Sexual Disorders

Last updated: April 24, 2019

EXAMINATION

1

Assessment of sexual functioning by physician should be routine part of complete medical evaluation (but often is not done because of anxiety or discomfort on part of physician).

1. media attention to sexual abuse by trusted care givers may cause some physicians to fear that questions about sex will be perceived by patient

1. only 10% of patients initiate discussion of sexual functioning, but 50% will discuss it if asked.

1. history is taken from both partners, interviewed separately as well as together.

1. method that uses chronology of sexuality throughout life cycle is less threatening to patient (provides better understanding of sexual functioning, implies that sexuality is natural function).

1. open-ended questions prefaced by educational comments are effective in encouraging patient. e.g. physicians could say, “Most well-adjusted people expect to have some experience with sexual interaction in their lives. Could you tell me some of your own experience with this?”

1. In case of organic disorders, ask patient “Many patients experience changes in sexual functioning as result of this problem. How has it affected you?”

1. accepted norms of sexual behavior & attitudes vary greatly within and among different cultures - health professionals should never be judgmental of sexual behaviors; accepted norms of sexual behavior & attitudes are influenced greatly by parenthood.

1. What is normal and abnormal cannot be defined by health professionals! If sexual behavior / difficulties bother patient or patient’s partner or cause harm, then treatment is warranted.

1. key questions

(a) first childhood awareness of sexuality (incl. attitudes and punishment)

(b) problems with gender identity

(c) first sexual experience (incl. masturbation)

(d) age of and reaction to puberty (incl. menarche in women)

(e) history of sexual abuse

(f) patient knowledge about sex and how knowledge was acquired

(g) first experience with sexual partner (incl. intercourse)

(h) homossexual, sadomasochistic, and other experiences and interests

SEXUAL DISFUNCTION

General Treatment

1

1. Inhibited female orgasm

1. Inhibited male orgasm

1. Premature ejaculation

1. Sexual perversion

1. Dyspareunia

1. Vaginismus

SUBSTANCE-INDUCED SEXUAL DYSFUNCTION

Alcohol

6

Drug abuse

6

Prescription drugs

6

Exhibitionism

6

Fetishism

6

Voyeurism

6

Prostitution

6

Sexual masochism

7

Sexual sadism

7

Paraphilia not otherwise specified

7

Etiology

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Diagnosis

Treatment

7

7

Prognosis

7

GENDER IDENTITY DISORDERS

Etiology

7

Treatment

8

PREMENSTRUAL SYNGYRIC DISORDER (DSM-IV), PREMENSTRUAL SYNDROME (PMS), LATE LUTEAL PHASE DYSFUNCTION (DSM-III-R)

COITUS (SEXUAL RESPONSE) physiology & anatomy → see p. 2533-2533a >> DEVELOPMENTAL ASPECTS of sexual behavior → see p. A199 >> PSYCHOSEXUAL ASPECTS of sexual behavior → see p. P171 >>

SEXUAL IDENTITY - biologic sexual characteristics (genitalia, hormonal composition, secondary sexual characteristics).

GENDER IDENTITY - subjective psychological sense of being masculine or feminine (“I am male” or “I am female”); set at age ≈ 3 yrs (end of toddler years - children become aware of anatomic differences between sexes).

GENDER ROLE - objective social behavior that allows others to categorize person as male or female; largely determined during preschool period (3-6 yrs of age).

SEXUAL ORIENTATION - erotic attraction felt toward persons or objects of particular type.

→ social groups may be formed based on sexual orientation (e.g. homosexuals, sadomasochists).

LIBIDO - conscious component of sexual function.

• changes in gender role, relationships, and expressed sexual orientation may occur throughout life cycle!
HOMOSEXUALITY, that occurs in all children (can develop before age of 1 year).

- Organic causes probably apply equally to heterosexual and same-sex homosexuals. The most important organic causes include:
  - Psychological factors: anxiety, depression, and stress.
  - Neurological factors: brain damage, lesions in specific brain areas.
  - Hormonal factors: abnormal levels of sex hormones (e.g., testosterone, estrogen).
  - Genetic factors: familial history of homosexuality.

- Social factors: family environment, peer pressure, cultural attitudes.

- Psychological factors: low self-esteem, feelings of rejection, internalized homophobia.

- Biological factors: brain structure, neurotransmitter levels, hormone levels.

- Environmental factors: upbringing, socialization, peer influences.

The development of homosexuality is thought to be influenced by a combination of genetic, hormonal, and environmental factors. The exact role of each factor is not fully understood, but studies suggest that a combination of these factors plays a role in the development of homosexuality.

SEXUAL DYSFUNCTION

- Sexual dysfunction refers to problems with the ability to achieve or maintain sexual function. It can be caused by medical, psychological, or physical factors.

- Medical conditions: Infections (e.g., HIV, hepatitis C), cardiovascular disease, diabetes, depression, anemia, and thyroid disorders can all affect sexual function.

- Psychological factors: Stress, anxiety, depression, low self-esteem, and relationship problems can affect sexual function.

- Physical factors: Age, medications (e.g., antidepressants, blood pressure medications), and certain medical conditions (e.g., diabetes, cardiovascular disease).

- Treatment options for sexual dysfunction include medication, behavioral therapy, and counseling. In some cases, surgery may be necessary.

- It is important to discuss sexual dysfunction with a healthcare provider to determine the underlying cause and to receive appropriate treatment.

SEXUAL ABUSE

- Sexual abuse refers to any sexual activity that is forced or performed on a person without their consent. It can occur at any age and can have serious long-term effects on a person's mental and emotional health.

- There are many different types of sexual abuse, including abuse by family members, acquaintances, or strangers.

- The effects of sexual abuse can be immediate or long-term and may include physical injuries, emotional trauma, and psychological distress.

- It is important to seek help if you or someone you know has experienced sexual abuse. There are resources available to provide support and assistance.

SEXUAL ORIENTATION

- Sexual orientation refers to a person's sexual attraction, whether to people of the same gender, opposite gender, or both.

- Sexual orientation can be determined by various factors, including genetics, hormones, and environmental influences.

- There is no one cause for sexual orientation, and it is not something that can be changed.

- Sexual orientation is a normal and natural part of human diversity.

- It is important to recognize and respect the sexual orientations of all individuals, regardless of their gender or cultural background.
disorders is diagnosed only when symptoms cause distress or interpersonal difficulty (most patients complain of anxiety, guilt, shame, frustration, and many develop physical symptoms).

some women may not be distressed or bothered.

although dysfunctions usually occur during sexual activity with partner, inquiry about function during masturbation is useful (if it is unfulfilled, cause may be interpersonal factors!).

Classified according to phase of sexual response cycle. see p. 2533a >>

• **MALE sexual dysfunction is problem with 1 of 4 main components:**
  - Libido
  - Erection
  - Ejaculation
  - Orgasm

• **FEMALE sexual response cycle is strongly influenced by quality of relationship with her partner (emotional intimacy is normal requirement for female sexual response)**.

almost all women with sexual dysfunction have features of more than one disorder.

• **women need to remind their partner of their need for nonphallic, physical nongenital, and nonintercourse genital stimulation**

### GENERAL TREATMENT

Before work of Masters and Johnson in 1970s, sexual dysfunction was regarded primarily as symptom of underlying individual psychopathology. Currently, sexual problem, although understood as being frequently related to deep-seated psychological (considered autonomous symptoms) may respond well to intervention that addresses problem directly.

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- **treat physical disorders** (e. g. medications that may increase or decrease sexual response, injectable vasoactive substances that produce erection, surgical prosthetic devices that simulate erection).
- **patient with lifelong disorder should be referred to psychiatrist**.
- **when psychologic factors predominate, counseling to remove causes helps; usually both partners should attend, individual, couple or group** (psychosurgery is sometimes useful).
- **flexible, short-term approach is favored!**
  - there is assumption that both members of couple are responsible for their sexual relationship!
  - to combat myths that may interfere with realistic understanding of relevant problems, couples are given information about basic physiology and psychology of sexual functioning.

Educational technique may be among most effective available treatments! Woman should understand function of her sexual organs and her responses (incl. best methods of stimulating clitoris and enhancing vaginal sensations).

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**Some patients may note that most women cannot have orgasm without some clinical stimulation**. In some women, sexual positions that pull down on labia minora can cause the clitoris to be stimulated, indirect stimulation of clitoris; woman is encouraged to talk about activities that the female stimulates.

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**Masters and Johnson 3-stage sensate focus exercises** (type of behavioral therapy; e. g. treatment for disorders that affect excitement phase) - helps couple become more aware of their sensory responsiveness; exercises begin with nongenital stimulation and lead stepwise to genital stimulation →→→ no mandemaning cottus; couple is encouraged to understand and express awareness of basic sensations of touch, smell, and hearing during exercises.

> for men with erectile dysfunction, prohibitions of intercourse during women's focus sessions removes anxiety and allows patient feeling of success in enjoying sexual.

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**most physicians use combined educational and behavioral technique** - P.LI-SS-IT model:

- **Permisson** (P) - physician's relaxed manner and interest facilitates discussion of sexual concerns; physician's authority contributes to approach effectiveness.
- **Limited information** (LI) - many cases of sexual dysfunction result from lack of information or misinformation about sex.
- **Specific suggestions** (SS) - couple is taught self-awareness exercises.

Intensive therapy (IT) - for patients who do not respond to basic therapy described above (therefore, associated psychopathologic - psychotherapy).

* Kegel's exercises strengthen voluntary control of pubococcygeus muscle - muscle is contracted 10-15 times (in 2-3 ms, perivaginal muscle tone improves, as does woman's sense of control and enjoyment of sexual).

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**Disorders affecting APPETITIVE PHASE**

### HYPOTHALAMIC SEXUAL DESIRE DISORDER

- (relative or absolute) lack of desire and fantasy regarding sexual activity. i.e. decreased libido greater than what might be expected based on age, life circumstances, and relationship duration.

Sexual anhedonia (decreased or absent pleasure in sexual activity) is not official diagnosis, is under hypothalamic sexual desire disorder - because lack of pleasure almost always results in loss of desire (although loss of desire may occur first).

causes infrequent sexual activity → marked distress or interpersonal difficulties (e. g. serious marital conflict).

some patients have sexual encounters fairly often to please their partners and may have no difficulty with performance but continue to have sexual apathy.

* prevalence - 20% women (most common type of sexual dysfunction in women?!), 10% men.

Female sexual desire lessen with age but increases with new partner at any age.

*relative lack of partners, untreated physiologic changes (e.g. atrophy of vaginal mucosa → dryness and painful coitus).

Biology (most commonly cause global deficiency of desire):
sexual desire is complex psychosomatic process based on brain activity (“generator” running in theistic cyclic fashion), poorly defined hormonal milieu, and cognitive scripting that includes sexual aspiration and motivation.

- desynchronization of these components results in hypoactive sexual desire disorder.
- sexual desire is sensitive to testosterone levels, general nutrition, health, and drugs.

1) hypogonadism (testosterone < 300 ng/dL in male and < 10 ng/dL in female) are considered potential causes.

- H. M (testosterone)

N.B. testosterone alone is not sufficient (correcting low levels may not correct generalized hypoactive sexual desire disorder)

2) general physical illness (e.g. anemia, terminal illness, endocrinopathies)

3) side effects of medications:
- weak androgen receptors antagonists (spironolactone, cimetidine)
- virtually all drugs that are active in CNS (both increase and decrease in libido have been reported with psychoactive agents):

- benzo diazepines can decrease libido, but in some patients, diminution of anxiety caused by these drugs enhances sexual function.

- between antidepressants, SSRIs contribute most to sexual dysfunction!

4) major depression, panic disorder, somatization disorder, marital difficulties (may include sexual satiation outside of marriage).

5) boredom or unhappiness in long-standing relationship (sexual desire may be normal or even intense with others - situational form).

6) traumatic events in childhood or adolescence.

7) secondary to impaired arousal or orgasm phases.

8) GASTRICA-CIRRHOSIS syndrome (interstitial syndrome in terminal lobe epilepsy) - hyposexuality associated with hypergraphia, hyper-elexigiosity, irritability, and elation; patients may also demonstrate “viscosity” (stickness of thought processes and interpersonal adhesiveness, and circumstantiality - difficulty in terminating conversations).

SEXUAL AVERSION DISORDER
- extreme avoidance of sexual activity (rather than simple lack of desire), i.e. genital sexual contact with partner.

- females > males.

- associated with anxiety, fear, disgust in sexual situations - causes marked distress or interpersonal difficulty.

- related to phobia (may be associated with actual panic attacks).

- patient may have history of sexual trauma (incest, sexual abuse, rape).

- may stem from initial attempts at intercourse that resulted in moderate to severe dyspareunia (even after dyspareunia disappeared, painful memories may persist).

- may occur in persons who attempt to or are expected to have sexual relations incongruent with their sexual orientation.

- treatment - psychotherapy (behavioral, psychodynamic, marital).

Disorders affecting EXCITEMENT (AROUSAL) PHASE

MALE ERECTILE DISORDER (IMPOTENCE)

- weep 2594 >>

N.B. delay in attaining erection and decreased fullness of erection are normal with aging and do not lead to impotence!

FEMALE SEXUAL AROUSAL DISORDER
- impaired secretion of lubricant fluid and impaired swelling of vaginal tissues during sexual activity.

- often not well understood as male erectile disorder.

- intercourse is painful; although sexual desire is preserved (patient avoids sex due to dyspareunia) - sexual arousal disorder almost invariably leads to ORGANIC DISORDER.

- patient usually complains of lack of orgasm, although some women say, “I don’t get turned on.”

Etiology:

1) deficiency of estrogen (in menopause)

N.B. both estrogens and androgens influence arousal!

2) ignorance of genital anatomy and function (particularly clitoral function)

3) often decreased sexual desire precedes decreased sexual arousal (hypoactive sexual desire disorder is primary diagnosis here!)

4) localized disorders (e.g. endometriosis, cystitis, vaginitis), systemic disorders (e.g. hypothyroidism, diabetes mellitus), nervous disorders (e.g. MS), muscular disorders (e.g. muscular dystrophy), drugs (e.g. oral contraceptives, antihypertensives, antidepressants), ablative surgery which negatively affects woman’s sexual self-image (e.g. hysterectomy, mastectomy).

Classification:

SUBJECTIVE SEXUAL AROUSAL DISORDER - subjective arousal in response to any type of sexual stimulation (e.g. kissing, dancing, watching erotic video, genital stimulation) is absent, but genital arousal (genital constrictions) is normal.

COMBINED SEXUAL AROUSAL DISORDER - subjective arousal in response to any type of sexual stimulation is absent, and women report absent physical genital arousal.

GENITAL AROUSAL DISORDER - subjective arousal in response to nongenital stimulation (e.g. erotic video) is normal, but subjective arousal, genital arousal, and sexual sensations in response to genital stimulation (including intercourse) are absent; typically affects postmenopausal women (often described as “genital deadness”).

H. local estrogens for refractory cases - try phosphodiesterase inhibitors: investigational therapy - 0.2 mL topical 2% TESTOSTERONE applied to clitoris.

Disorders affecting ORGASMIC PHASE

INHIBITED FEMALE ORGASM

- diagnosed only when there is no difficulty with arousal (excitement).

- must severe form - absolute inability to have orgasm (10% women never attain orgasm!)

- milder form - dissatisfaction with need for adjunctive clitoral stimulation during coitus to attain orgasm.

- most women attain orgasm with clitoral stimulation, but only 50% women regularly attain orgasm during coitus.

- psychological and biologic factors may be responsible (usually linked to difficulty in developing sufficient arousal).

- lovemaking that consistently ends before aroused woman reaches climax (e.g. due to inadequate foreplay, ignorance of clitoral/vaginal anatomy and function, premature ejaculation) may result in dyspareunia or even sexual aversion.

- depression is leading cause of Decreased sexual arousal and orgasm.

- treatment - encourage self-stimulation (e.g. place vibrator on mons close to clitoris), phosphodiesterase inhibitors may be tried for acquired disorder with autonomic nerve damage.
DISORDERS OF SEXUAL ORGAN function and dysfunction usually result from psychological, neurobiological, medical, or pharmacologic factors. While the majority of men experience some degree of sexual dysfunction at some time during their lives, women report sexual dysfunction less frequently. Despite this, sexual dysfunction in women is significant in that the etiologies are different from those of men.

DEFINITION

Sexual dysfunction is defined as a persistent physical or psychological problem that affects participation in sexual activity. It is important to determine whether the patient’s sexual desire is consistent with their gender in all situations. A sexual dysfunction diagnosis cannot be made based on a single episode of an inability to perform a specific sexual function. A diagnosis should only be given if the patient is interested in reinitiating sexual function.

SEXUAL FUNCTION

Sexual function is measured both by subjective report and by objective behavioral and physiological assessments. The most common measure is the International Index of Erectile Function (IIEF), which consists of five sections: erectile function, orgasmic function, sexual desire, sexual satisfaction, and overall sexual experience.

CAUSATION

The etiology of sexual dysfunction is multifactorial. Lifestyle factors, medical conditions, and psychological factors all contribute to the development of sexual dysfunction. The following sections discuss the etiology of sexual dysfunction and its management.

Lifestyle Factors

Lifestyle factors such as smoking, alcohol abuse, and drug use can all contribute to sexual dysfunction. These factors can lead to decreased sexual interest, decreased sexual desire, and decreased erectile function.

Medical Conditions

Medical conditions such as diabetes, hypertension, and cardiovascular disease can all contribute to sexual dysfunction. These conditions can lead to decreased sexual interest, decreased sexual desire, and decreased erectile function.

Psychological Factors

Psychological factors such as depression, anxiety, and stress can all contribute to sexual dysfunction. These factors can lead to decreased sexual interest, decreased sexual desire, and decreased erectile function.

SEXUAL DYSFUNCTIONS

Erectile Dysfunction

Erectile dysfunction is the most common sexual dysfunction in men. It is characterized by the inability to achieve or maintain an erection sufficient for sexual intercourse. The etiology of erectile dysfunction is multifactorial, with lifestyle factors, medical conditions, and psychological factors all contributing to its development.

Vaginismus

Vaginismus is a condition characterized by involuntary spasm of the muscles surrounding the vaginal opening. It is characterized by fear of penetration and can result in a lack of interest in sexual activity.

Sexual Pain Disorders

Sexual pain disorders are a group of conditions that cause pain during or after sexual activity. These conditions can range from mild discomfort to severe pain and can be caused by a variety of factors, including medical, psychological, and behavioral factors.

SEXUAL DISORDERS

DEFINITION

Sexual disorders are a group of conditions that affect a person’s ability to engage in sexual activity or participate in sexual relationships. These disorders can be caused by a variety of factors, including medical, psychological, and behavioral factors.

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SEXUAL DYSFUNCTION DUE TO GENERAL MEDICAL CONDITION

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Sexual dysfunction due to general medical condition is a group of conditions that affect a person’s ability to engage in sexual activity or participate in sexual relationships. These conditions can be caused by a variety of factors, including medical, psychological, and behavioral factors.
3. Vascular disease may be a primary factor contributing to sexual dysfunction that occurs with aging.

SUBSTANCE-INDUCED SEXUAL DYSFUNCTION
- sexual dysfunction fully explained by substance use (during or within month of substance intoxication).
  - any phase of sexual response cycle, except resolution, may be impaired.

ALCOHOL
- minor amounts enhance sexual desire by decreasing inhibitions.
- moderate amounts cause significant dysfunction in both men and women.
  - alcohol is CNS depressant (⇒ erectile dysfunction, orgasmic disorders that resolve when patient is not intoxicated).
  - diseases related to alcoholism (e.g. hypertension, cirrhosis, neuropathy, testicular atrophy).
- psychological disorders exacerbated by alcohol abuse.
- chronic alcohol abuse causes irreversible sexual dysfunction in some individuals:
  - men - inhibited desire, dyspareunia, orgasmic dysfunction.
  - women - inhibited desire, erecticle dysfunction, delayed orgasm or ejaculation.

DISEASES OF ABUSE
- often used initially to enhance sexuality.
- marijuana cannabis - decreases libido, impaired potency, decreased plasma testosterone levels, sperm count, and sperm motility.
- cocaine / amphetamines increase physical performance initially; chronic use (depletion of CNS dopamine stores) decreases sexual functioning and interest.
- narcotic addiction causes nonspecific erections and impotence in men and amenorrhea, infertility, reduced libido, and spontaneous abortions in women.
- barbiturates lower sexual inhibition; larger doses depress sexual performance.

PRESCRIPTION DRUGS
- antidepressants e.g. bupropion.
- antihistamines because of anticholinergic effects.
- neuroleptics ⇒ decrease sexual desire, erectile dysfunction, retarded ejaculation.
- sedative-hypnotics in small doses improve sexual functioning in anxious individuals; chronic use causes impaired performance (sexual benzodiazepines interfere with ejaculation).
- antianxiogenic drugs e.g. diazepam, chlordiazepoxide.
  - oral estrogen and oral contraceptives increase sex hormone-binding globulin (SHBG), decreasing amount of free androgen available for tissue receptor binding.

PARAPHILIAS
- recurrent, intense, sexually arousing behavior / urges / fantasies characterized by:
  a) preference for nonhuman objects (fetishism, zoophilia).
  b) activities that involve suffering or humiliation (sexual sadism, sexual masochism).
  c) sexual activity with nonconsenting partners (pedophilia, voyeurism, frotteurism, exhibitionism).

  - cause clinically significant distress or impairment functioning (in social, occupational, or other important areas).
  - often become obligatory for sexual functioning (i.e. erection or orgasm cannot occur without stimulus).
  - according to DSM-IV, diagnosis requires at least 6-month duration of either repetitive behaviors or significant distress associated with deviant sexual fantasies.
  - almost always occur in males.
  - most common are pedophilia, voyeurism, and exhibitionism.
  - only small subset break law and become sex offenders.

EXHIBITIONISM
- exposure of genitals to unsuspecting stranger, may also refer to strong desire to be observed by others during sexual activity.
  - exhibitionist may masturbate while exposing himself.
  - victim is almost always female adult or child of either sex.
  - age at onset - mid 20s (occasionally, first act occurs during preadolescence or middle age).
  - 30% apprehended male sex offenders are exhibitionists.
  - highest recidivism rate of all sex offenders (20-30% are re-arrested).
  - most exhibitionists are married, but marriage is often troubled by poor social and sexual adjustment.
  - very few females are diagnosed as exhibitionists, although society sanctions some exhibitionistic behaviors in females (through media and entertainment venues).

Variant - strong desire to have consenting audience watch their sexual acts.
- such people may make pornographic films or become adult entertainers.

FETISHISM
- use of nonliving / inanimate objects (e.g. female undergarments).
- in common parlance, used to describe particular sexual interests (such as sexual role-playing).
- preference for certain physical characteristics, and preferred sexual activities.
- minor fetishes, such as shoes, clothing, or objects (e.g. female undergarment or dress).
- major fetishes, such as human body parts (e.g. scalp, toe).  

Transvestic fetishism - cross-dressing of heterosexual male; behavior begins in late childhood.
- when partners are cooperative, these men have intercourse in private or full feminine attire.

Transvestic fetishism with gender dysphoria - if man has persistent discomfort with gender role or identity.

VOYEURISM
- observing unsuspecting person who is naked, in process of undressing, or engaging in sexual activity.
- desire to watch others in sexual situations is common and not in itself abnormal; when pathologic, voyeurists spend considerable time seeking out viewing opportunities.
- orgasm is usually achieved by masturbating during or after voyeuristic activity.
- voyeur does not seek sexual contact.

FROMITURISM
touching and rubbing against nonconsenting person.

**PEDOPHILIA** - sexual activity with prepubertal children (generally < 13 years of age).
- pedophile is at least 16 years of age and at least 5 years older than child.
- **treatment**: - exclusive (attracted only to children); nonexclusive: 
  - **behaviors**:
    1. sexually attracted to females only
    2. sexually attracted to males only
    3. sexually attracted to both sexes
    4. limited to incest
- pedophiles prefer opposite-sex to same-sex children 2:1.
- looking or touching seems more prevalent than genital contact.
- often leads to imprisonment.
- **treatment**: - antiandrogens.

**SEXUAL MASOCHISM** - intentional participation in activity (real, not simulated) in which one is humiliated, beaten, bound, or otherwise abused.
- masochistic fantasies / behavior between consenting adults is very common - humiliation and bearing are simply acted out in fantasy, with participants knowing that it is game and carefully avoiding actual humiliation or injury.
- real masochists increase severity of their activity with time → serious injury or death.
- patient may act on their masochistic fantasies themselves (e.g. binding themselves, piercing their skin, applying electrical shocks, burning themselves) or seek out sadist partner.
- activities with partner include: bondage, blindfolding, spanking, flagellation, humiliation by means of urination or defecation on person, forced cross-dressing, or simulated rape.

**SEXUAL SATISFACTION** - acts (real, not simulated) in which psychological or physical suffering (including humiliation) of victim is sexually exciting to person with this disorder.
- mild sadism is common sexual practice
- sexual sadism is not rape (sexual sadism is diagnosed in < 10% rapists) - most sadistic sexual behavior occurs between consenting adults.
- when practiced with nonconsenting partners, sexual sadism constitutes criminal activity and is likely to continue until sadist is apprehended.
- sexual sadism is particularly dangerous when associated with antisocial personality disorder.

**PARAPHILIA NOT OTHERWISE SPECIFIED**
- examples:
  - Telephone scatology — obscene phone calls
  - Necrophilia — corpses
  - Zoophilia — animals

**ETIOLOGY**
- **PSYCHODYNAMIC** processes (often before puberty):
  - anxiety or early emotional trauma interferes with normal psychosexual development.
  - standard pattern of arousal is replaced by another, sometimes through early exposure to highly charged sexual experiences that reinforce person's experience of sexual pleasure.
  - pattern of sexual arousal acquires symbolic and conditioning elements (e.g. fetish symbolizes object of arousal but may have been chosen because fetish was accidentally associated with sexual curiosity, desire, and excitement).

**DIAGNOSIS**
- penile plethysmography during exposure to paraphilic stimuli; negative test result is not definitive finding.

**TREATMENT**
- Psychotherapy with strong emphasis on BEHAVIORAL TECHNIQUES*, major component of treatment - aversive conditioning - pairing unpleasant associations with sexual fantasies (incl. facing applicable legal consequences).
- positive results first reported from these techniques tend to be only temporary.
- patients often have serious patterns of denial that complicates treatment.
- almost all patients lack appropriate social skills - group therapy often is included to teach social skills.

*PSYCHODYNAMIC and PSYCHONANALYTIC approaches do not seem to provide significant results

**Pharmacologic treatments** - reduce sexual drive rather than alter patient's focus of sexual interest (i.e. drugs are most effective in hypersexual patients):
- SSRIs (e.g. high-dose FLUOXETINE 60-80 mg once/day or FLUVOKAMINE 200-300 mg once/day)
- progestins (e.g. IM MEDROXYPROGESTERONE)
- anabolic steroids (e.g. CYPOTHRONE)
- GABA antagonists IM (e.g. LEUPROLIDE, COREXLIN).
- serum testosterone should be monitored and maintained in normal female range (< 62 ng/dL).
- treatment is long-term (deviant fantasies recur weeks to months after discontinuation of treatment).

**PROGNOSIS**
- factors of poor prognosis:
  1. poorly integrated or deficient sense of guilt
  2. early onset
  3. high frequency of paraphilic acts.

**GENDER IDENTITY DISORDERS**
- persistent distress about one's assigned gender (i.e. strong cross-gender identification, s. incongruity between anatomic sex and gender identity).
- differentiate from TRANSVESTITISM (paraphilia, because associated with strong sexual urges).
not associated with PHYSICAL INTEREST condition (i.e. inconsistency between genitalia and chromosomal makeup).

associated with various degrees of preoccupation with or modeling of stereotypical behaviors of opposite sex.

(1) consisting that one is of other sex
(2) cross-dressing
(3) preferring opposite-sex roles in play
(4) having intense desire to play games stereotypical of opposite sex
(5) during childhood, strongly preferring playmates of other sex
(6) during adolescence and adulthood, having conviction that one has feelings typical of other sex.

(7) frequently passing for other sex.
(8) believing that he or she was born wrong sex (victim of biologic accident — cruelly imprisoned in body incompatible with subjective gender identity).
(9) preoccupation with getting rid of primary and secondary sex characteristics (negative feelings toward own genitals).
(10) stating desire to be of other sex.

TRANSEXUALISM (most extreme form of gender identity disorder) is persistent preoccupation with becoming member of opposite sex.

ETIOLOGY
although biologic factors (genetic complement, prenatal hormonal milieu) largely determine gender identity, formation of unconflicted gender identity is influenced by social factors (such as character of parents’ emotional bond and relationship that each of them has with child).

childhood gender identity problems are usually present by age 2 yrs (most are not evaluated until they are age 6-9 yrs, at point when disorder is already chronic).

most children with gender identity disorder do not develop into adults with transsexualism (but many are homosexual or bisexual).

TREATMENT
- aimed to help patient adapt rather than to dissuade from identity.

N.B. labeling condition as “disorder” can add to distress!

A. Surgical - hormonal reassignment of gender. indicated for patients with stable, long-term dissatisfaction with their assigned gender (i.e. transsexuals).

- patient (before surgery) must meet criteria established by Harry Benjamin International Gender Dysphoria Association and have lived in desired gender role for at least 1 yr.

- male-to-female reconstruction surgery is performed 4 times more often than female-to-

- male reconstruction.

- many patients adopt well after surgery.

- anatomic results of neophallus are often less satisfactory than neovaginal procedures (e.g. extending urethra into neophallus).

- patients with concurrent psychiatric disorders (e.g. borderline personality disorder) risk suicide when they discover that surgery does not solve all of their problems.

- before surgery, patients need assistance with “passing” in public (incl. gestures, voice modulation).

- more stable adjustment is increased by taking moderate doses of feminizing / masculinizing hormone (e.g. ethinyl estradiol / testosterone).

B. Psychotherapy (behavioral or insight-oriented) - to help cope with orientation.

- little evidence that psychiatric interventions can reverse established patterns of gender dysphoria in people with primary gender identity disorder.

Premenstrual Dysphoric Disorder (DSM-IV), Premenstrual Syndrome (PMS), Late Luteal Phase Dysphoric Disorder (DSM-III-R)

- cyclic physical / psychological symptoms that begin week prior to menstruation and resolve shortly after onset of menstrual flow; symptom severity impairs functioning.

No longer official diagnosis - researchers question whether it is distinct entity, cultural belief pattern, or artifact of other disorders (esp. affective disorders).

- to make diagnosis, symptoms must be charted prospectively (retrospective reports have been shown to be invalid) - 80% women who complain of PMS do not meet criteria when prospective charting is used.

Symptoms
1. Psychological complaints: tension, irritability, depression, anxiety, affective lability, food cravings, concentration difficulty, lethargy.
2. Physical complaints: breast tenderness, weight gain, bloating, fatigue.

Etiology
- theories about estrogen - progestosterone imbalance have not been validated.

- effect of female gonadal hormones on CNS monoamine activity (particularly serotonin).

- thyroid abnormalities have been noted.

- endorphin activity may be altered by menstrual cycle.

- aldosterone levels may be elevated → water retention.

- progestaclone levels may be elevated → water retention, pain, dysphoria.

Treatment
- various empirical approaches:
  a. diet - regular, small meals low in sodium, sugar, caffeine, alcohol.
  b. regular physical exercise reduces tension and stress.
  c. medication: 1) SSRI – specifically beneficial effects on PMS!!! 2) antiinflammation medication – for tension and irritability.
  3) bromocriptine – for breast tenderness.
  4) diuretics – for weight gain and edema.
  5) progestin inhibitors – for dysmenorrhea.
  6) norepinephrine / dopamine agonists (e.g. oral contraceptives) are useful for some patients.
  7) unclear efficacy – progestosterone suppositories (were popular treatment for PMS), vit. B6 and magnesium supplementation.

BIBLIOGRAPHY for ch. “Psychiatry” -> follow this LINK >>