for this are that homosexuality itself is a deviation from traditional masculine gender role norms, resulting in gender role conflict; the relation between gender role and sexual orientation is different (Bailey & Zucker, 1995); and in same-sex sexuality two people with the same gender role socialization interact with one another. For a full understanding of gay men's sexual functioning it is also important to understand how they relate to the gay subculture as well as the role sexuality plays in the gay subculture.

References


SEXUAL PROBLEMS IN GAY MEN


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