Sexual Disorders and Gender Identity Disorder

Chapter 13

Sexual Disorders and Gender Identity Disorder

- Sexual behavior is a major focus of both our private thoughts and public discussions.
- Experts recognize two general categories of sexual disorders:
  - Sexual dysfunctions – problems with sexual responses
  - Paraphilias – repeated and intense sexual urges and fantasies in response to socially inappropriate objects or situations

Sexual Disorders and Gender Identity Disorder

- DSM-IV-TR also includes a diagnosis of gender identity disorder, a sex-related pattern in which people feel that they have been born to the wrong sex.
- Relatively little is known about racial and other cultural differences in sexuality.
Sexual Dysfunctions

• Sexual dysfunctions are disorders in which people cannot respond normally in key areas of sexual functioning
  — As many as 31% of men and 43% of women in the U.S. suffer from such a dysfunction during their lives
• Sexual dysfunctions are typically very distressing, and often lead to sexual frustration, guilt, loss of self-esteem, and interpersonal problems
  — Often these dysfunctions are interrelated; many patients with one dysfunction experience another as well

• The human sexual response can be described as a cycle with four phases:
  — Desire
  — Excitement
  — Orgasm
  — Resolution
• Sexual dysfunctions affect one or more of the first three phases

• Some people struggle with sexual dysfunction their whole lives (labeled “lifelong type” in DSM-IV-TR)
  — For others, normal sexual functioning preceded the disorder (labeled “acquired type”)
• In some cases the dysfunction is present during all sexual situations (labeled “generalized type”)
  — In others it is tied to particular situations (labeled “situational type”)
Disorders of Desire

- Desire phase of the sexual response cycle
  - Consists of an urge to have sex, sexual fantasies, and sexual attraction to others
- Two dysfunctions affect this phase:
  - Hypoactive sexual desire disorder
  - Sexual aversion disorder

Disorders of Desire

- Hypoactive sexual desire disorder
  - Characterized by a lack of interest in sex and little sexual activity
    - Physical responses may be normal
  - Prevalent in about 16% of men and 33% of women
  - DSM-IV-TR refers to “deficient” sexual interest/activity but provides no definition of “deficient”
    - In reality, this criterion is difficult to define

Disorders of Desire

- Sexual aversion disorder
  - Characterized by a total aversion to (disgust of) sex
    - Sexual advances may sicken, repulse, or frighten
  - This disorder seems to be rare in men and somewhat more common in women
Disorders of Desire

• A person’s sex drive is determined by a combination of biological, psychological, and sociocultural factors, and any of these may reduce sexual desire

• Most cases of low sexual desire or sexual aversion are caused primarily by sociocultural and psychological factors, but biological conditions can also lower sex drive significantly

Disorders of Desire

• Biological causes
  – A number of hormones interact to produce sexual desire and behavior
    • Abnormalities in their activity can lower sex drive
    • These hormones include prolactin, testosterone, and estrogen for both men and women
  – Sex drive can also be lowered by some medications (including birth control pills and pain medications), some psychotropic drugs, a number of illegal drugs, and chronic illness

Disorders of Desire

• Psychological causes
  – A general increase in anxiety, depression, or anger may reduce sexual desire in both men and women
  – Fears, attitudes, and memories may contribute to sexual dysfunction
  – Certain psychological disorders, including depression and obsessive-compulsive disorder, may lead to sexual desire disorders
Disorders of Desire

- Sociocultural causes
  - Attitudes, fears, and psychological disorders that contribute to sexual desire disorders occur within a social context
    - Many sufferers of desire disorders are feeling situational pressures
      - Examples: divorce, death, job stress, infertility, and/or relationship difficulties
    - Cultural standards can set the stage for development of these disorders
    - The trauma of sexual molestation or assault is especially likely to produce sexual dysfunction

Disorders of Excitement

- Excitement phase of the sexual response cycle
  - Marked by changes in the pelvic region, general physical arousal, and increases in heart rate, muscle tension, blood pressure, and rate of breathing
    - In men: erection of the penis
    - In women: swelling of the clitoris and labia and vaginal lubrication
- Two dysfunctions affect this phase:
  - Female sexual arousal disorder (formerly “frigidity”)
  - Male erectile disorder (formerly “impotence”)

Disorders of Excitement

- Female sexual arousal disorder
  - Characterized by persistent inability to maintain proper lubrication or genital swelling during sexual activity
  - It is estimated that more than 7% of women experience this disorder
  - Because this disorder is so often tied to an orgasmic disorder, researchers usually study the two together; causes of the two disorders will be examined together
Disorders of Excitement

- Male erectile disorder (ED)
  - Characterized by persistent inability to attain or maintain an adequate erection during sexual activity
  - This problem occurs in as much as 10% of the general male population
  - According to surveys, half of all adult men have erectile difficulty during intercourse at least some of the time

Disorders of Excitement

- Biological causes
  - The same hormonal imbalances that can cause hypoactive sexual desire can also produce ED
  - Most commonly, vascular problems are involved
  - ED can also be caused by damage to the nervous system from various diseases, disorders, or injuries
  - The use of certain medications and substances may interfere with erections

Disorders of Excitement

- Psychological causes
  - Any of the psychological causes of hypoactive sexual desire can also interfere with arousal and lead to erectile dysfunction
  - One well-supported cognitive explanation for ED emphasizes performance anxiety and the spectator role
Disorders of Excitement

• Sociocultural causes
  – Each of the sociocultural factors tied to hypoactive sexual desire has also been linked to ED
    • Job and marital distress are particularly relevant

Disorders of Orgasm

• Orgasm phase of the sexual response cycle
  – Sexual pleasure peaks and sexual tension is released as the muscles in the pelvic region contract rhythmically
    • For men: semen is ejaculated
    • For women: the outer third of the vaginal walls contract

• There are three disorders of this phase:
  – Rapid or Premature ejaculation
  – Male orgasmic disorder
  – Female orgasmic disorder

Disorders of Orgasm

• Rapid or Premature ejaculation
  – Characterized by persistent reaching of orgasm and ejaculation with little sexual stimulation
    • As many as 30% of men experience rapid ejaculation at some time
  – Psychological, particularly behavioral, explanations of this disorder have received more research support than other explanations
    • The dysfunction seems to be typical of young, sexually inexperienced men. It may also be related to anxiety, hurried masturbation experiences, or poor recognition of arousal
  – There is a growing belief among many clinical theorists that biological factors may also play a key role in many cases of this disorder
Disorders of Orgasm

• Male orgasmic disorder
  – Characterized by a repeated inability to reach orgasm or by a very delayed orgasm after normal sexual excitement
  – Biological causes include low testosterone, neurological disease, and head or spinal cord injury
    • Medications, including certain antidepressants (especially SSRIs) and drugs that slow down the sympathetic nervous system, can also affect ejaculation
  – A leading psychological cause appears to be performance anxiety and the spectator role, the cognitive factors involved in ED

Disorders of Orgasm

• Female orgasmic disorder
  – Characterized by persistent delay in or absence of orgasm following normal sexual excitement
    • Almost 24% of women appear to have this problem
      – 10% or more have never reached orgasm
      – An additional 9% reach orgasm only rarely
    • Women who are more sexually assertive and more comfortable with masturbation tend to have orgasms more regularly
    • Female orgasmic disorder is more common in single women than in married or cohabiting women

Disorders of Orgasm

• Female orgasmic disorder
  – Biological causes
    • A variety of physiological conditions can affect a woman's arousal and orgasm
      – These conditions include diabetes and multiple sclerosis
    • The same medications and illegal substances that affect erection in men can affect arousal and orgasm in women
    • Postmenopausal changes may also be responsible
Disorders of Orgasm

• Female orgasmic disorder
  – Psychological causes
    • The psychological causes of hypoactive sexual desire and sexual aversion, including depression, may also lead to female arousal and orgasmic disorders
    • Memories of childhood trauma and relationship distress may also be related

• Female orgasmic disorder
  – Sociocultural causes
    • Researchers suggest that unusually stressful events, traumas, or relationships may produce the fears, memories, and attitudes that characterize these dysfunctions
    • Research has also shown that women are more likely to be orgasmic when they had a relatively long relationship with their first sex partner.

Disorders of Sexual Pain

• Two sexual dysfunctions do not fit neatly into a specific phase of the sexual response cycle
  – These are the sexual pain disorders:
    • Vaginismus
    • Dyspareunia
Disorders of Sexual Pain

- **Vaginismus**
  - Characterized by involuntary contractions of the muscles of the outer third of the vagina
  - Severe cases can prevent a woman from having intercourse
  - This problem has received relatively little research, but estimates are that it occurs in fewer than 1% of all women

Disorders of Sexual Pain

- **Vaginismus**
  - Most clinicians agree with the cognitive-behavioral theory that vaginismus is a learned fear response
  - A variety of factors can set the stage for this fear, including anxiety and ignorance about intercourse, exaggerated stories, trauma caused by an unskilled partner, and the trauma of childhood sexual abuse or adult rape
  - Some women experience painful intercourse because of infection or disease
  - Many women with vaginismus also have other sexual disorders

Disorders of Sexual Pain

- **Dyspareunia**
  - Characterized by severe pain in the genitals during sexual activity
  - Dyspareunia in women usually has a physical cause, most commonly from injury sustained in childbirth
  - Although psychological factors or relationship problems may contribute to dyspareunia, psychosocial factors alone are rarely responsible
What Are the General Features of Sex Therapy?

• Modern sex therapy is short-term and instructive
  – Therapy typically lasts 15 to 20 sessions
  – It is centered on specific sexual problems rather than on broad personality issues

What Are the General Features of Sex Therapy?

• Modern sex therapy focuses on:
  – Assessment and conceptualization of the problem
  – Mutual responsibility
  – Education about sexuality
  – Emotion identification
  – Attitude change
  – Elimination of performance anxiety and the spectator role
  – Increasing sexual and general communication skills
  – Changing destructive lifestyles and marital interactions
  – Addressing physical and medical factors

What Techniques Are Applied to Particular Dysfunctions?

• Hypoactive sexual desire and sexual aversion
  – These disorders are among the most difficult to treat because of the many issues that feed into them
  – Therapists typically apply a combination of techniques, which may include:
    • Affectual awareness, self-instruction training, behavioral techniques, insight-oriented exercises, and biological interventions such as hormone treatments
What Techniques Are Applied to Particular Dysfunctions?

• Erectile disorder
  – Treatments for ED focus on reducing a man’s performance anxiety and/or increasing his stimulation
    • May include sensate-focus exercises such as the “tease technique”
  – Biological approaches have gained great momentum with the development of sildenafil (Viagra) and other erectile dysfunction drugs

What Techniques Are Applied to Particular Dysfunctions?

• Male orgasmic disorder
  – Like treatment for ED, therapies for this disorder include techniques to reduce performance anxiety and increase stimulation
  – When the cause of the disorder is physical, treatment may include a drug to increase arousal of the sympathetic nervous system

What Techniques Are Applied to Particular Dysfunctions?

• Rapid or Premature ejaculation
  – Premature ejaculation has been successfully treated for years by behavioral procedures such as the “stop-start” or “pause” procedure
  – Some clinicians use SSRIs, the serotonin-enhancing antidepressant drugs
    • Because these drugs often reduce sexual arousal or orgasm, they may be helpful in delaying premature ejaculation
    • Many studies have reported positive results with this approach
What Techniques Are Applied to Particular Dysfunctions?

• Female arousal and orgasmic disorders
  – Specific treatments for these disorders include cognitive-behavioral techniques, self-exploration, enhancement of body awareness, and directed masturbation training
    • Biological treatments, including hormone therapy or the use of sildenafil (Viagra), have also been tried, but research has not found such interventions to be consistently helpful

What Techniques Are Applied to Particular Dysfunctions?

• Female arousal and orgasmic disorders
  – Again, a lack of orgasm during intercourse is not necessarily a sexual dysfunction, provided the woman enjoys intercourse and is orgasmic through other means
    • For this reason, some therapists believe that the wisest course of action is simply to educate women whose only concern is lack of orgasm through intercourse

What Techniques Are Applied to Particular Dysfunctions?

• Vaginismus
  – Specific treatment for vaginismus typically involves two approaches:
    • Practice tightening and releasing the muscles of the vagina to gain more voluntary control
    • Overcome fear of penetration through gradual behavioral exposure treatment
  – Most women treated for vaginismus using these methods eventually report pain-free intercourse
What Techniques Are Applied to Particular Dysfunctions?

- **Dyspareunia**
  - Determining the specific cause of dyspareunia is the first stage of treatment
  - Given that most cases are caused by physical problems, medical intervention may be necessary

What Are the Current Trends in Sex Therapy?

- Therapists now treat unmarried couples, those with other psychological disorders, couples with severe marital discord, the elderly, the medically ill, the physically handicapped, gay clients, and clients with no long-term sex partner
- Therapists are paying more attention to excessive sexuality, which is sometimes called hypersexuality or sexual addiction
- The use of medications to treat sexual dysfunction is troubling to many therapists

Paraphilias

- These disorders are characterized by intense sexual urges, fantasies or behaviors that involve:
  - Nonhumans
  - Children
  - Nonconsenting adults
  - The experience of suffering or humiliation
Paraphilias

• Although theorists have proposed various explanations for paraphilias, there is little formal evidence to support them
  – None of the treatments applied to paraphilias have received much research or been proved clearly effective
  – Psychological and sociocultural treatments have been available the longest, but today’s professionals are also using biological interventions

Fetishism

• The key features of fetishism are recurrent intense sexual urges, sexually arousing fantasies, or behaviors that involve the use of a nonliving object, often to the exclusion of all other stimuli
  – The disorder, far more common in men than women, usually begins in adolescence
  – Almost anything can be a fetish
    • Women’s underwear, shoes, and boots are especially common

Fetishism

• Researchers have been unable to pinpoint the causes of fetishism
  – Psychodynamic theorists view fetishes as defense mechanisms, but therapy using this model has been unsuccessful
  – Behaviorists propose that fetishes are learned through classical conditioning
Transvestic Fetishism

- Also known as transvestism or cross-dressing
- Characterized by fantasies, urges, or behaviors involving dressing in the clothes of the opposite sex in order to achieve sexual arousal

The typical person with transvestism is a heterosexual male who began cross-dressing in childhood or adolescence

Transvestism is often confused with gender identity disorder (transsexualism), but the two are separate patterns

The development of the disorder seems to follow the behavioral principles of operant conditioning

Exhibitionism

- Characterized by arousal from the exposure of genitals in a public setting
  - Also known as “flashing”
  - Sexual contact is rarely initiated nor desired
- Usually begins before age 18 and is most common in males
- Treatment generally includes aversion therapy and masturbatory satiation
  - May be combined with orgasmic reorientation, social skills training, or cognitive-behavioral therapy
Voyeurism

• Characterized by repeated and intense sexual urges to observe people as they undress or to spy on couples having intercourse
  – The person may masturbate during the act of observing or while remembering it later
  – The risk of discovery often adds to the excitement

Voyeurism

• Many psychodynamic theorists propose that voyeurs are seeking power
• Behaviorists explain voyeurism as a learned behavior that can be traced to a chance and secret observation of a sexually arousing scene

Frotteurism

• A person who develops frotteurism has recurrent and intense fantasies, urges, or behaviors involving touching and rubbing against a nonconsenting person
  – Almost always male, the person fantasizes during the act that he is having a caring relationship with the victim
• Usually begins in the teen years or earlier
  – Acts generally decrease and disappear after age 25
Pedophilia

- Characterized by fantasies, urges, or behaviors involving sexual activity with a prepubescent child, usually 13 years of age or younger
  - Some people are satisfied with child pornography
  - Others are driven to watching, fondling, or engaging in sexual intercourse with children
  - Evidence suggests that two-thirds of victims are female

Pedophilia

- People with pedophilia develop the disorder in adolescence
  - Some were sexually abused as children
    - Many were neglected, excessively punished, or deprived of close relationships in childhood
  - Most are immature, display distorted thinking, and have an additional psychological disorder
  - Most people with pedophilia are imprisoned or forced into treatment

Sexual Masochism

- Characterized by fantasies, urges, or behaviors involving the act or the thought of being humiliated, beaten, bound, or otherwise made to suffer
- Most masochistic fantasies begin in childhood and seem to develop through the behavioral process of classical conditioning
Sexual Sadism

• A person with sexual sadism finds fantasies, urges, or behaviors involving the thought or act of psychological or physical suffering of a victim sexually exciting
  – People with sexual sadism imagine that they have total control over a sexual victim

Sexual Sadism

• Sadistic fantasies may first appear in childhood or adolescence
• Psychodynamic and cognitive theorists view people with sexual sadism as having underlying feelings of sexual inadequacy
• Biological studies have found signs of possible brain and hormonal abnormalities
• The primary treatment for this disorder is aversion therapy

A Word of Caution

• The definitions of paraphilias, like those of sexual dysfunctions, are strongly influenced by the norms of the particular society in which they occur
• Some clinicians argue that, except when people are hurt by them, many paraphilic behaviors should not be considered disorders at all
Gender Identity Disorder

- According to current DSM-IV-TR criteria, people with this disorder persistently feel that they have been assigned to the wrong biological sex, and gender changes would be desirable
  - They experience gender dysphoria and often seek treatment

Gender Identity Disorder

- People with this disorder would like to get rid of their primary and secondary sex characteristics and acquire the characteristics of the other sex
- Men outnumber women 2 to 1
- People with gender identity disorder often experience anxiety or depression and may have thoughts of suicide

Gender Identity Disorder

- The disorder sometimes emerges in childhood and disappears with adolescence
  - In some cases it develops into adult gender identity disorder
- Many clinicians suspect biological – perhaps genetic or prenatal – factors
  - Abnormalities in the brain, including the hypothalamus (particularly the bed nucleus of stria terminalis), are a potential link