

Lust, Lack of Desire, and Paraphilias: Some Thoughts and Possible Connections

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How one develops specific sexual interests (desires, eroticisms, orientation, lust, preferences, etc.) is a basic and essentially unanswered question in sexology. The present paper explores a theoretical relationship between the development of specific sexual interests and those individuals complaining of lack of desire. The ability of traditional sex therapy to intercede successfully in these problems is discussed.

How humans develop specific sexual interests,* or aversions, is a basic and essentially unanswered question in sexology. While a review of the extant theories is beyond the scope of the present article, one should not presume that there is only one process that determines these sexual interests. It can be assumed that a mechanism that establishes one sexual interest is analogous to a mechanism that establishes other sexual interests. If the process goes awry, it can produce an unwanted sexual interest (either in strength or direction), possibly eventuating in complaints of paraphilic attraction or lack of desire. Other names for this phenomenon are "inhibited sex desire," "desire phase disorders," "anorexia sexualis," etc.

The relative failures of sex therapy to treat successfully lack of desire, change sexual orientation, or extinguish unwanted paraphilias may be related. The relative success of traditional sex therapy in the treatment of some sexual dysfunctions (e.g., premature ejaculation, anorgasmia in women) implies that those dysfunctions are in the main learned, since treatment is based on a learning/behavioral model. The lack of success in treating people complaining of lack of desire implies that it is not learned as other sexual dysfunctions are. Similarly, paraphilias, sexual orientation, and gender identity are not learned, or at least not learned the same way sexual dysfunctions are learned.

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*The substance of the present paper is the definition of the concepts of sexual interest, preference, orientation, desire, lust, sexual want, sexual attraction, erotic, etc. The term "interest" is used here for expedience and is preliminary to the formal definitions developed later in the present paper.

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To be clear, this is a discussion of chronic nonspecific lack of desire. Lack of desire resulting from a traumatic experience or lack of desire that is clearly situational is usually a different issue. Additionally, lack of desire that is secondary to a medical or psychiatric problem, or its treatment, is also a different phenomenon. The present paper concerns only those people who report a lifelong pattern of low or no desire. These people may engage in sex, even frequently, but for reasons other than their own desire (e.g., marital duty, to prove that they can, as a form of self-treatment, to become pregnant, to promote intimacy, to please a partner, for self-esteem, etc.).

DEFINITIONS

Lust

Lust is a strong clearly sexual response to an individualized specific set of real or imagined sensory cues (visual, auditory, olfactory, tactile, and/or gustatory). Lust is a basic aspect of sexual identity, set early in life, unchangeable by common sex therapy techniques, and not learned in a classical sense. Paraphilia is lust after uncommon or inappropriate objects or characteristics of potential partners.

Lust may also be understood as passion, colloquially called "hot" or "hotness" related to sex. Some people seem to have a special sexual chemistry, that is, sex is especially passionate (hot) between them. Lust cues not only provide sexual intensity (hotness) between partners, but are the basis of sexual attraction. This could explain some cases of continued sexual attraction, despite recognition that the relationship is not in the person's best interests.

Erotization

Erotization is a response of variable intensity and not as powerfully sexual as lust. The eroticized behavior or object does not become a basic aspect of one's sexual identity, but can become quite important to the individual's sexual response pattern. What one eroticizes is amenable to change by common sex therapy techniques and has the characteristics of a learned behavior.

Erotization is another process by which a person learns to respond sexually to a set of cues. Using a variety of behavioral techniques, it is possible to pair erotic arousal with other stimuli. This can be useful in helping one partner participate in the other partner's lust cues. Simplistically, if one partner's lust cues include a certain costume during sexual interactions, the other partner may learn to eroticize this costume. The wearing or sight of the costume may elicit desire even in the nonlusting partner.

Nevertheless, the erotization process has limits. Eroticized objects and behaviors cannot completely replace lust cues. Additionally, not everything can be eroticized. The eroticized object or behavior must be presented in the context of an appropriate partner. For example, if a heterosexual man eroticizes certain types of lingerie, he may not have a sexual response by seeing it in a store or if worn by a male.

The eroticization process occurs spontaneously within the culture. For example, as fashion styles change, people eroticize the new styles. What would have appeared unfashionable at one time can become seen as enhancing the sexual attractiveness of the wearer.

Desire

Desire, often confused with lust, does not need to be triggered by outside stimuli. Desire is a conscious, probably hormonally mediated, perception of an interest in sex. The average person experiences a "desire" to engage in sexual behavior. After sex, the person will probably feel satisfied and not "desire" further sexual behavior. Nevertheless, if the appropriate lust cues are presented, arousal and interest in participating in sex acts involving the lust cues are probable outcomes.

OBSERVATIONS

It should be clear that what is presented as a problem with desire can actually be a problem with lust, that individuals may have an interest in sex but no lust cues to help direct that desire. The result is a person who reports no desire, but really has suppressed the desire because of the frustration of not having found an acceptable outlet.

Some people appear to have separate aesthetic and sexual ideals. A sexual ideal displays the individual's lust cues, even if they are not recognized as such by the individual. An aesthetic ideal is someone who fits a beauty stereotype. For example, someone may idolize tall blond lovers, but acknowledge that their last several satisfying sexual relationships have been with short dark lovers. The tall blond is the aesthetic ideal and the short dark is the sexual ideal. The person may indicate difficulty in functioning with the tall blond reportedly due to nervousness. While there may be denial of lust for short dark lovers, there will be minimal problems with sexual functioning when with the short dark lover. This is one way in which we can be unaware of our own lust cues.

The distinction among lust, desire, and erotization may help to explain other sexological observations. For example, masturbation when one wants partnered sex can be partially unfulfilling, despite repeated masturbatory orgasms. Meaning that the desire was satisfied, but not the lust. Note that not every partner would be acceptable, only those that meet at least some of the individual's specific lust cues. Someone may engage in sex with a non-lust-provoking partner because of desire, but will pursue, fantasize, dream, about a partner after whom they lust. This is true

whether or not there is any possibility of actually engaging in sex with a person who has the specific lust cues that are craved.

Sexual orientation dysphoria* and lack of lust can be conceptualized as variations of the same problem, a variant development of sexual interest. Sex offenders, at least the paraphilic ones rather than the antisocial ones,** have developed a lust to an inappropriate object (e.g., three-year-olds) or an inappropriate characteristic (e.g., seeing fear in their partner's face, as some rapists and exhibitionists report). Individuals complaining of a lack of lust may not have developed lust cues to anything. These people lack any lust cues and thus the capacity for lust.

While few sexologists believe that you can change an adult's sexual orientation regardless of their motivation, it is clear that some individuals can change their behavior. For example, there is a phenomenon known as "instant lesbians" or "political lesbians," when otherwise heterosexual women decide for political reasons to abandon sex with men in favor of lesbian relationships and a lesbian lifestyle. At least some of these women report fulfillment with their new sexual pattern and deny missing their previous lust cues.

Another interesting phenomenon is the response to antiandrogen therapy. The effect of antiandrogen therapy is to stop the man from reacting to his lust cues. The use of this treatment with women is rare. It should be noted that these men report that they still have some capability and interest in conventional sex behavior (consensual acts with an adult partner). Therefore, antiandrogen treatment appears to be a treatment for a lust disorder not a desire disorder, though it clearly has effects on both phenomena.

The reverse observation is also important to note. Relieving the sex offender from his lust disorder leaves him with desire. Relieving him of his desire, does not relieve him of his lust disorder. An important and ethically unambiguous*** goal of treatment with sex offenders is the establishment of a satisfying sexual relationship with an appropriate consenting partner. Surprisingly, in my clinical experience, many of the offenders who established a consensual adult-adult sexual relationship were those that reoffended. With hindsight, it appears that this goal is a

*This category contains all those people who seek treatment to change the type of person or object to which they are sexually drawn. This includes homosexuals, paraphiliacs, sex offenders (including rapophiles, pedophiles, exhibitionists, voyeurs, frotteurs, etc.). It does not include those people who suffer from Obsessive-Compulsive Disorder nor those people who are satisfied with their sexual pattern.

**Sex offender is a legal category, rather than a psychiatric or sexological category, which includes all those who violate society's rules/laws concerning sexual behavior. It is not surprising that those individuals who have difficulty abiding by society's laws in general, may violate society's laws regarding sexual conduct, too. Therefore, paraphiliacs and criminals are distinct groups of sex offenders. For example, people who suffer from Antisocial Personality Disorder may engage in sex with a child, but have neither a preference nor continuing interest for children as sex partners. Additionally, incest perpetrators are often perceived as acting out due to severe family pathology and family therapy appears helpful in these cases.

***The ethics of trying to change sexual orientation at the client's request are not clear. Nevertheless, when the person's sexual pattern includes engaging in sex without the partner's consent, these ethical considerations do not seem relevant. This includes those situations where the person is incapable of consent because of age, mental condition, or physical state.

variation of the colloquial "cure" for homosexuality (for lesbianism, good sex with a "real" man; for male homosexuality, a bottle of whiskey and a kindhearted prostitute). It is important to note that lesbians often report that they enjoyed sex with men, just as the sex offender often reports that he enjoys consensual sex with an adult partner. The sex lacked the lust component, which led these people to seek out partners that exhibit the lust cues that they crave. The implication is that enjoyable sex is not a substitute for hot or passionate sex with the appropriate lust cues.

CONCLUSIONS

Admittedly, new treatment concepts do not spring from this theoretical formulation. It does suggest that many of the treatment techniques we are currently using are and will continue to be ineffective. Possibly, the only modality that can be offered is to assist the individual with the acceptance of unwanted or absent lust cues.

We do not know how to change lust cues (e.g., we are ineffective in turning homosexuals into heterosexuals or vice versa, getting fetishists to give up their beloved object, and preventing pedophiles from erotically reacting to children), and we are equally ineffective in developing lust where it never existed. It may be discouraging to tell clients that we do not know how or why the development of their lust cues went awry, or how to correct this now. Nevertheless, it may save someone thousands of dollars in therapy and great amounts of grief and self-doubts. The search for the cause of their lack of "desire" may be futile.