Disorders of Sex and Gender

CHAPTER SUMMARY

Sexual behavior is a major focus of both private thoughts and public discussions. Sexual feelings are a crucial part of our development and daily functioning, sexual activity is tied to the satisfaction of our basic needs, and sexual performance is linked to our self-esteem. Most people are fascinated by the abnormal sexual behavior of others and worry about the normality of their own sexuality. This chapter explores what experts recognize as the two general categories of sexual disorders: sexual dysfunctions and paraphilic disorders.

TOPIC OVERVIEW

**Sexual Dysfunctions**
- Disorders of Desire
- Disorders of Excitement
- Disorders of Orgasm
- Disorders of Sexual Pain

**Treatments for Sexual Dysfunctions**
- What Are the General Features of Sex Therapy?
- What Techniques Are Applied to Particular Dysfunctions?
- What Are the Current Trends in Sex Therapy?

**Paraphilic Disorders**
- Fetishistic Disorder
- Transvestic Disorder
- Exhibitionistic Disorder
- Voyeuristic Disorder
- Frotteuristic Disorder
- Pedophilic Disorder
- Sexual Masochism Disorder
Sexual Sadism Disorder

Gender Dysphoria
Explanations of Gender Dysphoria
Treatments for Gender Dysphoria

Putting It Together: A Private Topic Draws Public Attention

LECTURE OUTLINE

I. DISORDERS OF SEX AND GENDER
   A. Sexual behavior is a major focus of both our private thoughts and public discussions
   B. Experts recognize two general categories of sexual disorders:
      1. Sexual dysfunctions—problems with sexual responses
      2. Paraphilic disorders—repeated and intense sexual urges and fantasies toward socially inappropriate objects or situations
   C. In addition to the sexual disorders, DSM-5 includes a diagnosis category called gender dysphoria (GID), a pattern in which people feel that they have been born to the wrong sex
   D. Relatively little is known about racial and other cultural differences in sexuality
      1. Sex therapists and sex researchers have only recently begun to attend systematically to the importance of culture and race

II. SEXUAL DYSFUNCTIONS
   A. Sexual dysfunctions are disorders in which people cannot respond normally in key areas of sexual functioning
      1. As many as 31 percent of men and 43 percent of women in the United States suffer from such a dysfunction during their lives
      2. Sexual dysfunctions typically are very distressing and often lead to sexual frustration, guilt, loss of self-esteem, and interpersonal problems
      3. Often these dysfunctions are interrelated; many patients with one dysfunction experience another as well
   B. The human sexual response can be described as a cycle with four phases (See Figure 13-1, text p. 426.):
      1. Desire
      2. Excitement
      3. Orgasm
      4. Resolution
   C. Sexual dysfunctions affect one or more of the first three phases
   D. Some people struggle with sexual dysfunction their whole lives (labeled “lifelong”); others have normal functioning that preceded the disorder (labeled “acquired”)
   E. In some cases, the dysfunction is present during all sexual situations (labeled “generalized”); in others, it is tied to particular situations (labeled “situational”)

III. DISORDERS OF DESIRE
   A. The desire phase of the sexual response cycle consists of an interest in or urge to have sex, sexual fantasies, and sexual attraction to others
   B. Two dysfunctions affect this phase:
      1. Male hypoactive sexual desire disorder
a. This disorder is characterized by a lack of interest in sex and little sexual activity
b. Physical responses may be normal
c. This disorder may be found in as many as 16 percent of men

2. Female sexual interest/arousal disorder
   a. This disorder is characterized by a lack of normal interest in sexual activity
      (a) Women with this condition rarely initiate sexual activity and may experience little excitement during sexual activity
   b. Reduced sexual interest and desire may be found in as many as 33 percent of women

C. A person’s sex drive is determined by a combination of biological, psychological, and sociocultural factors, and any of them may reduce sexual desire
D. Most cases of low sexual desire are caused primarily by sociocultural and psychological factors, but biological conditions can also lower sex drive significantly
   1. Biological causes
      a. A number of hormones interact to produce sexual desire and behavior
         (a) Abnormalities in their activity can lower sex drive
         (b) These hormones include prolactin, testosterone, and estrogen for both men and women
      b. Recent investigation has also linked sexual desire disorders to excessive activity of the neurotransmitters (NTs) serotonin and dopamine
      c. Sex drive also can be lowered by chronic illness, some medications (including birth control pills and pain medications), some psychotropic drugs, and a number of illegal drugs
   2. Psychological causes
      a. A general increase in anxiety, depression, or anger may reduce sexual desire in both men and women
      b. Fears, attitudes, and memories also may contribute to sexual dysfunction
      c. Certain psychological disorders also may lead to sexual desire disorders, including depression and obsessive-compulsive disorder
   3. Sociocultural causes
      a. The attitudes, fears, and psychological disorders that contribute to sexual desire disorders occur within a social context
      b. Many sufferers of desire disorders are experiencing situational pressures
         (a) For example: divorce, death, job stress, infertility, and/or relationship difficulties
      c. Cultural standards can set the stage for the development of these disorders
      d. The trauma of sexual molestation or assault also are especially likely to produce sexual dysfunction

IV. DISORDERS OF EXCITEMENT
   A. The excitement phase of the sexual response cycle is marked by changes in the pelvic region, general physical arousal, and increases in heart rate, muscle tension, blood pressure, and respiration
      1. In men: erection of the penis
      2. In women: swelling of the clitoris and labia and vaginal lubrication
   B. Female sexual interest/arousal disorder may include dysfunction during the excitement phase
   C. Erectile disorder (ED) (formerly involves dysfunction in the excitement phase only
      (See Table 13-2, text p. 430.)
      1. This disorder is characterized by persistent inability to attain or maintain an erection during sexual activity
      2. This problem occurs in as much as 10 percent of the general male population
3. According to surveys, half of all adult men experience erectile difficulty during intercourse at least some of the time

D. Most cases of erectile disorder result from an interaction of biological, psychological, and sociocultural processes

1. Biological causes
   a. The same hormonal imbalances that can cause male hypoactive sexual desire also can produce ED
      (a) Most commonly, vascular problems are involved
   b. ED can be caused by damage to the nervous system from various diseases, disorders, or injuries
   c. In addition, the use of certain medications and various forms of substance abuse may interfere with erections
   d. Medical procedures have been developed for diagnosing biological causes of ED
      (a) One strategy includes measuring nocturnal penile tumescence (NPT)
      (b) Men typically have erections during REM sleep; abnormal or absent nighttime erections usually indicate a physical basis for erectile failure

2. Psychological causes
   a. Any of the psychological causes of male hypoactive sexual desire also can interfere with arousal and lead to erectile dysfunction
      (a) For example, as many as 90 percent of men with severe depression experience some degree of ED
   b. One well-supported cognitive explanation for ED emphasizes performance anxiety and the spectator role
      (a) Once erectile difficulties have begun, men become fearful and worried during sexual encounters; instead of being a participant, the man becomes a spectator and judge
      (b) This can create a vicious cycle of sexual dysfunction where the original cause of the erectile failure becomes less important than the fear of failure

3. Sociocultural causes
   a. Each of the sociocultural factors that contribute to male hypoactive sexual desire also have been linked to ED
      (a) Job and marital distress are particularly relevant

V. DISORDERS OF ORGASM

A. During the orgasm phase of the sexual response cycle, an individual’s sexual pleasure peaks and sexual tension is released as the muscles in the pelvic region contract rhythmically
   1. For men: semen is ejaculated
   2. For women: the outer third of the vaginal walls contract

B. There are three disorders of this phase:
   1. Early ejaculation
      a. This disorder is characterized by persistent reaching of orgasm and ejaculation within one minute of beginning sexual activity with a partner and before he wishes to (See Table 13-3, text p. 433.)
         (a) As many as 30 percent of men experience early ejaculation at some time
      b. Psychological, particularly behavioral, explanations of this disorder have received more research support than other explanations
         (a) The dysfunction seems to be typical of young, sexually inexperienced men
      c. It also may be related to anxiety, hurried masturbation experiences, or poor recognition of arousal
d. There is a growing belief among many clinical theorists that biological factors may also play a key role in many cases of this disorder
   (a) One theory states that some men are born with a genetic predisposition
   (b) A second theory argues that the brains of men with early ejaculation contain certain serotonin receptors that are overactive and others that are underactive
   (c) A third explanation holds that men with this dysfunction experience greater sensitivity or nerve conduction in the area of their penis

2. Delayed ejaculation
   a. This disorder is characterized by repeated inability to ejaculate or by a very delayed ejaculation after normal sexual activity with a partner (See Table 13-3, text p. 433.)
      (a) This disorder occurs in 8 percent of the male population
   b. Biological causes include low testosterone, neurological disease, and head or spinal cord injury
   c. Medications also can affect ejaculation, including drugs that slow down the sympathetic nervous system and certain antidepressants (especially the SSRIs)
   d. A leading psychological cause appears to be performance anxiety and the spectator role, the cognitive factors involved in ED
      (a) Another psychological factor may be past masturbation habits
      (b) This disorder also may develop out of male hypoactive sexual desire disorder

3. Female orgasmic disorder
   a. This disorder is characterized by persistent failure to reach orgasm, experiencing orgasms of very low intensity, or delay in orgasm
      (a) Almost 24 percent of women appear to have this problem
      (b) 10 percent or more have never reached orgasm
      (c) An additional 9 percent reach orgasm only rarely
   b. Women who are more sexually assertive and more comfortable with masturbation tend to have orgasms more regularly
   c. Female orgasmic disorder appears more common in single women than in married or cohabiting women
   d. Most clinicians agree that orgasm during intercourse is not mandatory for normal sexual functioning
      (a) Lack of orgasm during intercourse was once considered to be pathological according to psychoanalytic theory—current evidence suggests this is untrue
   e. Once again, biological, psychological, and sociocultural factors may combine to produce these disorders
      (a) Biological causes
         (i) A variety of physiological conditions, including diabetes and multiple sclerosis, can affect a woman’s orgasm
         (ii) The same medications and illegal substances that affect erection in men also can affect arousal and orgasm in women
         (iii) Postmenopausal changes also may be responsible
      (b) Psychological causes
         (i) The psychological causes of female sexual interest/arousal disorder, including depression, also may lead to female arousal and orgasmic disorders
         (ii) In addition, memories of childhood trauma and relationship distress also may be related
      (c) Sociocultural causes
(i) For years, the leading sociocultural theory of female sexual orgasmic problems was that it resulted from sexually restrictive cultural messages; this theory has been challenged because:

1. Sexually restrictive histories are equally common in women with and without disorders
2. Cultural messages about female sexuality have been changing while the rate of female sexual dysfunction stays constant

(ii) Researchers suggest that unusually stressful events, traumas, or relationships may produce the fears, memories, and attitudes that characterize these dysfunctions

(iii) Research also has linked orgasmic behavior to certain qualities in a woman’s intimate relationships (such as emotional intimacy)

f. Because arousal plays a key role in orgasms, arousal difficulties often are featured in explanations of female orgasmic disorder

VI. DISORDERS OF SEXUAL PAIN
A. Certain sexual dysfunctions are characterized by enormous physical discomfort during intercourse and do not fit neatly into a specific phase of the sexual response cycle
B. These dysfunctions, collectively called genito-pelvic pain/penetration disorder, are experienced by women much more often than men (See Table 13-4, text p. 437.)
1. Some women with genito-pelvic pain/penetration disorder experience involuntary contractions of the muscles of the outer third of the vagina
   a. Known as vaginismus, severe cases can prevent a woman from having intercourse
   b. This problem has received relatively little research, but estimates are that it occurs in fewer than 1 percent of all women
   c. Most clinicians agree with the cognitive-behavioral theory that this form of genito-pelvic pain/penetration disorder is a learned fear response
   d. A variety of factors can set the stage for this fear, including anxiety and ignorance about intercourse, exaggerated stories, trauma of an unskilled partner, and the trauma of childhood sexual abuse or adult rape
      (a) Some women experience painful intercourse because of infection or disease
2. Other women with genito-pelvic pain/penetration disorder experience severe vaginal or pelvic pain during sexual intercourse
   a. This disorder is known medically as dyspareunia
      (a) As many as 14 percent of women suffer from this condition
   b. This form of genito-pelvic pain/penetration disorder usually has a physical cause, most commonly injury sustained in childbirth
   c. Although psychological factors or relationship problems may contribute, psychosocial factors alone rarely are responsible

VII. TREATMENTS FOR SEXUAL DYSFUNCTIONS
[Video: Openness to Casual Sex: A Study of Men Versus Women; Sex Addiction: Fact or Fiction?; The Development, Use, and Misuse of Viagra]
A. The last 40 years have brought major changes to the treatment of sexual dysfunction
B. A brief historical perspective:
   1. Early twentieth century: Psychodynamic approaches
      a. It was believed that sexual dysfunction was caused by a failure to progress through the stages of psychosexual development
      b. Therapy focused on gaining insight and making broad personality changes and generally was unhelpful
   2. 1950s and 1960s: Behavior therapy
a. Behavior therapists attempted to reduce fear by employing relaxation training and systematic desensitization
b. These approaches had some success but failed to work in cases where the key problems included misinformation, negative attitudes, and lack of effective sexual technique

3. 1970: Human Sexual Inadequacy
a. This text, published by William Masters and Virginia Johnson, revolutionized treatment of sexual dysfunction
b. This original “sex therapy” program has evolved into a complex, multidimensional approach, including techniques from cognitive-behavioral, couple, and family systems therapies along with a number of sex-specific techniques
c. More recently, biological interventions also have been incorporated

VIII. WHAT ARE THE GENERAL FEATURES OF SEX THERAPY?
A. These are the general features of sex therapy:
   1. Modern sex therapy is short-term and instructive
   2. Therapy typically lasts from 15 to 20 sessions
   3. It is centered on specific sexual problems rather than broad personality issues
   4. Modern sex therapy focuses on:
      a. Assessment and conceptualization of the problem
      b. Mutual responsibility
      c. Education about sexuality
      d. Emotion identification
      e. Attitude change
      f. Elimination of performance anxiety and the “spectator role”
      g. Increase of sexual and general communication skills
      h. Changing destructive lifestyles and marital interactions
      i. Addressing physical and medical factors

IX. WHAT TECHNIQUES ARE APPLIED TO PARTICULAR DYSFUNCTIONS?
A. These techniques are applied to particular dysfunctions:
   1. In addition to the general components of sex therapy, specific techniques can help in each of the sexual dysfunctions:
      a. Disorders of desire
         (a) These disorders are among the most difficult to treat because of the many issues that feed into them
         (b) 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
      b. Erectile disorder
         (a) 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”
         (b) Biological approaches have gained great momentum with the development of sildenafil (Viagra) and other erectile dysfunction drugs
         (c) Most other biological approaches have been around for decades and include gels, suppositories, penile injections, and a vacuum erection device (VED); these procedures are now viewed as “second-line” treatment
      c. Early ejaculation
         (a) Early ejaculation has been successfully treated for years by behavioral procedures, such as the “start-stop” or “pause” procedure
(b) Some clinicians use SSRIs, the serotonin-enhancing antidepressant drugs
   (i) Because these drugs often reduce sexual arousal or orgasm, they may
       be helpful in delaying premature ejaculation
   (ii) Many studies have reported positive results with this approach

d. Delayed ejaculation
   (a) Therapies to reduce this disorder include techniques to reduce
       performance anxiety and increase stimulation
   (b) When the cause of the disorder is physical, treatment may include a drug
       to increase arousal of the sympathetic nervous system

e. Female orgasmic disorders
   (a) Specific treatments for this disorder include cognitive-behavioral
       techniques, self-exploration, enhancement of body awareness, and
       directed masturbation training
   (i) 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
   (b) Again, a lack of orgasm during intercourse is not necessarily a sexual
       dysfunction, provided the woman enjoys intercourse and is orgasmic
       through other means
   (i) 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, informing them that they are quite
       normal

f. Genito-pelvic pain/penetration disorder
   (a) Specific treatment for involuntary contractions of the vaginal muscles
       typically involves two approaches:
       (i) Practice tightening and releasing the muscles of the vagina to gain
           more voluntary control
       (ii) Overcome fear of penetration through gradual behavioral exposure
           treatment
   (b) Most women treated using these methods eventually report pain-free
       intercourse
   (c) Different approaches are used to treat severe vaginal or pelvic pain during
       intercourse
   (d) Given that most cases are due to physical causes, medical intervention
       may be necessary

X. WHAT ARE THE CURRENT TRENDS IN SEX THERAPY?
   A. These are the current trends in sex therapy
      1. Sex therapists have moved well beyond the approach first developed by Masters
         and Johnson
         a. Treatment now includes unmarried couples, those with other psychological
            disorders, couples with severe marital discord, the elderly, the medically ill,
            the physically handicapped, gay clients, or clients with no long-term sex
            partner
      2. Recently, therapists began paying attention to excessive sexuality, sometimes
         called hypersexuality or sexual addiction
      3. Finally, the use of medications to treat sexual dysfunction is troubling to many
         therapists
         a. There is concern that therapists will choose biological interventions rather than
            a more integrated approach
XI. PARAPHILIC DISORDERS
A. Paraphilias are characterized by intense sexual urges, fantasies, or behaviors that involve objects or situations outside the usual sexual norms
B. Paraphilias often involve:
   1. Nonhuman objects
   2. Children
   3. Nonconsenting adults
   4. Humiliation of self or partner
C. According to DSM-5, a diagnosis of paraphilic disorder should be applied only when the urges, fantasies, or behaviors cause significant distress or impairment OR when the satisfaction of the disorder places the individual or others at risk of harm—either currently or in the past
D. For example, people who initiate sexual contact with children warrant a diagnosis of pedophilic disorder regardless of how troubled the individuals may or may not be over their behavior
E. Although theorists have proposed various explanations for paraphilic disorders, there is little formal evidence to support them
F. None of the treatments applied to paraphilias has received much research or proved clearly effective; psychological and sociocultural treatments have been available the longest, but today’s professionals are also using biological interventions
G. Some practitioners administer drugs called antiandrogens that lower the production of testosterone
H. Clinicians are also increasingly administering SSRIs, the serotonin-enhancing antidepressant medications, to (hopefully) reduce the compulsion-like sexual behaviors
   1. These drugs also have a common side effect of lowered sexual arousal
I. The eight paraphilic disorders are:
   1. Fetishism
      a. The key features of this disorder are recurrent intense sexual urges, sexually arousing fantasies, or behavior that involves the use of a nonliving object, often to the exclusion of all other stimuli
      b. The disorder, far more common in men than women, usually begins in adolescence
      c. Almost anything can be a fetish; women’s underwear, shoes, and boots are especially common
      d. Researchers have been unable to pinpoint the causes of fetishistic disorder
         (a) Psychodynamic theorists view fetishes as defense mechanisms, but therapy using this model has been unsuccessful
         (b) Behaviorists propose that fetishes are learned through classical conditioning
            (i) Fetishes are sometimes treated with aversion therapy or covert sensitization
            (ii) Another behavioral treatment is masturbatory satiation, where clients are instructed to masturbate to boredom while imagining the fetish object
            (iii) A final behavioral approach to fetishes is orgasmic reorientation, a process that teaches individuals to respond to more appropriate sources of sexual stimulation
   2. Transvestic disorder (also known as transvestism or cross-dressing)
      a. This disorder is characterized by fantasies, urges, or behaviors involving dressing in clothes of the opposite sex as a means of sexual arousal
b. The typical case is a heterosexual male who began cross-dressing in childhood or adolescence

c. This pattern often is confused with gender dysphoria, but the two are separate conditions

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

3. Exhibitionistic disorder
   a. Also known as “flashing,” this disorder is characterized by arousal from the exposure of genitals in a public setting
   b. Most often, the person wants to provoke shock or surprise, rather than initiate sexual contact
   c. Generally, the disorder begins before age 18 and is most common in males
   d. Treatment generally includes aversion therapy and masturbatory satiation, possibly combined with orgasmic reorientation, social skills training, or cognitive-behavioral therapy

4. Voyeuristic disorder
   a. This disorder is characterized by repeated and intense sexual urges to observe people as they undress or engage in sexual activity
   b. The person may masturbate during the act of observing or while remembering it later
   c. The risk of being discovered often adds to the excitement
   d. Many psychodynamic theorists propose that people with this disorder are seeking power
   e. Behaviorists explain the disorder as a learned behavior that can be traced to chance

5. Frotteuristic disorder
   a. A person with frotteuristic disorder has repeated and intense fantasies, urges, or behaviors involving touching and rubbing against a nonconsenting person
   b. Almost always male, the person fantasizes during the act that a caring relationship is occurring with the victim
   c. The disorder usually begins in the teenage years or earlier
   d. Acts generally decrease and disappear after age 25

6. Pedophilic disorder
   a. This disorder is characterized by fantasies, urges, or behaviors involving sexual arousal from prepubescent or early pubescent children
   b. Some people are satisfied with child pornography; others are driven to watching, fondling, or engaging in sexual intercourse with children
   c. Victims may be male, but evidence suggests that two-thirds are female
   d. People with this disorder develop it in adolescence
      (a) Some were sexually abused as children
      (b) Many were neglected, excessively punished, or deprived of close relationships in childhood
   e. Most are immature, display distorted thinking, and have an additional psychological disorder
   f. Some theorists have proposed a biochemical or brain structure abnormality, but clear biological factors have yet to emerge in research
   g. Most people with pedophilia are imprisoned or forced into treatment
   h. Treatments include aversion therapy, masturbatory satiation, orgasmic reorientation, and treatment with antiandrogen drugs
      (a) There also is a cognitive-behavioral treatment: relapse prevention training, modeled after programs used for substance dependence

7. Sexual masochism disorder
a. This disorder is characterized by fantasies, urges, or behaviors involving the act or thought of being humiliated, beaten, bound, or otherwise made to suffer
   (a) Only those who are very distressed or impaired by such fantasies receive the diagnosis
b. Most masochistic fantasies begin in childhood and seem to develop through the behavioral process of classical conditioning

8. Sexual sadism disorder
a. A person with sexual sadism disorder, usually a male, is repeatedly and intensely aroused by the physical or psychological suffering of another individual
b. This arousal may be expressed through fantasies, urges, or behaviors
c. Named for the infamous Marquis de Sade, people who fantasize sexual sadism imagine that they have total control over a sexual victim
d. Fantasies may first appear in childhood or adolescence and the pattern is long-term
e. Sadism appears to be related to classical conditioning and/or modeling
f. Psychodynamic and cognitive theorists view people with sexual sadism disorder as having underlying feelings of sexual inadequacy
g. Biological studies have found signs of possible brain and hormonal abnormalities
h. The primary treatment for this disorder is aversion therapy

J. A word of caution
   1. The definitions of various paraphilic disorders, like those of sexual dysfunctions, are strongly influenced by the norms of the particular society in which they occur
   2. Some clinicians argue that, except when people are hurt by them, at least some paraphilic behaviors should not be considered disorders at all

XII. GENDER DYSPHORIA
[Video: Renee Richards: A Long Journey; The Boy Who Was Turned into a Girl]
A. According to current DSM-5 criteria, people with this disorder persistently feel that they have been assigned to the wrong biological sex and gender changes would be desirable (See Table 13-6, text p. 456.)
   1. They would like to remove their primary and secondary sex characteristics and acquire the characteristics of the other sex
B. The DSM-5 categorization of this disorder is controversial
   1. Many people believe that transgender experiences reflect alternative—not pathological—ways of experiencing one’s gender identity
   2. Others argue that gender dysphoria is in fact a medical problem that may produce personal unhappiness
C. Men with this disorder outnumber women 2 to 1
D. People with gender dysphoria often experience anxiety or depression and may have thoughts of suicide
E. The disorder sometimes emerges in childhood and disappears with adolescence
   1. In some cases, it develops into adult gender dysphoria
F. Many clinicians suspect biological—perhaps genetic or prenatal—factors
   1. Abnormalities in the brain, including the hypothalamus (particularly the bed nucleus of stria terminalus [BST]), are a potential link
G. To more effectively assess and treat those with the disorder, clinical theorists have tried to distinguish the most common patterns of gender dysphoria:
   1. Female-to-male
   2. Male-to-female: androphilic type
   3. Male-to-female: autogynephilic type
H. Many adults with gender dysphoria receive psychotherapy
1. Some adults with this disorder change their sexual characteristics by way of hormones; others opt for sexual reassignment (sex-change) surgery.

I. Clinicians have debated heatedly whether sexual reassignment surgery is appropriate.

1. Some consider it humane, others argue that it is a “drastic nonsolution” for a complex disorder.

J. Research into the outcomes of such surgery has yielded mixed results.

**LEARNING OBJECTIVES**

13.1. Describe each of the four phases of the sexual response cycle: desire, excitement, orgasm, and resolution.

13.2. Explain the two most common dysfunctions of the desire phase, male hypoactive sexual desire and female sexual interest/arousal disorder; then describe the primary dysfunction of the excitement phase, erectile disorder.

13.3. Discuss the orgasmic sexual dysfunctions of early ejaculation, delayed ejaculation, and female orgasmic disorder.

13.4. Discuss the sexual pain disorders.

13.5. Discuss treatments for the sexual dysfunctions.

13.6. Define paraphilic disorders and describe general behavioral treatment for such conditions.

13.7. Define, compare, and contrast the major paraphilic disorders.


**KEY TERMS**

delayed ejaculation
desire phase
directed masturbation training
erectile disorder
excitement phase
exhibitionistic disorder
female orgasmic disorder
female sexual interest/arousal disorder
fetishistic disorder
frotteuristic disorder
gender dysphoria
penito-pelvic pain/penetration disorder
male hypoactive sexual desire disorder
masturbatory satiation
nocturnal penile tumescence (NPT)
orgasm phase
orgasmic reorientation
paraphilias
paraphilic disorder
pedophilic disorder
Internet Sites

Please see Appendix A for full and comprehensive references. Sites relevant to Chapter 13 material are:

http://www.sca-recovery.org (Sexual Compulsives Anonymous)
SCA is a fellowship of men and women who share their experience, strength, and hope with each other so that they may solve their common problem and help others to recover from sexual compulsion.

http://www.aasect.org/
The American Association of Sex Educators, Counselors, and Therapists (AASECT) is a not-for-profit, interdisciplinary professional organization that promotes understanding of human sexuality and healthy sexual behavior.

http://www.siecus.org/
The Sexuality Information and Education Council of the U.S. (SIECUS) is a national, nonprofit organization that affirms that sexuality is a natural and healthy part of living.

http://www.guttmacher.org/
The Alan Guttmacher Institute (AGI) is a nonprofit organization focused on sexual and reproductive health research, policy analysis, and public education.

Mainstream Films

Films relevant to Chapter 13 material are listed and summarized below.

Key to Film Listings:
P = psychopathology focus
T = treatment focus
E = ethical issues raised

Please note that some of the films suggested may have graphic sexual or violent content due to the nature of certain subject matter.

Adventures of Priscilla, Queen of the Desert
This Australian film from 1994 follows three cabaret drag queens who trek across the outback. P, comedy
Belle de Jour
Scandalous when first released in 1965, this film is Luis Bunuel’s story of an affluent housewife (Catherine Deneuve) who acts out her sexual fantasies by taking a job at a Paris brothel. **P, serious film**

The Birdcage
A remake of the French *La Cage Aux Folles*, this American film from 1996 stars Robin Williams and Nathan Lane as a gay cabaret owner and his transvestite companion (actually a drag performer) trying to hide their relationship so that their son can introduce them to his fiancée’s conservative parents. **P, comedy**

Boys Don’t Cry
From 1999, this powerful film stars Hilary Swank as Teena Brandon, a young woman who claims a new male identity in the rural town of Falls City, Nebraska. Based on a true story. **P, E, serious film**

A Clockwork Orange
In this 1971 film by Stanley Kubrick, Alex, a member of a brutal teenage gang, is imprisoned and agrees to aversion therapy. **P, T, E, serious film**

The Crying Game
This 1992 film focuses on the relationship between a person with gender identity disorder and his unsuspecting partner. **P, serious film**

Damage
This 1993 film portrays the troubling story of a married and respected middle-aged member of Britain’s Parliament who becomes romantically and obsessively involved with his son’s fiancée. **P, E, serious film**

Kinsey
From 2004, this biopic stars Liam Neeson as Alfred Kinsey, a man who created a media sensation with his sexuality research and subsequent book *Sexual Behavior in the Human Male*. **P, E, serious film**

Kiss of the Spider Woman
From 1985, this film stars William Hurt and Raul Julia as two cellmates in a South American prison—the first is a man who molested a young boy and the other is a political activist. **P, E, serious film**

Lolita
From 1962, this Stanley Kubrick adaptation of Nabokov’s book is set in 1947 and details a troubled man in a troubled relationship with a very young girl. **P, E, comedic/serious film**

Looking for Mr. Goodbar
Starring Diane Keaton, this 1977 film paints an intense portrait of the free-spirited singles scene in New York City and the turmoil of one woman’s attempt to find her own sexual identity. **P, serious film**

Ma vie en rose
In this Golden Globe–winning film from 1997, Ludovic is a boy who cross-dresses, acts like a girl, and talks of marrying his neighbor’s son. **P, serious film**

Normal
This 2003 film provides a relatively realistic portrayal of a married man undergoing gender transition. **P, E, serious film**
Secretary
From 2002, this film depicts Maggie Gyllenhall as a smart, quirky masochistic woman having an unorthodox relationship with her boss. **P, E, serious film**

*sex, lies, and videotape*
This 1989 film directed by Steven Soderbergh examines the triangle created when an old college friend reenters the lives of a sexually repressed woman and her husband. They discover their friend has a fetish for videotaping women talking about sex. His appearance forces them to reexamine their marriage. **P, T, E, serious film**

*Transamerica*
This Oscar-nominated film stars Felicity Huffman as a preoperative male-to-female transsexual trying to forge a relationship with her son. **P, serious film**

*The Woodsman*
This 2004 film stars Kevin Bacon as a child molester who returns to his hometown after his release from prison. **P, E, serious film**

*The World According to Garp*
From 1982, this acclaimed adaptation of the John Irving book follows a feminist activist (Glenn Close) who publishes a feminist manifesto that makes her a lightning rod for all manner of victimized women. Among her followers is a transsexual ex-football player (John Lithgow). **P, T, comedy/serious film**

Other Films:
*Auto-Focus* (2002), exhibitionism and sexual addiction. **P, serious film**
*Body Double* (1984), voyeurism. **P, commercial/serious film**
*Crash* (1996), paraphilia. **P, serious film (Note: Graphic sexual content)**

Recommendations for Purchase or Rental
Films on Demand is a Web-based digital delivery service that has impressive psychology holdings. The catalog can be accessed at [http://ffh.films.com/digitallanding.aspx](http://ffh.films.com/digitallanding.aspx). In addition, the following videos and other media are available for purchase or rental and appropriate for use in class or for assignment outside of class.

*Phallacies*
Bullfrog Films
P.O. Box 149
Oley, PA 19547
Tel: (610) 779-8226
Fax: (610) 370-1978

*Sex: Unknown*
WGBH
P.O. Box 200
Boston, MA 02134
Tel: (617) 300-5400
http://main.wgbh.org/wgbh/shop/
CLASS DEMONSTRATIONS AND ACTIVITIES

Case Study
Present a case study to the class.

Panel Discussion
Have students volunteer (or assign them) to portray mental health “workers” from different theoretical perspectives in a panel discussion. Each student should present the main explanation and treatment for the sexual disorders (or for gender identity disorder) from his or her theoretical background. Students in the audience can ask questions of the panelists. In addition, other students can role-play patients suffering from particular sexual disorders. (NOTE: A brief reminder about sensitivity and professionalism is useful here.) Have the panelists attempt to diagnose based on their theoretical orientation.

“It’s Debatable: Is Sexual Activity in Video Games Appropriate?” (See the Preface of this Instructor’s Resource Manual for conducting this activity.)
Have students volunteer (or assign them) in teams to opposite sides of the debate topic—use the box on text p. 462 as a starting point. Have students present their cases in class, following standard debate guidelines.

“It’s Debatable: Serving the Public Good (See the Preface of this Instructor’s Resource Manual for conducting this activity.)
Have students volunteer (or assign them) in teams to opposite sides of the debate topic. (See PsychWatch, text p. 453.) Have students present their cases in class, following standard debate guidelines.

The Anonymous Five-Minute Essay
Take five minutes and permit students to write any concerns or questions they might have about sexuality, including variations of sexual behavior. Review the responses and answer them (or as many as you can) in the next class period.

Group Work: Childhood Misconceptions
Have the class form small groups to create lists of sexual messages and misconceptions they were exposed to during childhood. Have each group develop a list and elect a spokesperson to discuss their list. Have class members listen for themes or common misconceptions. Ask them how such misinformation might influence someone’s sexual behavior as an adult.
Childhood Sexual Abuse Controversies

Introduce students to some of the controversies surrounding the evaluation of possible victims of sexual abuse of children (some of whom are evaluated as adults). Have students discuss the controversies and suggest solutions. Some of the difficulties include the following:

A. Discrepancies
Discrepancies are often noted between the stories told by children and those told by their accused offenders. Although denial or minimization can play a role in the offender’s account, differences are also found in the types of sexual behavior described in events and their sequences, as well as in timing. One big problem is that young children’s sequencing abilities are not adequate to enable them to encode some facts accurately. The feelings they express are likely to reflect their experiences more accurately than the details of the events they describe.

B. Leading Questions
Leading questions, such as “Did he touch your private parts?” can influence what children say and come to believe. Such questions are inadmissible as evidence in the courtroom, and they are ill-advised in therapy, too.

C. Anatomically Correct Dolls
Some clinicians believe that anatomically correct dolls are leading questions in another form. Indeed, they increase the probability of a sexual response, whether or not it is accurate (nonvictimized children also may play at pseudosexual behavior with these dolls). They are more useful as a facilitative tool in therapy than as an investigative tool.

SUGGESTED TOPICS FOR DISCUSSION

Sex-Role Myths
Lead a discussion on the myths of male and female sexuality. Be sure to correct these misconceptions and discuss the realities. A related discussion point is the impact of shows like Sex and the City or Girls, as a more modern example, on beliefs and perceptions about sexuality.

Open Discussion: Cultural and Sexual Behavior
Point out how cultural norms, beliefs, and values influence what is considered healthy sexuality. For example, homosexual intercourse is not only permitted but encouraged in some cultures. Discuss how cultural norms change. For example, homosexuality was considered a mental illness in early versions of the DSM (students are fascinated by overheads of these particular pages from the manual). Outmoded terms such as “nymphomania” (which in the Victorian era applied to women who were regularly orgasmic and enjoyed sex) and “masturbatory insanity” (in the 1930s, physicians believed that masturbation could cause fatigue, physical illness, and mental illness) can be used for illustration. Some of these ideas persist today without scientific evidence to support them. For example, many varsity coaches insist that college players not have sex before a game because having it will reduce their athletic ability.

Open Discussion: Sexual Fantasies
Ask students to define “sexual fantasy.” Ask them to then determine at what point normal fantasy becomes abnormal.
Open Discussion: False Memory Syndrome

Some people believe that therapists have helped create false memories of childhood abuse in some patients. Whereas, unfortunately, many people have been sexually abused as children, it is also true that memories can be forgotten, distorted, and created (i.e., generated from nothing).
ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

Write a Pamphlet
Using a software program like Microsoft Publisher or simply paper and markers, students can create a pamphlet on one or all of the sexual disorders or gender dysphoria. Students should be encouraged to be as accurate and up-to-date as possible and also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal
In addition to helping students synthesize material, this activity is helpful in developing writing skills. Have students keep a journal of their thoughts on course material throughout the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Have students submit their journals for review on an ongoing basis because students can tend to delay writing until the end of the semester. Some suggestions for journal topics include reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, and so on.

Essay Topics
For homework or extra credit, have students write an essay addressing one (or more) of the following topics:

(1) Where do you stand on the topic of Viagra vs. the Pill (see PsychWatch, text p. 443)? What are the differences between the two medications that support the disparate policies? What are the similarities that refute it?

(2) Discuss the implications of the changes to the DSM-5 criteria for paraphilias versus paraphilic disorders.

(3) Discuss the implications of homosexuality being listed as a DSM disorder and being removed from the DSM in the 1980 edition. What parallels may be drawn to changes in DSM-5?

Research Topics
For homework or extra credit, have students write a research report addressing one (or more) of the following topics:

(1) Conduct a “Psych Info” search and write an annotated bibliography on treatments for three of the sexual dysfunctions described in the text. Which treatments are proving most effective?

(2) Research and review the literature on “cybersex”—what are the research findings on Internet pornography as it relates to sexual dysfunction? Are there any positive findings?

(3) Research and review the literature on Internet chat rooms for children and teens and the link to pedophilia.

Film Review
To earn extra credit, have students watch one (or more) of the mainstream films listed earlier in the chapter and write a brief paper (3 to 5 pages). Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but should focus their papers on the depiction of psychological abnormality. What errors or liberties did the filmmaker take? What is the message (implicit or explicit) concerning people with mental illness?