

# Sexual Disorders

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***SEXUAL***

***DISORDERS***

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*For my patients—who continue to be my best  
teachers*

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# CHAPTER 1

## INTRODUCTION

Sexuality as well as expression of that sexuality is an important part of all of our lives. Sexual expression enriches our relationships, and provides a meaningful physical way to express care for those we love in the special connection we share with our partners. However, as in all interpersonal or physical aspects of our lives, there can be problems in sex, and sexual behavior. Perhaps no part of medical care is dominated by as much stigma as sexuality, and perhaps no other area carries as much misunderstanding as sexuality and sexual disorders.

We feel uncomfortable talking about sex with others, and as mental health practitioners this discomfort does not stop at the consultation door. We continue to be embarrassed when talking about

sexual issues with our patients, and feel even more uncomfortable discussing sexual disorders.

Over the next few pages, I will present a brief overview of sexual disorders. The purpose of this brief book is not to fully describe sexuality and its disorders, but rather to give a brief overview for the mental health clinician. To begin, I will discuss issues in normal sexuality including how to obtain a sexual history with a patient. This will be followed by a discussion of the sexual response cycle.

Subsequent chapters will discuss sexual dysfunction including problems in erectile dysfunction in men, and sexual arousal disorders. A brief description of orgasmic disorders and sexual pain disorders follows these topics.

Then, a description of the paraphilias, or abnormal sexual expression will be presented, followed by a discussion of the limited value of the laboratory and blood tests in the exploration of these conditions.

A very brief discussion of treatment of these disorders is presented. The discussion will be brief, not because treatment of these conditions is easy—quite the contrary is true. Rather, the presentation is brief because it is assumed that many of these individuals will be referred for treatment to specialty centers offering intensive treatment for these conditions.

Finally, a discussion of gender dysphoria, where an individual feels that they are locked in the body the opposite sex completes this discussion of sexual disorders.

In the discussion of all of these complex issues, brevity and simple clinical descriptions will take precedence over a full discussion of the research in the area, or even expert treatment. We clinicians too often begin assessment of individuals with sexual disorders with surprise and ignorance.

By reading these pages, I hope to eliminate some of both.

## CHAPTER 2

# NORMAL SEXUALITY

Sexuality is a neglected area of health care. Because of the intensely personal nature of the subject, practitioners usually neglect to ask about it, and patients are often embarrassed to talk about it—whether they are experiencing sexual problems or not. Because of this, practitioners unfortunately, follow a “don’t ask, don’t tell” approach. Health practitioners usually would rather not hear about sexual difficulties, and patients all too often are happy to oblige.

In this chapter, we will review normal sexuality, as well as some hints practitioners may use in assessing different sexual issues and problems. Often, even experienced mental health professionals may need to force themselves to ask about and confront sexual questions and problems in their patients. But, asking about these experiences is



an important skill, and one leading to a much more complete care of the patient and his problems.

Sexuality and sexual problems of course, have always been part of the human experience and the experience of health care providers. But how sexuality and the problems associated with sex have been recognized or treated in society varied from time to time and from place to place even within the same time period. In Victorian England and Europe at the end of the nineteenth century, sexuality was ignored, or repressed, leading Freud to feel that many of the “neurotic” conflicts in his patients were a result of repressed sexual urges. As the twentieth century progressed, sexuality emerged from the shadows, and feelings about sexuality also changed. As cultural changes passed through the more open cultural period and excesses of “the roaring twenties”, the crises of the world wars, and the post war period of the “return to normalcy”, feelings about sexuality reflected the overall mores and conflicts of each of these times. During the fifties, following World War II, with the economic expansion of the era,

the culture recognized sexuality, but not sexual problems. “Prim and proper” was the order of the day, which was followed by the backlash leading to the cultural upheaval of the 60’s, when “sex, drugs and rock and roll” seemed to permeate popular culture.

The women’s movement emerged during this time, as well as medications offering an easier form of birth control. The emotional recovery seen in the 1970’s was shattered by the onset of HIV disease, and the worldwide spread of this sexually transmitted and often fatal disease. The 1990’s offered an information explosion about all issues including sex with the onset of the internet, and the cultural assault the internet brings from influences both outside and within an individual culture. Where we are heading now in terms of our view of sexuality and sexual influences is anyone’s guess. But, what is certain is that any culture, will change yet again.

Sexuality and views of sexual problems change as the culture shifts. The popular culture, of which medicine is a prominent part,

changed its views of sex as time progressed. Medicine and medical diagnoses change along with the times.

Masturbation, for example, at times was thought to be unusual, or at least somewhat harmful. However, it was later accepted to be a normal part of sexual expression. Views of a family changed also as culture changed. The “typical family” with both parents at home raising children was surpassed by “blended families” and “single parent families” trying to manage different sexual relationships within the context of the changing view of the family. With this, sexuality and sexual expression also changed, and what is “usual” changed as well as views of what is “acceptable” or even “disordered.”

Homosexuality reflected all of these changes as well. Homosexuality was viewed as a “disorder” until 1973 in the United States, and was finally removed from The American Psychiatric Association’s DSM in 1980 with the publication of DSM III. Still, however, homosexuality is a hotly debated topic in the United States,

with gay marriage being a political issue which is debated, a legal question that is decided and even an economic issue affecting spending, neighborhood growth, and the emergence of new businesses catering to gay interests. In the rest of the world, homosexuality is hotly debated as well, and “aggressive sexuality” is a crime in Uganda carrying with it severe punishment. (I don’t know what “aggressive sexuality” is either.)

Of course, we in medicine and in mental health are swayed by the cultural tides which wash against our practices. Psychotherapies which purport to “fix” or “cure” homosexuality emerged, and then were attacked. There is no data that these “therapies” are at all effective or even helpful. While they are not supported by any data or the medical establishment, “corrective therapies” to treat homosexuality continue to be hotly debated in the popular culture, leading to attempts to declare such treatments illegal. Debate about gay marriage and relationships continues in many cultures.

What certainly is true at this point is a series of clear, essential points. Sexuality is an essential part of almost everyone's life. Sexuality involves relationships with others, and as such, carries the potential to strengthen relationships or to destroy them. Sexuality is also a physical process and can be a symptom of recognized systemic diseases, such as diabetes, or can herald the onset of vascular problems seen in cardiovascular disease. Certainly, sexual health continues to be important to us, and is an integral part of our personhood. Care for sexual health is an essential part of overall health care.

Mental health practitioners, being the experts in personal feelings and relationships, are often called upon to confront and treat sexual disorders. When a patient comes to us with a sexual problem we sometimes swallow hard, and wonder what to do.

Here are some tips.

## TAKING A SEXUAL HISTORY

The first general rule in taking a sexual history is to be open about the subject matter, and treat it in an understanding and non-judgmental way. While you may be embarrassed about talking about it, the patient is usually much more ill at ease. The key, as in all clinical interview situations, is not to be judgmental—especially at first. It is much more important to find out exactly what the problem is, and how the patient feels about any issue before you render your verdict that “it’s OK”, or “it’s normal”. An air of curious concern should be conveyed as you do your assessment. After you collect all of the clinical data, and after you formulate a diagnosis and treatment plan is the time to convey support, or concern.

In obtaining information in a sexual history, it is helpful to find out how the patient obtained information about sex. Many sexual problems have at their base knowledge deficits about basic aspects of human sexuality, or how sexuality and relationships weave their way together. Sexuality is often a taboo subject, and the patient may have

little knowledge on which to base any idea or opinion about any sexual problem. So, fears or “old wives tales” take over. Finding out how the patient learned about sex, and then what is their basic knowledge about sex can be essential in obtaining further information about their sexual history. No question is too basic in this part of the interview.

In discussing how sexual knowledge emerged in your patient, it is important to understand how sexuality was addressed in their family of upbringing as well. The two topics are usually linked. If sexual knowledge was ignored or shunned, sexual knowledge is all too often lacking. In obtaining the history of sexuality in the patient’s upbringing, the practitioner should ALWAYS, ALWAYS ask about any history of incest or sexual abuse as well as about any history of physical or verbal abuse. Many sexual problems and relationship problems have at their heart sexual abuse by those who were supposed to be caring for the patient as a child. Sexual abuse can shatter views of trust, sexuality and relationships. These can then be altered, and confused. The trauma of being attacked or raped is added onto the confusion relationships as

the powerless child is overwhelmed by the attack or rape. In the attack, sex, sexual feelings, pain and the demonstrated lack of trust evident in this type of abusive relationship are all mixed into the experience, affecting the memory and the view of sexuality in general.

While not all people who have been sexually abused as children demonstrate sexual or relationship problems later in life, it is a common progenitor of psychiatric conditions we see in our offices daily. As childhood sexual attacks become publicized, virtually every child care agency from the Catholic Church to the Boy Scouts has been shown to have problems with sexual abuse. Ask about it, and expect to see it commonly in your practice.

(For a fictional “case” of how childhood rape can happen and be experienced and influence someone’s life– see my novel The President’s Secret, by Paul Kettl (1), which explores the history of a fictional case, as well as how psychotherapy can be helpful in treatment. In this story, America’s first woman president seeks



psychotherapy to confront her demons originating from childhood sexual abuse.)

As the developmental history advances to questions concerning adolescence, ask about early sexual experiences. How old was the patient when he or she began to experience sex? With whom did it occur? Was it pleasant or not? How did sexuality and sexual practice emerge, or become a “habit”?

In adulthood, ask about the patient’s relationship history. When asked “What is health?” Freud is purported to have said, “Health is the ability to work and to love.” In this part of the history, we find out the patient’s ability to love. Have they been able to establish relationships? How long has each relationship lasted? What is the quality of the relationship?

Now, we are ready to ask about the patient’s current relationship. What is their current relationship like? What is sexual activity like?

What is good, and what is bad about both their current relationship and sexual expression?

In asking about sexual activity, find out about the frequency of sex, and the number of partners with whom they are currently sexually involved. Do they practice any kind of birth control? Do they engage in protected sex, using a condom? Are there some sexual practices which seem to go well, and that they enjoy, and some which seem to be a problem for them or their partner? Are there signs of intimacy (kisses or hugs, or holding hands) in the relationship outside of having sex?

Sometimes sexual problems can be due to a difference in the level of sexual interest or sexual drive in each of the two members of a relationship. This “interest gap” is not a disorder, but it can be a problem which needs to be negotiated between the two members of the couple. Asking about who is more interested in sex, and what is the “gap” in interest can often be useful in assessing a problem and treatment plan.

A question which can be very helpful in assessing the level of sexual drive in a patient is to ask how often the patient masturbates. Masturbation is personal sexual expression, which is largely free of cultural or relationship problems—and the frequency of masturbation can give a good idea of the level of sex drive in an individual.

Likewise, asking the patient what is the fantasy they think about while masturbating can give essential information about who they find to be the most attractive sexual partner, and what sorts of sexual expression they may find most exciting. For example, in a confused teenager, asking about masturbatory fantasies can give information on how attracted they may be to the same or opposite sex. Likewise, if the patient says that during masturbation, he thinks of pre-pubertal children that response can give essential information to clarify other parts of the history or diagnosis including the presence of a paraphilia.

So then, questions about masturbatory frequency give information about sex drive while questions about masturbatory fantasy give information about sexual orientation or desires.

Finally, in the sexual history, ask about the nature of the sexual problem they may be experiencing. What is the sexual problem? How do they view the problem? How does this affect their relationships, or overall health? It is essential to get the patient's view of their partner's sense of the sexual problem. They may or may not be correct in their assessment of their partner's feelings—but at least asking about this can be a very useful first step.

#### **SUMMARY: TAKING A SEX HISTORY:**

- ▶ Be open, matter of fact
- ▶ How did you get information about sex?
- ▶ What is knowledge about sex?
- ▶ History of sexual abuse/physical/verbal abuse
- ▶ Early sexual experiences

- ▶ Relationship history
- ▶ Current relationship(s), sexual activity
- ▶ Sexual activity
  - frequency, number of partners?
  - birth control, protected sex?
  - with whom?
  - masturbatory frequency
  - fantasy during masturbation
- ▶ Problem? Partner's view of the problem?

### **NORMAL SEXUAL RESPONSE CYCLE**

The classic normal sexual response cycle consists of four parts: Desire, Excitement, Orgasm, and Resolution.

The first, desire, is the experience of a growing sexual excitement or urge. Of course, this first step of the cycle can occur without the others, and consists of becoming sexually aroused. The biology of this first step is housed in the brain, and is affected not only by the

stimulus in the mind presenting itself to the person, but also by any memory of sex, sexual experiences and cultural teachings concerning sexuality as well.

The second step in the normal sexual response cycle is excitement. In this phase, the male experiences an increase in sexual desire, and the penis becomes harder. I will discuss the biology of this later, but basically, the penis becomes harder when filled with fluid or blood. This vasocongestion is the essence of obtaining an erection. Problems in blood flow to the penis can lead to problems in erectile function. In the woman, sexual desire also grows in the excitement phase of the sexual response cycle, and is reflected physiologically by the clitoris becoming harder.

The third stage of the normal sexual response cycle is orgasm where the individual feels a building stage of excitement, followed by a gratifying sense of release of sexual tension. This is associated by

ejaculation of seminal fluid in the man, and by the rhythmic contraction of perineal muscles in the woman.

The fourth stage is resolution. In this stage is the detumescence of the penis or clitoris, and a feeling of both emotional and physiologic relaxation is experienced by both sexes.

This set of events can begin again. Many women are able to go back and forth between excitement and orgasm phases easier than a man, achieving "multiple orgasms" whereas typically the man requires a period of time in resolution before being able to reach another orgasm. While some men may be able to achieve multiple successive orgasms, many more women are able to achieve this more routinely.

As for the frequency of sexual acts or orgasm there is no normal. Some individuals have a greater sexual appetite, and have sex more frequently, and other less. The sexual drive of both members of the couple, as well as their past histories and cultural setting can influence

sexual frequency. Many other factors including fatigue, work schedules, or the demands of other parts of life can impinge on one's sexual life just as they can steal attention from other parts of life. Frequency of sex is not always associated with quality of sex, or sexual gratification, either. There is no "normal" or "abnormal" frequency of sex. Rather, each couple defines sexual frequency and what seems to work the best for them. If a problem arises for the individual or the couple, it needs to be addressed with the individual and his or her partner.

Often, sexual problems may not be truly sexual problems at all. Rather, they may be problems in communication about sex, or communication in general about issues in their relationship. Acknowledging these problems and trying to improve communication within the couple is essential and will often improve sex as well.



## CHAPTER 3

# SEXUAL DYSFUNCTION

Sexual dysfunctions can occur in any aspect of sexuality or sexual functioning. These problems may be initiated by changes in health, changes in life or lifestyle, and also can be caused by side effects of medications or surgery. Sexual dysfunctions affect both sexes in both happy and unhappy relationships. Unfortunately, too often, they are ignored by the mental health practitioner. A simple understanding of the basic kinds of sexual dysfunction can be helpful as the mental health practitioner tries to understand the many clients they see.

By definition, all of the disorders of sexual dysfunction must be severe enough to cause a problem for either the individual, or the other individual in the relationship. In addition, they must last for a long enough period (by definition—six months or more) to cause trouble. For example, being unable to achieve an erection once is

normal, but being unable to achieve an erection many times over a six-month period is a disorder warranting attention. Likewise, the inability to achieve orgasm at times during a sexual encounter is normal, but being unable to achieve an orgasm over a period of six months or more is a disorder which deserves further investigation and treatment.

## **ERECTILE DYSFUNCTION**

Erectile dysfunction in men occurs when a man is unable to achieve a penile erection sufficient for sex satisfying for him or his partner. As one ages virtually all parts of the body begin not to work as well, and the series of organs involved in sex is not immune from sexual dysfunction.

Rates and severity of sexual dysfunction both increase with age. About five percent of men have erectile dysfunction at age forty, but this increases to about 15% by age seventy. Moderate erectile dysfunction is more common, and also increases in frequency with age. About seventeen percent of men have moderately severe erectile

dysfunction at age forty, but this increases to about thirty four percent by age 70. (2)

While these rates were understood for a long time, we had limited effective treatment to offer men for erectile dysfunction until the onset of a better scientific understanding of the erectile process, including the role of nitric oxide. The increased understanding of the role nitric oxide plays in the erectile process led to medications such as sildenafil which effectively treats many men suffering from erectile dysfunction.

Nitric oxide is produced by the parasympathetic, noncholinergic cells and leads to the relaxation of smooth muscle cells. These cells present in blood vessels relax, or expand, and this expansion occludes the outflow of blood from the penis. When the outflow of blood is blocked from the penis, the penis fills with blood. When the outflow of this blood is prevented, the penis becomes stiff and stays stiff, leading to an erection.

Because blood flow to the penis is essential to cause an erection, any disease which affects blood flow in the body, including all the risk factors for cardiovascular health, are risk factors for erectile dysfunction.

These risk factors for erectile dysfunction include any type of cardiovascular disease. About two thirds of men had erectile dysfunction before the onset of coronary artery disease, so the new onset of erectile dysfunction warrants a referral to the patient's internist or cardiologist for evaluation of poor vascular health in other parts of the body—such as the heart or brain. Erectile dysfunction can herald the onset of vascular disease.

Likewise, the history of stroke or heart disease is a risk factor for erectile dysfunction since the vascular disease leading to stroke or heart disease would likely lead to poor penile blood flow leading to erectile dysfunction as well.

Other cardiovascular risk factors are risk factors for erectile dysfunction as well. Metabolic syndrome or diabetes are prominent risk factors. Tobacco use doubles the risk of erectile dysfunction.

In addition, any surgery that involves the pelvic neural tree or vasculature can also affect erectile competence. Unfortunately, erectile dysfunction is a common side effect of prostate surgery.

Medications of various sorts can lead to erectile dysfunction. Common medications that can lead to erectile dysfunction include the anti hypertensives and the specific serotonin reuptake inhibitors. Various studies of the SSRI's (fluoxetine, sertraline, paroxetine, citalopram, and escitalopram) show erectile dysfunction as a side effect in up to fifty percent of the patients who take them. The SSRI's can lead to a variety of sexual problems involving almost all aspects of sexuality and sexual expression. SSRI's can lead to a decreased desire in sex, problems in obtaining an erection or ejaculation, as well as problems achieving orgasm in both sexes.

The evaluation of a patient with erectile dysfunction follows the usual questions which should give an idea of someone's general medical health. Their medical history, with special attention to cardiovascular disease should be completed. In addition to evaluating current medications, any temporal relationship between the onset of the sexual dysfunction and the beginning use of these medications should be noted. Unfortunately, many psychoactive medications lead to sexual dysfunction. Among the antidepressants, bupropion and mirtazapine are not likely to lead to sexual dysfunction. However, the other antidepressants are often likely culprits in the etiology of sexual dysfunction. A patient seeking care for depression often presents with decreased interest in pleasurable activities, including sex. Sometimes, it is only after the patient's begins to improve, and interests in sex begin to return that the patient reports the side effect of sexual dysfunction to their clinician.

A sexual history, including the aspects covered in the previous chapter should be obtained as well. The specific situations in which

sexual dysfunction occur is helpful to understand. For example, if a man has problems achieving an erection only with some partners, or in some situations, but is able to successfully achieve an erection with other partners, or in other situations would suggest that the problem may not be “organic” but rather a reflection of that particular problematic relationship or circumstance.

A psychosocial history, or biography, of the individual is always important, but it is especially important in the evaluation of sexual problems. A complete drug and alcohol history should be obtained. Alcohol abuse is a frequent cause of poor sexual function, and other drugs of abuse can also affect the ability to successfully perform sexually as well. Remember that tobacco use is associated with an increased risk of sexual dysfunction, presumably by affecting one’s cardiovascular health.

In the past, sexual problems were at times divided into “organic”, that is sexual problems caused by diseases or medications; or

“psychogenic”, that is sexual problems caused by emotions or relationship issues. This dichotomy is seldom useful, since virtually all middle aged individuals have some kind of medical problem, and almost all people have some kind of ongoing relationship or personal issues that concern them. The question is not whether a sexual problem is either physiological or psychological in etiology, but rather how much of the problem may be related to a medical issue, and how much may be related to interpersonal concerns. Taking a good medical history, especially examining the presence of heart disease or cardiac health risk factors is important. Accordingly, taking a good relationship history including the views of the patient and his or her partner about the sexual problem is essential as well.

Likewise, the onset of sexual problems associated with the use of medications which commonly cause erectile dysfunction is an important piece of history. In these circumstances, changing medication if possible, can often “cure” the sexual dysfunction.



Laboratory tests are not usually helpful in evaluating erectile dysfunction. However, because the disorder is so often associated with cardiac disease, checking glucose, renal blood tests, and a lipid profile can be helpful for general health maintenance. Serum testosterone is sometimes obtained, but testosterone has a rather wide normal range, and the addition of testosterone is not always helpful in restoring sexual function. Evaluation of testosterone and hormonal function should probably be left to urologists, endocrinologists, or psychiatrists specializing in sexual function.

Unfortunately, medications are often associated with sexual dysfunction in men. Also unfortunately, these same men need these medications to treat their high blood pressure or depression, or other diseases. Managing these situations can be difficult. So, perhaps the most important thing that can be done is getting a history of any sexual dysfunction before prescribing these medications. If any form of sexual dysfunction is present, prescribing a medication that has a lower potential for sexual side effects is useful.

However, if it seems clear that a patient or client has new onset of sexual dysfunction temporally related to the timing of starting a new medication several things can be tried to help the patient with this new problem. Some simple things can be tried first, but are seldom effective. These include scheduling sex before the dosing of the medication dose, hoping that the blood level of the medication would be lowest before the onset of the new dose. However, the half-life of many medications is usually too long for this to be an adequate solution. Some practitioners advocate a "drug holiday" or stopping the drug on the day of sexual activity. This also is seldom effective, and can introduce problems. First, because the half-life of the drug is often longer than a day, it is not effective. In addition, however, instructing a patient not to take a medication is often exactly the wrong message for a patient suffering a side effect for an illness that already carries a difficult stigma. So, a "drug holiday" is usually not good advice.

If an SSRI antidepressant is the cause of erectile or sexual dysfunction, the addition of bupropion to a psychiatric medication is

sometimes tried as a way to “counteract” the sexual side effects present with the first offending medication. While this is occasionally helpful (3), it works to remove the sexual dysfunction less than half the time; so switching from the medication causing the sexual side effects to another medication free of these side effects is usually needed.

So, if a medication causes erectile dysfunction, we search for another medication to treat the same medical or psychiatric condition, which has a lower sexual side effect profile. Among the antidepressant medications, bupropion and mirtazapine have low incidences of causing erectile dysfunction, and should be kept in mind for those patients.

Psychotherapy and “sex therapy” can also be tried in patients with erectile dysfunction. However, if it is determined that likely the cause of the sexual dysfunction is an offending medication, psychotherapy is not usually helpful in eliminating the problem. While psychotherapy or sex therapy may be helpful for the individual or the couple—especially

in improving communication in the couple, removing the medication is usually needed to resolve the erectile dysfunction.

Medication treatment for erectile dysfunction centers on the phosphodiesterase type 5 inhibitors. Sildenafil, vardenafil, and tadalafil are likely all equally effective. They are effective in restoring erectile ability in most men who do not have other systemic disease. But, in men who have diabetes, they are helpful only about half the time, and after prostate surgery, they probably are even less helpful. They should not be given to men who use nitrates for their cardiac disease. Men who have ongoing cardiac disease should get an assessment from their internist or cardiologist before beginning the medication. These medications work by affecting the nitric oxide induced vasodilatation, and work by blocking the enzyme phosphodiesterase type 5 helping to maintain vasodilation. In other words, the medication helps to block the blood flow back from the penis, to maintain an erection. But, these medications can also decrease blood pressure. So, while these medications represent a remarkable step forward in the treatment of

erectile dysfunction, having a physician expert in the use of these medications working with you is a must.

If these medications are not helpful for a patient with erectile dysfunction, the next treatment option is injection or insertion of alprostadil into the penis. This medication also encourages the inflow of blood to the penis, and blocks outflow of blood from the penis, leading to the erection. However, an injection of alprostadil into the penis, or insertion of the medication into the urethra needs to be done with each sexual encounter. The patient needs to be instructed carefully by his urologist on the proper use of the injection and medication. Pain is a frequent side effect of this treatment, and can limit its usefulness. If alprostadil is inserted into the penis, the penis needs to be massaged for a minute following this to allow for the proper distribution of the medication.

The next treatment option is the use of vacuum assist devices. The use of this device involves placing a vacuum device over the penis, and

pumping it up to create a vacuum. The vacuum draws blood into the penis, and then when erect, a ring or band is applied to the base of the penis to prevent outflow of blood. This helps to maintain the erection for as long as the band is in place. But, the band prevents ejaculation through the penis since the band blocks outflow of the semen. Of course, when sexual activity is finished, the band must be removed from the base of the penis to restore proper blood flow.

Surgery is available to insert penile prostheses. This surgery is rather invasive, and is done much less often than before—with the advent of medications that often are helpful in treating sexual dysfunction.

Psychotherapy can be tried, but is usually only helpful if anxiety is a strong cause of sexual dysfunction. To begin the process of psychotherapy, the patient is assessed for any ongoing, untreated psychiatric disorder. Then, an exploration of communication in the relationship ensues. Often, the sexual problem between two

individuals begins with a problem in communication in the relationship. Understanding this is the first step in the psychotherapeutic treatment of the couple.

Typically, psychotherapy then explores sensate focus exercises. These exercises include typical behavioral interventions including gradual exposure to anxiety producing sexual situations, with time allowed to habituate to the anxiety before moving on to progressively more anxiety producing sexual encounters. For example, one member of the couple may rub the back of his partner, while communicating what feels good or bad in the touch. This is done until it no longer produces any anxiety, and then the partner may rub the abdomen, and then continue to progress slowly to more sexually stimulating situations. Sexual intercourse is prohibited in these early stages of the behavioral conditioning. With these exercises, a therapist works with the patient and his partner, and after a period of history taking and education, the patient is gradually exposed to progressive sexually arousing stimuli. At the beginning, both partners are fully clothed, and

spend sessions touching each other, but avoiding touch to genitals and breasts. Sessions involve gradually increasing exposure to progressive sexually arousing situations, and communication between the partners about what feels good, or what is anxiety arousing is encouraged. Typically, sexual intercourse is prohibited during these initial sessions as the focus of treatment centers on the reduction of anxiety in sexually arousing situations, and an increase in communication within the couple. However, as the behavioral treatment progresses, the same exercises are done unclothed, and then sexual contact is allowed by touching of breasts and then genitals, and finally sexual intercourse. All the while, communication about what feels pleasant and sexually stimulating, and what does not feel good is encouraged throughout these exercises and the couple should report back to the therapist both progress as well as problems.

While these sessions can be helpful to decrease anxiety and improve communication, if the etiology of sexual dysfunction is poor vascular flow, a more medical approach is needed in treatment.



## SEXUAL DESIRE AND AROUSAL DISORDERS IN WOMEN

By definition, these disorders present clinically with a decrease in sexual desire, and/or a decrease in sexual arousal in women. These disorders are common, and while the exact prevalence is not known, likely a significant minority of women experiences this at some point in their lifetime (4).

In the beginning of treatment, a good sexual history is essential. Understanding the view of sex in the patient's life, and early sexual experiences can be helpful to further understand her current sexual problem. Unfortunately, rape and sexual abuse is all too common in women, and that often plays a large role in the etiology of sexual problems, sexual activity, and the overall view of the woman toward sexual activity. Obtaining a history of the woman's current relationship, and sexual experiences and sexual expectations is also important.

At times, there is no "dysfunction" evident. Rather, there is a "desire discrepancy" between the two members of the couple. In this clinical situation, one member of the couple may have a higher sex drive or desire for sex than the other member of the couple. This discordance can lead to conflict. While this is not a disorder, it is important to understand, communicate and negotiate possible solutions within the relationship.

Fatigue can also play a role in one's desire for sex or any other activity. Today, with both members of the couple working, taking care of the children, taking care of the home, as well as taking care of members in the extended family there sometimes is no energy or time left for sexual activity. Here again, communication between the two members of the couple and an open discussion of where they are in their relationship is essential. The therapist encourages this discussion and at times, a "prescription" for time for each other including a prescription for sexual activity can be helpful.

It should be understood that the etiology of sexual arousal disorders can have a wide array of causes. It is not uncommon for women to experience a change in sexual desire at menopause because of the hormonal changes occurring then. In addition, the hormonal changes leading to decreased vaginal lubrication or decreased vaginal thickness in the tissue can lead to pain during intercourse, and this can certainly interfere with sex. Here, using a lubricant during sex can be a great aid to ongoing sexual activity and sexual satisfaction in women.

Unfortunately, because so many women have experienced rape or sexual abuse, this experience of sexual abuse also affects normal sexual expression, and sexual enjoyment in women. In the United States, it is estimated that as many as one in four women have been raped by the time they reach age 21, and in other cultures, it may occur even more often. The memory and experience of rape or sexual abuse can be associated with any sexual contact—even with a loved and supportive partner, and can lead to decreased sexual desire or sexual arousal. Every woman experiencing sexual desire or arousal

problems should be asked about a history of sexual abuse at any time in their lives. If it is present, of course, a more full discussion of how these memories may affect them, including symptoms of Post Traumatic Stress Disorder should be begun. An explanation for the other member of the couple about memory, how memories are stored and encoded in the psyche is important as well.

In addition, interpersonal factors in the relationship can also be a “turn off” for sexual arousal, and can inhibit sexual expression commonly as well. Sexual problems in the woman’s partner can contribute to problems in sexual arousal as well. At times in couples who have been together for a long time, one or both members of the couple may take sexual activity or the other partner for granted. Here, attention to hygiene, as well as attention to the sexual needs of their partner is always important.

For those in whom a history of sexual abuse, or relationship problems seem prominent in the etiology of sexual difficulties,

individual or couples counseling is recommended to address these problems. More open communication between the members of the couple, as well as an understanding of how the past can affect the present is essential in these cases. Here also, treatment with sensate focus exercises can help the couple in the same way as described for men with erectile difficulties.

Women with systemic disease such as diabetes, or heart disease can also experience changes in sexual desire. An investigation into the general health of the woman and good health maintenance can be a very helpful treatment approach as well.

Approximately a quarter of all women who experience sexual desire and arousal disorders have medication use as the cause (4). Both the SSRI antidepressant medications (such as fluoxetine, sertraline, paroxetine, citalopram and escitalopram) as well as oral contraceptive medications can lead to problems in sexual desire and arousal commonly. Here again, the use of the medication should be

examined. Any alternative medication or contraceptive methods can be investigated to see if any other medication which could be effective, without the side effect burden of sexual dysfunction.

Pelvic exams are helpful in good health maintenance in women, but they seldom are helpful in identifying a cause for a sexual arousal disorder. Likewise, laboratory evaluations are also not typically helpful, but routine health maintenance of glucose, lipid profiles, and blood pressure are important to maintain overall health.

Treatment of sexual arousal disorders vary, depending on the cause. As discussed, psychotherapy including education about sex and communication can be helpful. Sensate focus exercises between the two members of the couple can be helpful in decreasing anxiety and increasing communication between the members of the couple. If sexual abuse led to PTSD, treatment of the PTSD symptoms through the use of prolonged exposure or an SSRI medication, or both, can be helpful.

Specific medication approaches have not been as helpful with sexual dysfunction in women as they have been with the treatment of erectile dysfunction in men. Trials of sildenafil, testosterone or estrogen replacement have been tried, but with mixed results.

One medication option a mental health practitioner should keep in mind is a trial of bupropion in a woman with a sexual arousal disorder. While there are no large trials to support treatment with bupropion, some case reports (5) cite improvement in sexual arousal or desire in women who have used bupropion. Because this is a commonly used antidepressant medication, use of bupropion could be considered as an uncomplicated or even a first line potential treatment for decreased sexual arousal or desire in women.

Exercise has also been investigated. Cardiovascular exercise (that is, thirty minutes of exercise reaching 75% of maximum heart rate) in one trial led to improved sexual desire and sexual function, but did not

improve sexual satisfaction. Interestingly, scheduling sex did seem to improve orgasm in the women in the study (6).

## **ORGASMIC DISORDERS**

An orgasmic disorder consists of the delay or absence of orgasm following a normal sexual excitement phase. This is relatively uncommon in men, but more common in women. While exact prevalence is not clear, it may occur in as many as one in five women.

The cause varies. Alcohol use disorder is a prime contributor to the problem. Ongoing issues in relationships can affect the sexual response of patients as well. And, unfortunately, the experience of sexual abuse in the past can also lead to decreased sexual pleasure and the decreased experience of sexual orgasm in the woman who has experienced sexual abuse or rape in the past.

Once again, the SSRI medications (fluoxetine, sertraline, paroxetine, citalopram and escitalopram) can contribute to this sexual



side effect of a decreased ability to achieve an orgasm as well. Other psychotropic medications can also cause an orgasm disorder as a side effect.

The treatment involves first examining the list of medications a patient is taking, as well as obtaining a sexual history. Removing offending medications is helpful. Treatment involving couples counseling and sensate focus exposure treatments are probably the first line treatment for orgasmic disorders not caused by medications. Orgasmic disorders have traditionally been the condition for which this treatment was first explored.

The phosphodiesterase-5 inhibitors such as sildenafil have been tried for treatment of orgasm disorder in women—without clear results.

## GENITO-PELVIC PAIN/PENETRATION DISORDERS

Sexual problems related to pain, or problems with penetration are less frequent. Dyspareunia is the experience of pain during intercourse. In perimenopausal and postmenopausal women, the lack of vaginal lubrication is the most common cause. Here, use of a vaginal lubricant for sex can greatly diminish vaginal dryness and discomfort.

A history of pelvic radiation for cancer treatment can also lead to tissue changes leading the vagina to be more friable, or have decreased lubrication. Here again, use of a vaginal lubricant can be helpful.

Vaginismus is the involuntary contraction of the muscles surrounding the outer third of the vagina. When this is a persistent problem, look especially for the history of sexual trauma in the patient, or ongoing relationship issues between the patient and her partner. Here again, individual psychotherapy or treatment for PTSD from sexual abuse or rape can be helpful. Sensate focus exercises for the

couple can be helpful in managing this condition for the patient and her partner. In these exercises, as discussed earlier, gradually progressive sexually stimulating sexual exercises are explored. With vaginismus, however, much more time is spent trying to decrease any anxiety surrounding sexual intercourse. In this situation, the vaginal area is stroked or massaged by the male member of the couple. Manipulation of the vaginal area and clitoris with a finger then proceeds in later exercises until this is not associated with anxiety, and then is viewed as being pleasurable. Only then is intercourse with the partner's penis attempted in a gradual way, and again in a way where hopefully anxiety is limited.

### **PREMATURE EJACULATION**

Premature ejaculation is defined in DSM V (7) as ejaculation in the first minute of sexual intercourse. The prevalence of this disorder is not clear, but likely, more men are concerned about it than actually have the disorder. Anxiety about sex or sexual performance may be a

contributing factor in many cases. As well, anxiety about the relationship can be a contributing factor.

A variety of treatment approaches are available. Use of a condom may decrease the risk of premature ejaculation. The condom may decrease penile sensation during sexual activity, and therefore decrease or delay sexual excitement and hence ejaculation.

The “squeeze technique” is a behavioral option that can be tried. In this technique, intercourse is begun, and if the man is feeling as though he is about to ejaculate, the penis is withdrawn, and the tip is “squeezed” by the man or his partner, until the urge to ejaculate is decreased, and then intercourse begins again. A series of the “squeezes” increases the time to ejaculation through gradual exposure to more and more stimulation. Of course, a very understanding partner is needed to pursue this technique.

The “stop-start technique” is another behavioral method which can be employed to delay ejaculation. In this technique, the man

begins intercourse, and then when he feels he is about to ejaculate, he will stop vaginal thrusting until excitement decreases, and then he will begin penile thrusting again, etc. until ejaculation. This behavioral technique lengthens the time to ejaculation, but again, a very understanding partner is needed to work with the patient in this behavioral exercise.

Another way to increase time to ejaculation is to masturbate one to two hours before sex. Here, sexual appetites and excitement are somewhat reduced by the prior masturbatory activity, and this may well lead to prolonged time to ejaculation during subsequent sexual activity.

Several small trials have shown some efficacy of the SSRI antidepressant medications (fluoxetine, sertraline, paroxetine) in the treatment of premature ejaculation. These medication trials take advantage of the sexual side effects of the SSRI medications to delay ejaculation.

## CHAPTER 4

# PARAPHILIAS

A paraphilic disorder is an intense and persistent sexual interest other than sexual arousal in genital contact, or kissing or fondling of lips, breasts or genitals of a consenting adult. For example, extensive sexual interest in an object, or children would be a paraphilia. A paraphilia also could involve sexual contact between two partners which involves suffering in one of both of the members.

Commonly those engaged in paraphilic contact explore a wide range of sexual approaches, and it is not uncommon for those engaged in paraphilias to be engaged in many types of sexual expression or sexual contact, and have many different sexual paraphilias. The patient may not complain or even discuss these different paraphilias, feeling that they are simply “sexually adventurous”.

Substance abuse is a common co-existing condition in those who pursue paraphilias, and paraphilic activity can often occur with the person engaged in the activity being intoxicated. Personality disorder or depression can also occur frequently in those pursuing paraphilias.

A patient will often not present complaining of a paraphilia. Rather, often they are referred for care after being arrested for the paraphilic sexual contact leading to their arrest. At times, a paraphilia can be discovered in the course of a psychiatric evaluation for depression or a personality disorder.

In the evaluation of a patient with a paraphilia, it is important to distinguish it from an accompanying behavior due to another psychiatric condition. For example, if the paraphilic behavior had a new onset in late life, a fronto-temporal dementia may be the cause. If the unusual or intense sexual activity or desire occurs only intermittently, a diagnosis of mania or substance abuse must be considered.

## TYPES OF PARAPHILIAS:

### EXHIBITIONISTIC DISORDER

Exhibitionistic disorder is the act of exposing one's genitals to a stranger. This is almost an exclusively male activity or disorder. By definition, this disorder must cause distress or impairment in the subject or his victim for it to be a disorder. Often, a man may come to treatment only after being arrested for the offense, and often he would have engaged in this behavior many, many times before finally being apprehended, and referred for care.

Most men who are exhibitionists do not typically go on to sexual contact offenses, but a small minority—probably less than ten percent, also engage in other sexual contact offenses or rape and have exhibitionism as part of their sexual behavior repertoire.

Substance abuse can fuel this sexual misbehavior, and so an individual presenting with exhibitionism should be screened for the presence of a substance use disorder.



Because almost all offenders who engage in exhibitionism are men, if a woman is referred for care after exposing herself, the manic phase of bipolar disorder, or the presence of a frontal lobe head injury must be considered in the differential. Some argue that the reason why exhibitionists are almost always men is because if a woman wants to engage in exposing herself, the sex industry gives a ready outlet for this pursuit.

Treatment for exhibitionism involves first the evaluation of the patient for other disorders including a substance use disorder, or mania. Individual psychotherapy is often offered to try to obtain a further sexual history of abuse in the past experience of the perpetrator, or a sexual history including the sexual knowledge and experience of the perpetrator. It is not unusual for the man pursuing this activity to have poor social skills and to somehow expect that exposing himself may lead to the beginning of a relationship. While this is obviously ludicrous, it may reflect the poor social abilities of some individuals who pursue this behavior. For these individuals with

poor social skills, group therapy can be helpful to practice social skills as well as to learn and discuss ways of avoiding this behavior. Group discussion can also be helpful in exploring what behaviors or activities may put him at risk for further offenses.

### **FETISHISTIC DISORDER**

A fetishistic disorder involves sexual urges and fantasies involving non-human objects, or non-genital body parts. For example, a man may be sexually aroused by women's shoes or underwear, and may seek to get close to those items. These items are then used to stimulate him sexually during masturbation. With this disorder, the man may come to the attention of the criminal justice system after stealing a woman's shoes or underwear which he will later use for sexual arousal to masturbate. Men who are engaged in fetishistic disorders may prefer "used" clothing feeling it brings them closer physically to the woman who once wore the shoes or garment.

Attraction to one body part, such as a woman's feet—is sometimes called “partialism”, and refers to sexual excitement concerning only one part of a woman's body.

By definition, these urges must cause distress or social impairment for the man who suffers from this disorder. (I have been using the male pronoun in this section—because fetishistic disorders occur almost exclusively in men.)

In addition, these fetishes are not limited to articles that can serve to stimulate the genitals (such as vibrators or plastic devices designed to insert into the rectum). Fetishism is also not cross-dressing. While a man may find dressing as the opposite sex entertaining, it is a disorder only when he must do this for sexual gratification.

Treatment for this condition is difficult, and often is not successful. As always, taking a good sexual history including the history of abuse can be helpful in elucidating how this disorder came about in the

individual. An understanding of this can be helpful for the patient. The next step involves understanding what behavior may lead to legal or interpersonal trouble, as well as what steps may lead to behavior involving the fetish. The first step should involve discussion about steps that would limit behavior leading to legal or interpersonal trouble. Seeking a goal of control of the behavior is usually more successful than a goal of eliminating it altogether. Aversive conditioning is sometimes tried in this disorder. This is a behavioral approach where an aversive stimulus or punishment is connected to the sexually arousing object in the hope that the punishment will be remembered and associated with the sexual object. This is not usually successful.

Here again, looking for an underlying psychiatric disorder, such as depression is important since depression is much more readily treatable. At times, the SSRI medications are tried as treatment for this sexual disorder with the hope that the sexual side effects of these medications will decrease the sex drive of the patient. It is hoped the

patient's sex drive will be diminished, making these paraphilic urges easier to control.

### **FROTTEURISTIC DISORDER**

Someone who engages in frotteurism has sexual urges and fantasies of rubbing against a non-consenting person. Patients who do this are almost always male. They seek out crowded places such as subways where they can rub against their target, seemingly by "accident". In such places, as well, escape is easier in case their target becomes upset or calls the police or for help.

Patients who engage in frotteurism usually do not seek treatment voluntarily. Instead, they may come to care after being arrested for lewd behavior, and are mandated for treatment by the legal system.

Here again the hallmarks of treatment are investigation into the person's sexual past, education about proper sexual expression, and a search for associated psychiatric conditions which are more treatable. Again, at times a trial of SSRI's is attempted to decrease the

individual's sex drive. Searching for ways to anticipate the behavior, and therefore control the behavior and its adverse consequences is essential.

### **VOYEURISTIC DISORDER**

A voyeur is someone who obtains sexual pleasure or gratification by observing an unsuspecting person who is naked, disrobing, or involved in sexual activity. Again, by definition, this behavior is not an isolated event, and must be a continuing problem for the patient for at least a six-month period. The behavior must be causing the individual distress, or impairment in social activities.

The frequency of this disorder is not known. Again, few patients voluntarily come to treatment, but may be mandated to get care after arrests for trespassing, or lewd behavior in public.

For this behavior to be a disorder, it must cause the individual distress. The sex industry provides many opportunities for the man interested in seeing women disrobe in striptease shows, "peep shows",

or in pornography. Men who view pornography do not have a disorder, unless the behavior causes significant distress, or impairment in functioning or in their relationships. The pornography or “adult entertainment” industry is huge. So, it can be assumed that some amount of voyeurism via pornography or sex shows is common, but the disorder (i.e. behaviors causing significant impairment) is not.

### **SEXUAL MASOCHISM DISORDER**

Sexual masochism is the act of being humiliated, beaten, tied up, or made to suffer in some way connected with sexual gratification. Associated with this disorder are fantasies involving personal suffering which are sexually stimulating. The person who is aroused in being made to suffer is often linked with someone who has sexual fantasies of making someone suffer, that is a sadist. However, those who suffer from sexual masochism disorder may also simply be involved with someone who is carrying out their requests as a favor to them, but does not get sexual gratification from inducing suffering. This could

occur with someone who is in a relationship with the person, as well as with sex workers may also be hired to carry out specific fantasies the patient may have.

The prevalence of sexual masochism disorder is not known, and it is uncommon for the patient with this disorder to voluntarily come to a psychiatric clinic. Individuals with sexual masochism disorder may present to the emergency room after being injured in some way in a sexual act seeking medical attention. They may come to the emergency room with genital or rectal trauma and a mental health consult may be obtained leading them to care.

Masochistic fantasies may date back to childhood, and often the same fantasy is chronic, leading to the same act or series of acts to be repeated again and again for the patient. The patient may be reenacting a past experience of abuse which continues to dominate their sexual life. They may hire someone to enact the sexual fantasy for the patient. Here again, a good sexual history is paramount to the



understanding of the disorder. Sexual disorders are more common in an individual with a history of sexual abuse, and if the sexual history reveals that the act which is being reenacted is the story of former sexual abuse, it opens the door to a psychotherapeutic approach which may be productive.

The prevalence of sexual masochism disorder is not known. Treatment involves education about sexuality and advice on avoiding injury. It is not clear that psychological understanding of the act decreases the frequency of the act or the psychic or physical risk for the individual.

Hypoxiphilia is an act where the patient deprives himself of oxygen, usually in a hanging, with the belief that less oxygen, or more risk, heightens sexual excitement or heightens the sense of orgasm. In this situation, the individual typically will arrange a hanging situation, and engage in masturbation, with the expectation that the ligature will be released once he achieves orgasm. However, on occasion, the

ligature may remain in place for too long, or may be hard to release, and the individual suffocates and dies. While uncommon, this tragic outcome gains significant attention when it occurs.

## **TRANSVESTIC DISORDER**

Transvestic disorder occurs in a heterosexual male who has recurrent sexually arousing urges and fantasies involving dressing as a woman. Again, by definition, this must involve significant distress or impairment in usual functioning to be considered a disorder.

This must involve sexual gratification, and is not simply a man dressing as a woman as an expression of personal style, as a costume, or in some other expression that does not involve sexual gratification.

This is not transsexualism—where someone believes he or she is actually a person of the opposite sex, and wants to become someone of the opposite sex. Rather, it is an individual, usually a man, who becomes sexually aroused dressing as a woman. He believes he is a man, and continues to want to be a man, but he has sexual urges to

dress like a woman. In this disorder sexual behavior is manifested in cross-dressing as a woman to achieve sexual gratification.

Someone who dresses as a woman, and enjoys being a “drag queen”, presenting himself dramatically in social situations usually does not have distress doing this. Rather, they enjoy the public spectacle or public expression involved in this situation. This may not cause problems for the individual in certain social settings, and therefore is not a disorder.

#### **PEDOPHILIC DISORDER**

Pedophilia is the fantasy or act of sexual contact with a child. The child involved as a victim in this behavior can be any age before reaching adult age, but the child victimized is often before the age of puberty. It is helpful when diagnosing this condition to describe the specific sexual attraction of the child for the patient.

Most patients who suffer from pedophilia are men, although it can occur in women. By definition, someone suffering from pedophilia

must be older than sixteen, and the child who is the target of sexual abuse must be at least five years younger. In other words, if two teens are dating and become sexually involved with each other, it is not pedophilia.

In exploring this disorder, it is helpful to ask about masturbatory fantasies. Asking about what the patient thinks about or fantasizes about during masturbation can be a helpful clue about the type and severity of disorder he has. Also the frequency of thinking about sexual behavior with a child during masturbation can also be helpful. If a man has a fantasy of a young boy all the time when he masturbates—this suggests a more severe disorder than if he only thinks of this sexual scene very occasionally. While both are, of course, a matter of great concern, the degree sexual interest in children can be sometimes gauged by questions about masturbatory fantasy—if the patient is being honest with the therapist. In addition, the presence of child pornography in the patient's home or computer or cloud storage area is a typical and useful sign that an individual is suffering from

pedophilia. Because of this, having a library of child pornography is, in itself, an offense. It should be remembered that a clinician, at least in the United States, is mandated to report any suspicion of child abuse to authorities. This should be done with the full knowledge of the patient. While difficult, the safety of children or potential victims is always paramount and supersedes any burden of confidentiality in the psychotherapeutic relationship.

Pedophilia is a special concern among the paraphilias because the victim or victims are children. Children, who have not yet solidified their personal or sexual identity are not only physically assaulted by these sex acts, but also suffer injury to their self esteem, and sense of identity and sexual identity in this abuse. Children are often selected as victims who may be more confused, socially inept, or troubled. These children may be more unsuspecting of the predator, or may be more grateful for adult support or encouragement. In either case, they may be easier victims for the perpetrator to select. These children who have pre-existing psychological problems or issues are even more at

risk, making these sexual attacks even more disruptive to the child's life. All too common, these sexual attacks are also linked with physical threats, multiplying the injury to the child. The victim may be left with not only the vestiges of the attack, but also the vestiges of confusion about relationships, sexuality, and indeed trust of adults and those in authority.

Unfortunately, pedophilia is all too common. While it is hard to come up with exact numbers, it is thought that about one third of all sexual assault victims are under the age of twelve. And, of course, those who engage in pedophilia are attracted to children, and choose careers or hobbies that involve children. Almost all institutions that serve children, such as the Catholic Church, or Boy Scouts have been rocked by revelations of sexual misconduct of those in roles of authority over children.

Patients with pedophilia often report that they themselves were sexually victimized as children by other pedophiles. Their behavior may

be seen as re-enactment of earlier abuse, but it is not clear that insight oriented psychotherapy exploring these memories or conflicts are at all helpful. In these patients, pedophilia appears to be a lifelong condition. While it may be controlled at times with treatment, or judicial punishment, it is not clear that it usually disappears.

Treatment involves attempts to reduce the sex drive of the perpetrator. Treatment is almost always pursued in centers that specialize in this disorder—both because of the severe nature of the disorder as well as the potential severe consequences to the child victim involved. Treatment is often pursued by using anti-androgen compounds such as Depo-Provera, or at times by surgical castration. Lupron or flutamide which can also decrease testosterone may be tried as well in an attempt to decrease sexual desire.

Individual or group therapy is often attempted as well. Group therapy may be more useful in a group of other individuals who also suffer from pedophilia. Here, group support as well as confrontation of

illegal or damaging behavior is often helpful for the patient to avoid sexual assaults on children.

### **OTHER SEXUAL MISBEHAVIOR**

Clinically, it must be remembered that sexual misbehavior can occur in a variety of clinical situations where the underlying pathology is not necessarily a sexual disorder. Rather, the psychiatric condition may be a wide array of conditions which lead to sexual symptoms as part of the underlying disorder.

For example, mania commonly has hypersexuality as a presenting symptom. While this symptom can cause significant distress to an individual, his or her relationships and life, it is limited to the manic phase of bipolar disorder. The hypersexuality and associated behaviors disappear when the manic phase of the disorder passes, and is not typical of the patient's behavior in general. When the patient becomes euthymic, they are often sad about their behavior that occurred when ill, and work to repair their relationships and lives.



Rarely, those suffering from a psychotic illness, such as schizophrenia may have unusual sexual behavior manifest as part of their delusional system. More often, however, when hypersexuality and hypersexual behavior is a consequence of a major psychiatric disorder, the patient suffers from mania.

Sexual misbehavior may also occur in an individual with brain injury. Patients with dementia can present at times with new sexual aggression or misbehavior, and this can be a particularly disturbing symptom to treat since it may well involve as victims other residents of the nursing home who also suffer from dementia and physical frailty. This makes them particularly vulnerable and the situation especially tragic. Or, the victim of sexual assault may be staff members trying to assist the patient in routine care such as dressing and bathing. The demented individual may misinterpret care from a staff member removing his clothes, or bathing him as a sexual act, and engage in sexual misconduct or sexual assault. If possible, having a staff member

of the same sex care for this patient, or at least having more than one person provide care sometimes is helpful in these situations.

Likewise, sexual misbehavior can occur in those with brain injury as a consequence of the injury to the brain. Typically, frontal lobe injury can be associated with this dramatic lack of insight into behavior, or lack of control of behavior, and can be very distressing for family members and those seeking to provide care for the patient.

Those with intellectual disability may also display sexual behavior that is inappropriate. Public masturbation, or inappropriate sexual advances or even sexual assault may occur because of lack of understanding of the social situation, or lack of personal control of impulses. Here, education and understanding of the situation is a good starting point for correcting the behavior. Behavioral methods trying to corral the behavior are usually attempted before trying medications.

Those with Parkinson's disease, or parkinsonian related medical symptoms may present with agitation or sexual misbehavior. When

this occurs, it is due to the use of dopamine agonist medications. These medications push levels of dopamine in the brain to try to correct parkinsonian symptoms, but in so doing, also increase the risk of agitation, and sexual agitation. (8)

## CHAPTER 5

# LABORATORY EVALUATION OF SEXUAL DISORDERS

As in some other areas of psychiatry, the laboratory evaluation of those with sexual disorders is not typically helpful. While sex hormone levels can be readily measured, sexuality is a complex behavior, with links not only to hormones, but also to emotions, and emotional memories of experiences from the past. Measuring sex hormone levels of testosterone, or follicle stimulating hormone (FSH) and luteinizing hormone (LH) can be readily accomplished through a blood draw. Unfortunately, the results from these tests do not typically lead to clear treatment strategies. Moreover, simply measuring these levels does little to address the emotional connections present in sexual expression or sexual disorders.

In one study of 771 male sex offenders who were followed for up to twenty years, the mean levels of FSH, LH and testosterone were within the normal limits overall. FSH levels and LH levels were better predictors of recidivism of sexual offenses than was testosterone, but because the mean levels were within normal limits overall, measuring these hormones may well have limited usefulness. (9)

More useful is a medication evaluation of each patient. If sexual misbehavior is relatively new, the medication list should be examined for any new medications. For example, the dopamine agonists that are used to treat Parkinson's disease can lead to agitation and sexual misbehavior in a small minority of patients. Unfortunately, most sex offenders are young men, and have never been exposed to these medications.

In evaluating a patient who may be a candidate for hormone mediating medication treatment for a sexual disorder, commonly labs are done as a baseline to monitor any changes in sex hormones which

may result from treatments designed to blunt the effects of testosterone. Often, luteinizing hormone (LH) levels, and testosterone levels are obtained. Medroxyprogesterone can be used to decrease testosterone and hopefully decrease sex drive. CBC, liver function tests, glucose, FSH, LH, testosterone and prolactin levels are usually obtained before this treatment is initiated. In addition, because the medication can affect bone density, a bone scan is often done at the initiation of treatment. Blood pressure and weight should be monitored throughout treatment with medroxyprogesterone in men. If the patient continues in treatment, follow up measures of testosterone, FSH, LH should be done every four to six months to continue to monitor these hormonal levels in men in treatment.

In older men, prostate specific antigen (PSA) is obtained at times in case the older man may also have prostate disease—which may be affected by the different antiandrogen compounds.

## CHAPTER 6

# TREATMENT OF SEX OFFENDERS

Medication treatment of sexual offenses is quite limited. No drug is approved by the FDA for this use. The medications used are given to patients in the hope that their sexual drive and appetite for sexual offenses will be decreased. Medications are given coupled with individual or group therapy with the hope that if sexual drive is diminished, then lessons learned in group or individual therapy can be more readily applied. The medications used for sex offenders fall into two categories—the SSRI's (specific serotonin reuptake inhibitors, very often used as antidepressant medications), and the antiandrogen agents.

SSRI medications often have sexual side effects. Close to half of the time, men who use these medications for treatment of depression will experience erectile dysfunction or decreased interest in sex. So, at

times, SSRI medications such as paroxetine are given with the hope that the man who receives them will get this side effect which would lead to decreased sexual drive, or problems getting an erection. (10) The success rate for this treatment is not what would be hoped for in this difficult population.

More commonly, medroxyprogesterone acetate is given to men who are sex offenders who desire medication treatment for the disorder. This medication inhibits pituitary gonadotropin release, which then decreases testosterone levels. (11) But, patients should be monitored for testosterone levels, as well for bone density loss. They should also be aware of the increased risk of deep venous thrombosis with the use of these medications, especially in older, less active men.

Medroxyprogesterone acetate is available both as pills and as depot injections which are given weekly through intramuscular injection. For men who are in treatment for sexual disorders,



treatment is typically through intramuscular injection to avoid problems in compliance.

There are other medications which can reduce testosterone levels. Leuprolide and flutamide are used in the treatment of prostate cancer, and these medications have been used at times as well to reduce testosterone levels in men who sexually misbehave. Leuprolide can also be given as an intramuscular injection monthly. Because with the initiation of leuprolide treatment, testosterone levels can transiently increase, flutamide (an oral pill) is sometimes given in the first few days of treatment to cover the patient's testosterone level if the patient is not in a controlled environment such as a hospital.

The use of medroxyprogesterone or other medications is usually done by practitioners or clinics with experience with the treatment of sex offenders. Because this group can be difficult to manage, and because selecting the right treatment for the right

patient is so important in patients referred because of sexual assault, experts are best in managing the population.

Medications should not be given in isolation, without other forms of education and psychotherapy, however. Treatment programs involve heavy doses of both education and group or individual therapy.

Because sex offenders were often sexually abused themselves as children, and because they have often been wrestling with deviant sexual urges for some time, the first step of interpersonal psychotherapy treatment involves education about sexuality and relationships. In addition, discussion of the abnormal sexual act, and its consequences for the victim of the sexual assault should be presented along with the legal consequences for the patient. Not only denial, but heavy amounts of misunderstanding can sometimes be a barrier for the patient to initiate treatment, and education about the abnormal sexual act, as well as how it affects the victim need to be clearly discussed.

Supportive psychotherapy is often used individually to explore strengths of the individual, and how these strengths can be used to help the patient avoid further offenses, and better use their personal strengths to build a better life. Assertiveness training can sometimes be helpful to enable a patient to better express anger or personal concerns in social situations. Aggression can be expressed through sexual acts, and giving the sex offender education about other options to express this emotion can sometimes be helpful.

Because some individuals sexually offend at times of stress in their lives, an exploration of what may be stressful for them, as well as avenues to better manage this stress can sometimes be helpful. The growing success and popularity of cognitive behavioral therapy is being applied to sex offenders, and at times meets with some success.

Aversive conditioning has been tried as well to link the sexual act or offense to negative outcomes. Getting individuals to continue in

treatment using aversive conditioning is always difficult, and outcomes are not typically hopeful.

Group therapy is often very helpful to allow a patient the chance to discuss problems with others who have experienced abnormal sexual urges, as well as resultant legal problems. Group support can also be helpful to help a patient maintain problem free behavior.

Unfortunately, little data is available on the success rates of any of these treatments. While each treatment has face value, the effectiveness of any treatment varies widely with the population of patients selected for treatment, the experience of the practitioners involved, and the specific combination of any individual treatment for the individual. Reviews of treatment generally show few randomized trials, and of those few that exist, almost none show clear promise.

(14)

Still, these individuals continue to present to the criminal justice system and the criminal justice system often turns to mental health authorities with the hope that treatment will work better than incarceration. While a small number present with major mental illness that can be treated, the large majority present with ongoing personal issues. The hope is that psychological or medical treatment or both would be useful. While it can be stated that psychological reflection provides help for the individual, whether that leads to a reduction in offenses is unclear. Clearly, better treatment trials, and more research are needed to assist this difficult group of patients.

## CHAPTER 7

# GENDER DYSPHORIA

Gender dysphoria is the disagreement an individual has with their gender they have carried since birth and the gender they feel they should be, or really are. These individuals feel that even though they have been born as a male or female, that actually they are the opposite gender. They feel that they actually are the opposite gender and should be treated as though they were the opposite gender. To further achieve this goal, they appear both in dress and in physical appearance as the opposite gender. In this condition, men feel they are women, and should become physically women to match this feeling, and women who feel they are really men want to become men as well with the physical genitalia and secondary sexual characteristics of men.

DSM V changed the term for this condition from “Gender Identity Disorder” to “Gender Dysphoria.” Still, the condition continues to have a significant amount of stigma and discussion surrounding it. Advocates for those who believe that an individual has the right to feel sexually in any way which makes them comfortable and indeed to become that sex, believe that calling the condition a “disorder” is an affront. On the other hand, if this is a life choice and not a disorder, then there is no reason for any insurance or health care plan to cover care for it—whether that be for psychotherapy, hormone treatment, or surgery to remove the genitalia of one sex, and replace it with approximations of the genitalia of the opposite sex.

In any case, those who have the condition strongly believe that their body betrays them. They feel that they are indeed the opposite sex, and should be treated as the opposite sex, and should indeed look like the opposite sex. They say that they have always felt uncomfortable with their assigned sex, and even as children desired to be the opposite sex. As children, they report, they typically would want

to play the role of the opposite gender in play, and preferred toys typically assigned to the other gender. They also report a dislike of their own anatomy, and would feel more comfortable with the anatomy of the opposite sex. This discomfort continued into adolescence and into adult sex roles, and they feel that if they could be the opposite sex that they would be more comfortable and more personally fulfilled.

The frequency of the disorder is not clearly known since many with the condition do not come forward, but estimates of frequency are less than one adult for every 50,000 individuals. Some reports show that it seems to be more common in males.

The etiology of the condition is also not clear. Those with the disorder firmly believe that they truly are in the wrong body, and wonder if they had different levels of hormones in early life or different intrauterine hormonal levels leading to this outcome. There are some suggestions that those with the disorder have different



hormone levels, or different response to testosterone, or at least different response to the hormones in the brain.

Some psychotherapists who work with these individuals wonder if the condition may be an extreme of those who feel uncomfortable with themselves and their identity. Those with gender dysphoria, some therapists believe, simply are uncomfortable with their self-concept and want a different physical presence to confirm this belief.

Another, more analytic view held by some psychotherapists, is the notion that some individuals who have gender dysphoria are “self stigmatized homosexuals”. In other words, these are individuals who are attracted sexually to members of the same sex, but cannot bring themselves to believe that they are homosexual. Instead, they feel that if they are attracted to the same sex, then they must truly be the opposite sex. These individuals that fit this pattern best come from very conservative, very religious backgrounds where homosexuality is

viewed as being bad or sinful. They are “self stigmatized” believing that they should not or cannot be gay. If they are attracted to the same sex, then, they must be the opposite sex, and seek to prove that by taking on the physical attributes of the opposite sex. As in other psychoanalytic ideas, this is a theory, with little data supporting it. But, some clinicians find it to be a helpful organizing theory.

A separate syndrome involves cases of adrenogenital syndrome where a baby is born with very high levels of 17-hydroxyprogesterone, a sex hormone. This condition is due to a deficiency of 21 hydroxylase, which breaks down 17 hydroxyprogesterone. Screening tests in neonates are now readily available to identify this condition. Girls with the disorder can be born with clitoral enlargement, and some fusion of the labial folds making the genitalia appear male-like, or at least they may present as infants with ambiguous genitalia. Infant boys may present with an enlarged penis or scrotal hyperpigmentation. These individuals as infants may also present with low levels of sodium and high levels of potassium,

which can present as a medical crisis. This is a disorder of the adrenal glands, and presents in about one in every 15000 babies. (13) This uncommon condition should not be confused with gender dysphoria.

Those individuals with transvestic disorder who derive sexual satisfaction from dressing as a member of the opposite sex, really have no question about their gender. These individuals are not suffering from gender dysphoria. Likewise, those who choose not to follow culturally defined gender roles also, of course, do not have gender dysphoria as well. Very rarely, an individual could have the delusion that they are the opposite sex as part of schizophrenia, but this is very uncommon.

The treatment of gender dysphoria proceeds in a variety of steps.

In the first step of treatment, the individual has a psychiatric assessment where not only is the diagnosis clarified, but the individual

also is evaluated for the presence of other psychiatric conditions to fully evaluate the differential diagnosis of the condition.

Next, the individual begins to live in the desired sex role, dressing as the individual would as the opposite sex. Their families are informed of their decision to seek sex reassignment, and the individual investigates changing names to one of the opposite sex.

Psychotherapy is required during this period to review progress in stability of one's identity in the opposite sex role as well as to continue to monitor overall health.

Next, hormone treatments are given—to feminize men, and to masculinize women. The medical consequences of these treatments with the side effects implied in all of these treatments must be discussed with the patient in ongoing therapy. They must also be followed by internists and endocrinologists familiar with the disorder and condition. In general, the longer an individual is followed in psychotherapy and with hormonal treatments, the better they do. But,

at least a year of hormone treatment is generally required before an individual undergoes surgery to replace their original genitalia with the genitalia approximating those of the opposite sex.

In surgery for the condition, the genitalia of the opposite sex are fashioned in the pelvis for the individual, and the individual is followed both medically and psychiatrically. Surgery is not always readily available, and payment for the surgery is also not always available through insurance plans as well. But, after the surgery, the individual lives as a person in the opposite sex role both psychologically, as well as physically.

Following surgery, an individual may want to continue in psychotherapy for a time to continue to assess their sex roles and identity of an individual of the opposite sex. Many personal and interpersonal issues continue to occur for the individual during this period immediately after sex reassignment surgery. Having the

opportunity to review these issues with an understanding therapist  
can indeed be helpful.

## CHAPTER 8

# CONCLUSIONS

This brief discussion of sexual disorders is simply a beginning exploration of the topic. Many papers and books are available on sexuality and sexual disorders and if this brief treatise causes further exploration of the topic, then it has been a success.

The goal for a therapist who does not specialize in the topic of sexual disorders is to be familiar enough with the topic to treat those with the disorder described with understanding and empathy. The ability to take a good sexual history is essential in the overall practice of any mental health practitioner, and at least passing knowledge of the sexual disorders, such as with the information presented here can be helpful to understand and identify problems, at least enough to discuss them with your patients and refer the patient for further care.

Sexual functioning and sexual disorders are common issues in mental health practice. Being comfortable discussing these issues with your patients is essential for a complete assessment and treatment of your patients. Being able to take a good sexual history, and recognize sexual disorders is essential. An understanding of the terrible consequences sexual abuse can have in an individual is also essential and basic to the mental health care of your patients.

If I have encouraged you to discover more about the topic, and be more aware of sexual issues in your patients, then I have succeeded in my goal. If you are motivated to read more, and become more proficient in identifying and treating these disorders, then you will be more proficient in your goal of becoming a more complete mental health practitioner.



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Paul Kettl, MD is a Clinical Professor of Psychiatry at the Perelman School of Medicine of the University of Pennsylvania. This book is derived from lectures on the topic given to the Penn psychiatry residents, and he is indebted to them for their intellectual curiosity, and wonderful questions over the years. Dr. Kettl is also education director for behavioral health at the Philadelphia VA Medical Center.

An exploration of psychotherapy with an individual who has been sexually abused is explored in Dr. Kettl's fictional novel, *The President's Secret*, which is available on Amazon. This novel explores the role the experience of sexual abuse can have in a successful woman, and how psychotherapy can be helpful to explore and resolve the subject.