Psychiatric Medicine II

The Sexual Disorders

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I. Introduction

Human sexuality is important to the well-being and health of individuals of all ages. The World Health Organization has defined sexual health as "the integration of the somatic, emotional, intellectual and social aspects of the sexual being."

Individuals also of all ages have sexuality concerns and questions; it is often their physicians to whom they turn for answers.

As individuals, we all hold our own set of personal values, attitudes, and beliefs regarding "appropriate" sexual behavior. The physician should be aware of these values, and how they may affect patient care. There is enormous cross-cultural diversity; it is important to respect differences in sexual norms and mores across cultures, religious and ethnic groups, and life stages.

Ideology also affects how sexual issues and problems are approached. Biological, socio-cultural, political, religious beliefs and therapeutic perspectives all interact with each other. At different stages of a person's life, one or more of these may assume greater importance.

Because sexuality is a major part of life, when there is a problem, there is usually great concern. However, patients are generally uncomfortable in bringing up their sexual issues. Therefore, part of the physician's role is to inquire about sexual functioning and satisfaction. The ease with which the physician models comfort in discussing sexual issues will help give the patient permission to feel more relaxed. Assurances of confidentiality and normalizing any patient anxiety can help set a more relaxed tone.

Part of the physician's role is to assist her/his patient in adapting to and coping with life experiences that have impacted on sexuality. For example, it is important to inquire as to sexual functioning satisfaction when seeing a patient for a physical exam or if the patient has medical illness which might affect sexual functioning (e.g., diabetes or has undergone a medical procedure which may impact on a person's body image (such as mastectomy). This can be

accomplished by the physician being: 1) informed; 2) asking questions about sexual functioning in a non-judgmental, accepting manner, 3) listening to the patient; and 4) making recommendations and referrals when appropriate.

The physician might ask: "Are you having any sexual difficulties or concerns?" or have there been any major changes in your sexual functioning or satisfaction?"

If the patients answers "yes" then it is appropriate to take a more detailed history to determine if a referral is needed.

II. The Sexual Dysfunctions

Definitions of sexual function and dysfunction are influenced by current values, social belief and knowledge. For example, in the 18th century, masturbation was condemned. Currently it is considered "normal" and even prescribed as part of sexual therapy.

The current medical classification scheme for sexual dysfunctions (DSM IV) divides women's and men's sexual problems into 4 categories; sexual desire disorders, sexual arousal disorders, orgasmic disorders and sexual pain disorders. Masters and Johnson first developed this classification in the 1960's who described a normative sexual response pattern, which proceeds sequentially from sexual drive through stages of desire, arousal and orgasm. However, the above approach to diagnosis tends to focus on physiological or behavioral dysfunctions. That is, individuals may be "dysfunctional", but they are not necessarily dissatisfied! Sexual health involves more than just intact physiology and functioning. Relational aspects of sexuality often affect sexual satisfaction i.e., desire for intimacy, and subjective feelings about a partner. Therefore, sexologists have begun to develop a more integrated approach that builds in attention to psychosocial factors and recognizes the complexity of the relationship between desire, arousal and orgasm.

Sexual problems may be characterized as:

1. Primary (lifelong) or secondary (acquired)

2. Generalized (occurring with all partners and in all sexual situations) or situational (occurring only with certain partners or in certain situations)

Etiology

A. Multiple factors in client history. Sexual problems result from multiple factors:

1. **Predisposing factors (**such as diabetes or childhood sexual trauma)
2. **Precipitating or triggering factors** (such as loss of job or love)
3. **Maintaining factors** (such as heavy drinking or domestic strife)
4. **Lack of information or misinformation** (myths)
5. **Guilt and anxiety**

B. Causes of sexual problems may be determined to be:

1. **Medical of biological** (hormone change)
2. **Psychological** (depression or anxiety)
3. **Related to social context** (communication failure in a marriage)

<u>Assessment of sexual problems includes:</u>

A. Detailed Sexual History
B. Sexual Inventories
C. Psychophysiologic Assessment
NPT – NOCTURNAL PENILE TUMESCENCE
UROLOGICAL OR GYNECOLOGICAL EVALUATION

<u>Differential Diagnosis:</u>

Patients presenting with a sexual dysfunction should be medically evaluated by a gynecologist or urologist to rule out treatable organic etiologies. There may be local diseases of the genitals, endocrine disorders, vascular illness, neurological diseases, or systematic illness. The patient should always be asked about medications including over the counter medicines as well as illegal drugs.

Annon (1974) provides an overview of a model for treating sexual dysfunctions. This model is labeled the PLISSIT model:

P= PERMISSION
LI= LIMITED INFORMATION
SS= SPECIFIC SUGGESTIONS
IT= INTENSIVE THERAPY

P = Some patients who enter counseling are seeking permission to engage or not engage in sexual behavior. Examples would be self exploration, masturbation or permission in terms of acceptable behavior.

LT = Is useful in helping some individuals resolve their sexual problems, such as the importance of foreplay for vaginal lubrication in women.

SS = Other individuals are in need of specific suggestions, such as the use of specific lubricants or homework activities to enhance physical control or sensation.

IT = Finally, some patients are in need of intensive therapy to help them deal with their sexual problems.

Types of sexual dysfunctions

Women's commonly reported sexual problems are:

- Anorgasmia – the inability to experience orgasm

- Vulvadynia – a general painful vulvar condition that interferes with sexual satisfaction, which has multiples causes.

- Lack of desire - The relational context of sexuality is extremely important for women. In a recent survey by Ellison and **Ulbergeid** (2000), the top 3 items women associated with satisfying sex in an ongoing relationship were "feeling close to my partner before sex, emotional closeness after sexual activity, and feeling loved." In general, women need to feel good about themselves to feel satisfied sexually, and associate sexual satisfaction in an ongoing relationship with closeness, love, acceptance and safety.

Men's commonly reported sexual problems are:

- erectile dysfunction

- premature ejaculation

- lack of desire

Treatment

A strength of sex therapy has been its ability to treat specific sexual problems quickly and effectively, as compared to traditional psychotherapy.

In general, sex therapy treats the specific symptoms and mechanical problems very effectively. Critics have claimed that sex therapy is too genital and goal oriented. In addition, currently, an emphasis is on medical and pharmacological interventions.

TREATMENT STRATEGIES FOR SEXUAL PROBLEMS

THE PRESCRIPTION OF BEHAVIORAL TASKS

Insight has traditionally been viewed as the most powerful agent of change in psychotherapy. Insight is useful, but not sufficient in overcoming specific sexual problems. The judicious integration of carefully selected behavioral tasks augments and facilitates treatment.

Behavioral tasks are employed to (1) overcome performance anxiety. (2) aid with diagnostic assessment and clarification of underlying dynamics, (3) alter the previous destructive sexual system, (4) confront resistances in each partner, (5) alleviate couple's anxiety about physical intimacy, (6) dispel myths and educate patients regarding sexual function and anatomy, (7) counteract negative body image concerns, and (9) heighten sensuality.

Techniques that have been successfully used in treating sexual dysfunction are:

Systematic Desensitization: A procedure to eliminate maladaptive anxiety. Sensate focus: Behavioral exercises are frequently employed to help patients achieve the three requirements necessary for a good sexual life-willingness, relaxation, and sensuality. Masters and Johnson developed these structured exercises to heighten sensuality and arousal, while minimizing performance demands.

Behavioral Rehearsal: A special form of the role-playing, which enables the client to practice certain situational behaviors with the clinician before engaging in such behaviors in an actual situation.

Guided Imaging: A covert procedure designed to increase the probability of the occurrence of a certain behavior that the client wishes to engage in, but is anxious about doing so.

Restructuring Belief Systems / Cognitive-Behavioral Therapy

Medical Interventions Used

- Drug therapy
- Mechanical devices
- Other surgical interventions

In addition to the previous mentioned treatment, for many individuals or couples more intensive therapy is required to help them understand why they continue to have sexual problems. These include:

- Increasing self awareness
- Enhancing sexual experiences through improved communication and skills
- Reducing anxiety
- Expanding sexual scripts or repertoires
- Encouraging erotic responses

B. PARAPHILIAS

Historically, paraphilias were termed perversions. Paraphiliac disorders are characterized by repetitive or preferred sexual fantasies or acts that involved non-human objects or nonconsenting partners. In order to make the diagnosis of a paraphilia, the fantasies must have existed for at least six-months, and the person should have either acted on the fantasies or suffered serious distress because of them. There are numerous categories of paraphilias, including:

Exhibitionism: Involves exposing the genital to an unsuspecting stranger. Exhibitionists may expose their genitals to children, adolescents or adults, and in some cases may masturbate while exposing their genitals.

Frotteurism: A frotteur is an individual who achieves sexual gratification by rubbing up against a nonconsenting person. The behavior usually occurs in crowded places, such as elevators, bus, or subways.

Fetishism: The sexual attraction is to inanimate objects and these often include woman's clothing, such as shoes, stockings or undergarments. Or, person can be attracted to a specific body part. Usually, the person with a fetish fondles the article to which he or she is attracted, to achieve sexual gratification.

Pedophilia: The sexual arousal to prepubescent children. Some pedophiles are exclusively attracted to girls or boys while other pedophiles, termed bisexual pedophiles, do not discriminate in their attraction, and might sexually molest both male and female children.

Sexual Sadism: A sexual sadist is an individual who is sexually aroused by inflicting pain or suffering on another person. There can be an escalation in the severely of the maltreatment of the victim over time.

EPIDEMIOLOGY

The majority of individuals who experience paraphilias are male in gender. About 50% of the people with paraphilias experience the development of the paraphilic disorder in adolescence. Furthermore, it is not unusual for the person to develop two or more paraphilias. The majority of people may have both a paraphilic and non paraphilic, (nonsexually deviant) arousal pattern at the same time. An individual who has paraphilia is rarely distressed by the paraphilia and when this person presents for an evaluation or treatment, it is usually because of sexual partner or criminal justice system has recommended or mandated that an evaluation and /or treatment be given. This is particularly true of individuals who are pedophiles or ephebophiles (engage in sexual activity with those of pubertal age). The reason for this is that the individual with a paraphilia, in the majority of cases, finds the fantasies and behavior exciting and rewarding, and does not want to give up what he or she finds to be sexually exciting.

Historically, it was believed that an individual would have only one type of paraphilia. However, recent studies have indicated that it is not uncommon for individuals to have more than one form of paraphilia. Also, in some cases, there can be an escalation. For example, some exhibitionists also molest children or rape adult women.

Information on what percentage of male and female paraphilias in the United States is lacking. These data are difficult to obtain because not all people who have paraphilias are forthcoming in discussing their sexual atypical interests.

In making the diagnosis of paraphilia, it is important for the clinician to remember that not all forms of inappropriate sexual behavior are the result of a paraphilic interest patter. For example, a patient with a psychosis may, as part of his delusional system, engage in sexual activity that he might not ordinarily engage in. On occasion, individuals who are diagnosed as manic may become hypersexual and engage in forms of paraphilic behavior. Once the mania is treated pharmacologically, the inappropriate behavior may cease.

Clinical Course and Prognosis

Various forms of treatment have been defined in the psychological and psychiatric literature for the treatment of individuals with paraphilias. These treatments can be grouped into biological treatment, psychodynamic treatment, and a variety of behavioral therapies.

Recent treatment methodologies that have shown the greatest promise are:

1. Cognitive Behavioral Therapy

Comprehensive Cognitive-behavioral Therapy Program for sex offenders generally includes components in the following areas: (a) behavior therapy to reduce inappropriate sexual arousal and to enhance or maintain appropriate sexual arousal, (b) training to develop or to enhance prosocial skills, (c) modification of distorted cognitions and development of victim empathy, and (d) relapse and development to enhance maintenance of treatment gains.

2. Behavior Therapy

The primary goal of behavior therapy is to teach patients techniques that they can employ to decrease and/or to control their deviant sexual urges and behaviors. A number of behavior therapies have been developed or adapted for use with sexual offenders, including electrical aversion, olfactory aversion, covert sensitization, various masturbatory reconditioning techniques, modified aversive behavioral rehearsal, and imaginal desensitization training.

3. Medication Therapy

Anti-androgenic medication has been utilized with paraphilias. Their mechanism of action is, to decrease testosterone, upon which sexually motivated behavior depends, and thus libido or the sexual drive. This consequently diminishes the individual's pattern of compulsive paraphilic behavior. Once the medication is discontinued, sexual drive returns. Consequently, it is important that the patient also receive other forms of therapy that will help redirect their sexual interests.

The main anti-androgens currently in use are the gonadotropin releasing hormone analogues that are also used for a broad range of other illnesses, including prostatic cancer, endometriosis and premature onset of puberty.

The serotonin re-uptake inhibitors are a class of antidepressants that have also been used with success to treat hypersexual states.

Paraphilic behavior is frequently accompanied by antecedent anxiety, depressive symptoms or obsessive-compulsive disorder.

In addition, paraphiliacs have been treated with antipsychotics, antianxiety agents, lithium, and antidepressants, but placebo-controlled studies demonstrating efficacy are lacking.

Clinical research studies have demonstrated that treatment interventions utilizing a multicomponent approach have relatively high success rates in treating individuals who have paraphilias. Not only are such treatments effective in teaching individuals who have paraphilic behavior and thereby reducing future victimization, but also they are also cost-effective. For every individual who is successful treated, there are tens if not hundreds of people who needs to focus on early identification of individuals at risk of developing paraphilias as well as developing new forms of interventions, because there is no intervention that is effective in 100% of the cases.

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