

Sexual Disorders and Gender Identity Disorder

TOPIC OVERVIEW

Sexual Dysfunctions

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

Treatments for Sexual Dysfunctions

- What are the General Features of Sex Therapy?
- What Techniques Are Applied to Particular Dysfunctions?
- What Are the Current Trends in Sex Therapy?

Paraphilias

- Fetishism
- Transvestic Fetishism
- Exhibitionism
- Voyeurism
- Frotteurism
- Pedophilia
- Sexual Masochism
- Sexual Sadism
- A Word of Caution

Gender Identity Disorder

Putting It Together: A Private Topic Draws Public Attention

LECTURE OUTLINE

I. SEXUAL DISORDERS AND GENDER-IDENTITY DISORDER

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

II. SEXUAL DYSFUNCTIONS

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

III. DISORDERS OF DESIRE

- A. The desire phase of the sexual response cycle consists of an urge to have sex, sexual fantasies, and sexual attraction to others
- B. Two dysfunctions affect this phase:
 1. Hypoactive sexual desire disorder
 - a. This disorder is characterized by a lack of interest in sex and little sexual activity
 - b. Physical responses may be normal
 - c. This disorder may be found in as many as 16 percent of men and 33 percent of women
 - d. DSM-IV-TR criteria refers to “deficient” sexual interest/activity but provides no definition of “deficient”
 - (a) In reality, this criterion is difficult to define
 2. Sexual aversion disorder
 - a. This disorder is characterized by a total aversion to (disgust of) sex
 - (a) Sexual advances may sicken, repulse, or frighten
 - b. This disorder seems to be rare in men and more common in women

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

IV. DISORDERS OF EXCITEMENT

- A. The excitement phase of the sexual response cycle is marked by changes in the pelvic region, general physical arousal, and increases in heart rate, muscle tension, blood pressure, and respiration
 - 1. In men: erection of the penis
 - 2. In women: swelling of the clitoris and labia and vaginal lubrication
- B. Two dysfunctions affect this phase:
 - 1. Female sexual arousal disorder (formerly "frigidity")
 - a. This disorder is characterized by repeated inability to maintain proper lubrication or genital swelling during sexual activity
 - b. Desire and orgasmic disorders often co-occur with this disorder
 - c. It is estimated that more than 10 percent of women experience this disorder
 - d. Because this disorder co-occurs so often with orgasmic disorder, researchers usually study the two together; causes of the two disorders will be examined together
 - 2. Male erectile disorder (formerly "impotence")
 - a. This disorder is characterized by repeated inability to attain or maintain an adequate erection during sexual activity
 - b. It is estimated that about 10 percent of men experience this disorder
 - c. According to surveys, half of all adult men experience erectile difficulty during intercourse at least some of the time
- C. Most cases of erectile disorder result from an interaction of biological, psychological, and sociocultural processes; even minor physical impairment of the erection response may make a man vulnerable to the effects of psychosocial factors
 - 1. Biological causes
 - a. The same hormonal imbalances that can cause hypoactive sexual desire also can produce ED
 - (a) Most commonly vascular problems are involved

- b. ED can be caused by damage to the nervous system from various diseases, disorders, or injuries
- c. Additionally, the use of certain medications and substances may interfere with erections
- d. Medical devices have been developed for diagnosing biological causes of ED
 - (a) One strategy includes measuring nocturnal penile tumescence (NPT)
 - (b) Men typically have erections during REM sleep; abnormal or absent night-time erections usually indicate a physical basis for erectile failure
- 2. Psychological causes
 - a. Any of the psychological causes of hypoactive sexual desire also can interfere with arousal and lead to erectile dysfunction
 - (a) For example, as many as 90 percent of men with severe depression experience some degree of ED
 - b. One well-supported cognitive explanation for ED emphasizes performance anxiety and the spectator role
 - (a) Once erectile difficulties have begun, men become fearful and worried during sexual encounters; instead of being a participant, the man becomes a spectator and judge
 - (b) This can create a vicious cycle of sexual dysfunction where the original cause of the erectile failure becomes less important than the fear of failure
- 3. Sociocultural causes
 - a. Each of the sociocultural factors tied to hypoactive sexual desire also have been linked to ED
 - (a) Job and marital distress are particularly relevant

V. DISORDERS OF ORGASM

- A. During the orgasm phase of the sexual response cycle, an individual's sexual pleasure peaks and sexual tension is released as the muscles in the pelvic region contract rhythmically
 - 1. For men: semen is ejaculated
 - 2. For women: the outer third of the vaginal walls contract
- B. There are three disorders of this phase:
 - 1. Rapid, or premature, ejaculation
 - a. This disorder is characterized by persistent reaching of orgasm and ejaculation with little sexual stimulation
 - (a) Almost 30 percent of men experience rapid ejaculation at some time
 - b. Psychological, particularly behavioral, explanations of this disorder have received more research support than other explanations
 - (a) The dysfunction seems to be typical of young, sexually inexperienced men
 - c. It also may be related to anxiety, hurried masturbation experiences, or poor recognition of arousal
 - d. There is a growing belief among many clinical theorists that biological factors may also play a key role in many cases of this disorder
 - (a) One theory states that some men are born with a genetic predisposition
 - (b) A second theory argues that the brains of men with rapid ejaculation contain certain serotonin receptors that are overactive and others that are underactive
 - (c) A third explanation holds that men with this dysfunction experience greater sensitivity or nerve conduction in the area of their penis
 - 2. Male orgasmic disorder
 - a. This disorder is characterized by repeated inability to reach or a very delayed orgasm after normal sexual excitement
 - (a) This disorder occurs in 8 percent of the male population
 - b. Biological causes include low testosterone, neurological disease, and head or spinal cord injury

- c. Medications also can affect ejaculation, including drugs that slow down the central nervous system and certain antidepressants (especially the SSRIs)
 - d. A leading psychological cause appears to be performance anxiety and the spectator role, the cognitive factors involved in ED
3. Female orgasmic disorder
- a. This disorder is characterized by persistent delay in or absence of orgasm following normal sexual excitement
 - (a) Almost 25 percent of women appear to have this problem
 - (b) 10 percent or more have never reached orgasm
 - (c) An additional 10 percent reach orgasm only rarely
 - b. Women who are more sexually assertive and more comfortable with masturbation tend to have orgasms more regularly
 - c. Female orgasmic disorder appears more common in single women than in married or cohabiting women
 - d. Most clinicians agree that orgasm during intercourse is not mandatory for normal sexual functioning
 - (a) Lack of orgasm during intercourse was once considered to be pathological according to psychoanalytic theory
 - e. This disorder typically is linked to female sexual arousal disorder, and the two tend to be studied and treated together
 - f. Once again, biological, psychological, and sociocultural factors may combine to produce these disorders
 - (a) Biological causes
 - (i) A variety of physiological conditions can affect a woman's arousal and orgasm
 - 1. These conditions include diabetes and multiple sclerosis
 - (ii) The same medications and illegal substances that affect erection in men also can affect arousal and orgasm in women
 - (iii) Postmenopausal changes also may be responsible
 - (b) Psychological causes
 - (i) The psychological causes of hypoactive sexual desire and sexual aversion, including depression, also may lead to female arousal and orgasmic disorders
 - (ii) In addition, memories of childhood trauma and relationship distress also may be related
 - (c) Sociocultural Causes
 - (i) Sexually restrictive culture was the leading sociocultural theory of female sexual dysfunction for decades
 - 1. This theory has been challenged because:
 - a. Sexually restrictive histories are equally common in women with and without disorders
 - b. Cultural messages about female sexuality have been changing while the rate of female sexual dysfunction stays constant
 - (ii) Researchers suggest that unusually stressful events, traumas, or relationships may produce the fears, memories, and attitudes that characterize these dysfunctions
 - (iii) Research also has linked certain qualities in a woman's intimate relationships (like emotional intimacy) and orgasmic behavior

VI. DISORDERS OF SEXUAL PAIN

- A. Two sexual dysfunctions do not fit neatly into a specific phase of the sexual response cycle
- B. These are the sexual pain disorders:
 - 1. Vaginismus
 - a. This disorder is characterized by involuntary contractions of the muscles of the outer third of the vagina

- (a) Severe cases can prevent a woman from having intercourse
- (b) Perhaps 20 percent of women occasionally experience pain during intercourse but vaginismus occurs in less than 1 percent of all women
- b. Most clinicians agree with the cognitive-behavioral theory that vaginismus is a learned fear response
- c. A variety of factors can set the stage for this fear, including anxiety and ignorance about intercourse, trauma of an unskilled partner, and childhood sexual abuse
 - (a) Some women experience painful intercourse because of infection or disease, leading to “rational” vaginismus
- d. Most women with vaginismus also experience other sexual disorders as well
- 2. Dyspareunia
 - a. This disorder is characterized by severe pain in the genitals during sexual activity
 - (a) As many as 14 percent of women and about 3 percent of men suffer from this condition
 - b. Dyspareunia in women usually has a physical cause, usually injury sustained in childbirth
 - c. Although relationship problems or psychological trauma from abuse may contribute, psychosocial factors alone rarely are responsible

VII. TREATMENTS FOR SEXUAL DYSFUNCTIONS

- A. The last thirty-five years have brought major changes to the treatment of sexual dysfunction
- B. A brief historical perspective:
 - 1. Early 20th century: Psychodynamic approaches
 - a. It was believed that sexual dysfunction was caused by a failure to negotiate the stages of psychosexual development
 - b. Therapy focused on gaining insight and making broad personality changes and generally was unhelpful
 - 2. 1950s and 1960s: Behavior therapy
 - a. Behavior therapists attempted to reduce fear by employing relaxation training and systematic desensitization
 - b. These approaches had moderate success but failed to work in cases where the key problems included misinformation, negative attitudes, and lack of effective sexual technique
 - 3. 1970: *Human Sexual Inadequacy*
 - a. This text, published by William Masters and Virginia Johnson, revolutionized treatment of sexual dysfunction
 - b. This original “sex therapy” program has evolved into a complex, multidimensional approach, including techniques from cognitive-behavioral, couples, and family systems therapies along with a number of sex-specific techniques
 - c. More recently, biological interventions also have been incorporated

VIII. WHAT ARE THE GENERAL FEATURES OF SEX THERAPY?

- A. These are the general features of sex therapy:
 - 1. Modern sex therapy is short-term and instructive
 - 2. Therapy typically lasts from 15 to 20 sessions
 - 3. It is centered on specific sexual problems rather than broad personality issues
 - 4. Modern sex therapy includes:
 - a. Assessment and conceptualization of the problem
 - b. Assignment of “mutual responsibility” for the problem
 - c. Education about sexuality
 - d. Attitude change
 - e. Elimination of performance anxiety and the “spectator role”
 - f. Increase of sexual and general communication skills

- g. Changing destructive lifestyles and marital interactions
- h. Addressing physical and medical factors

IX. WHAT TECHNIQUES ARE APPLIED TO PARTICULAR DYSFUNCTIONS?

- A. These techniques are applied to particular dysfunctions:
 - 1. In addition to the universal components of sex therapy, specific techniques can help in each of the sexual dysfunctions:
 - a. Hypoactive sexual desire and sexual aversion
 - (a) These disorders are among the most difficult to treat because of the many issues that feed into them
 - (b) Therapists typically apply a combination of techniques which may include:
 - (i) Affectual awareness, self-instruction training, behavioral techniques, insight-oriented exercises, and biological interventions, such as hormone treatments
 - b. Erectile disorder
 - (a) Treatments for ED focus on reducing a man's performance anxiety and/or increasing his stimulation
 - (i) Therapist may suggest sensate focus exercises with the "tease technique"
 - (b) Biological approaches, applied when the ED has biological causes, have gained great momentum with the development of sildenafil (Viagra) and other erectile dysfunction drugs
 - (c) Most other biological approaches have been around for decades and include gels suppositories, penile injections, and a vacuum erection device (VED)
 - (i) These procedures are now viewed as "second-line" treatment
 - (d) Another biological approach—penile prosthesis—is performed only rarely
 - c. Male orgasmic disorder
 - (a) Like treatment for ED, therapies to reduce this disorder include techniques to reduce performance anxiety and increase stimulation
 - (b) When the cause of the disorder is physical, treatment may include a drug to increase arousal of the sympathetic nervous system
 - d. Rapid, or premature, ejaculation
 - (a) Premature ejaculation has been successfully treated for years by behavioral procedures, such as the "start-stop" or "pause" procedure and the "squeeze" technique
 - (b) Some clinicians favor the use of fluoxetine (Prozac) and other serotonin-enhancing antidepressant drugs
 - (i) Because these drugs often reduce sexual arousal or orgasm, they may be helpful in delaying premature ejaculation
 - (ii) Many studies have reported positive results with this approach
 - e. Female arousal and orgasmic disorders
 - (a) Specific treatments for these disorders include cognitive-behavioral techniques, self-exploration, enhancement of body awareness, and directed masturbation training
 - (i) Biological treatments, including hormone therapy or the use of sildenafil (Viagra), have also been tried, but research has not found such interventions to be consistently helpful
 - (b) Again, a lack of orgasm during intercourse is not necessarily a sexual dysfunction, provided the woman enjoys intercourse and is orgasmic through other means
 - (i) For this reason, some therapists believe that the wisest course of action is simply to educate women whose only concern is lack of orgasm through intercourse, informing them that they are quite normal

- f. Vaginismus
 - (a) Specific treatment for vaginismus takes two approaches:
 - (i) Practice tightening and releasing the muscles of the vagina to gain more voluntary control
 - (ii) Overcome fear of intercourse through gradual behavioral exposure treatment
 - (b) Most women treated for vaginismus using these methods eventually report pain-free intercourse
- g. Dyspareunia
 - (a) Determining the specific cause of dyspareunia is the first stage of treatment
 - (b) Given that most cases are due to physical causes, medical intervention may be necessary

X. WHAT ARE THE CURRENT TRENDS IN SEX THERAPY?

- A. These are the current trends in sex therapy
 - 1. Over the past 30 years, sex therapists have moved beyond the approach first developed by Masters and Johnson
 - a. Treatment now includes unmarried couples, those with other psychological disorders, couples with severe marital discord, the elderly, the medically ill, the physically handicapped, clients with a homosexual orientation, or clients with no long-term sex partner
 - 2. Recently, therapists began paying attention to excessive sexuality, sometimes called hypersexuality or *sexual addiction*
 - 3. Finally, the use of medications to treat sexual dysfunction is troubling to many therapists
 - a. There is concern that therapists will choose biological interventions rather than a more integrated approach

XI. PARAPHILIAS

- A. These disorders are characterized by unusual fantasies and sexual urges or behaviors that are recurrent and sexually arousing
- B. Paraphilias often involve:
 - 1. Nonhuman objects
 - 2. Children
 - 3. Nonconsenting adults
 - 4. Humiliation of self or partner
- C. According to DSM-IV-TR, paraphilias should be diagnosed only when the urges, fantasies, or behaviors last at least six months
- D. For most paraphilias, the urges, fantasies, or behaviors must also cause great distress or impairment
 - 1. For certain paraphilias, however, performance of the behavior itself is indicative of a disorder even if the individual experiences no distress or impairment
 - a. Example: Sexual contact with children
- E. Some people with one kind of paraphilia display others as well
 - 1. Relatively few people receive a formal diagnosis but clinicians believe that the patterns may be quite common
- F. Some experts argue that, with the exception of nonconsensual paraphilias, paraphilic activities should be considered a disorder only when they are the exclusive or preferred means of achieving sexual excitement and orgasm
- G. Although theorists have proposed various explanations for paraphilias, there is little formal evidence to support them
- H. None of the treatments applied to paraphilias has received much research or proved clearly effective
 - 1. Psychological and sociocultural treatments have been available the longest, but today's professionals are also using biological interventions
- I. The eight paraphilias are:

1. Fetishism
 - a. The key features of fetishism are recurrent intense sexual urges, sexually arousing fantasies, or behavior that involves the use of a nonliving object, often to the exclusion of all other stimuli
 - b. Usually the disorder begins in adolescence
 - c. Almost anything can be a fetish
 - (a) Women's underwear, shoes, and boots are especially common
 - d. Researchers have been unable to pinpoint the causes of fetishism
 - (a) Psychodynamic theorists view fetishes as defense mechanisms but therapy using this model has been unsuccessful
 - (b) Behaviorists propose that fetishes are learned through classical conditioning
 - (i) Fetishes sometimes treated with aversion therapy, covert sensitization, or imaginal exposure
 - (ii) Another behavioral treatment is masturbatory satiation, where clients are instructed to masturbate to boredom while imagining the fetish object
 - (iii) A final behavioral approach to fetishes is orgasmic reorientation, a process which teaches individuals to respond to more appropriate sources of sexual stimulation
2. Transvestic fetishism (also known as transvestism or cross-dressing)
 - a. This disorder is characterized by fantasies, urges, or behaviors involving dressing in clothes of the opposite sex as a means of sexual arousal
 - b. The typical case is a heterosexual male who began cross-dressing in childhood or adolescence
 - c. This pattern often is confused with gender identity disorder (transsexualism), but the two are separate conditions
 - d. The development of the disorder seems to follow the behavioral principles of operant conditioning
3. Exhibitionism
 - a. Also known as "flashing," this disorder is characterized by arousal from the exposure of genitals in a public setting
 - b. Sexual contact is neither initiated nor desired
 - c. Generally the disorder begins before age 18 and is most common in males
 - d. Treatment generally includes aversion therapy and masturbatory satiation, possibly combined with orgasmic reorientation, social skills training, or cognitive-behavioral therapy
4. Voyeurism
 - a. This disorder is characterized by fantasies, urges, or behaviors involving the act of observing an unsuspecting person as they undress or to spy on couples having intercourse
 - b. The person may masturbate during the act of observing or while remembering it later
 - c. The risk of discovery often adds to the excitement
 - d. Many psychodynamic theorists propose that voyeurs are seeking power
 - (a) Others have explained it as an attempt to reduce fears of castration
 - e. Behaviorists explain the disorder as a learned behavior that can be traced to chance
5. Frotteurism
 - a. A person who develops frotteurism has repeated and intense fantasies, urges, or behaviors involving touching and rubbing against a nonconsenting person
 - b. Almost always male, the person fantasizes during the act that a caring relationship is occurring with the victim
 - c. The disorder usually begins in the teenage years or earlier
 - d. Acts generally decrease and disappear after age 25
6. Pedophilia
 - a. This disorder is characterized by fantasies, urges, or behaviors involving sexual activity with a prepubescent child, usually 13 years of age or younger

- b. Some people are satisfied with child pornography; others are driven to watching, fondling, or engaging in sexual intercourse with children
 - c. Victims may be male, but evidence suggests that two-thirds are female
 - d. People with pedophilia develop the disorder in adolescence
 - (a) Some were sexually abused as children
 - (b) Many were neglected, excessively punished, or deprived of close relationships in childhood
 - e. Most are immature, display distorted thinking, and have an additional psychological disorder
 - f. Some theorists have proposed a biochemical or brain structure abnormality but clear biological factors have yet to emerge in research
 - g. Most people with pedophilia are imprisoned or forced into treatment
 - h. Treatments include aversion therapy, masturbatory satiation, orgasmic reorientation, and treatment with antiandrogen drugs
 - (a) There also is a cognitive-behavioral treatment: relapse prevention training, modeled after programs used for substance dependence
7. Sexual masochism
- a. A person with sexual masochism has fantasies, urges, or behaviors involving the act or thought of being humiliated, beaten, bound, or otherwise made to suffer
 - b. Most masochistic fantasies begin in childhood and seem to develop through the behavioral process of classical conditioning
8. Sexual sadism
- a. A person with sexual sadism finds fantasies, urges, or behaviors involving the thought or act of psychological or physical suffering of a victim sexually exciting
 - b. Named for the infamous Marquis de Sade, people with sexual sadism imagine that they have total control over a sexual victim
 - c. Fantasies may first appear in childhood and the pattern is long-term
 - d. Sadism appears to be related to classical conditioning and/or modeling
 - e. Psychodynamic and cognitive theorists view people with sexual sadism as having underlying feelings of sexual inadequacy
 - f. Biological studies have found possible abnormalities in the endocrine system
 - g. The primary treatment for this disorder is aversion therapy
- J. A word of caution
- 1. The definitions of paraphilias, like those of sexual dysfunctions, are strongly influenced by the norms of the particular society in which they occur
 - 2. Some clinicians argue that, except when people are hurt by them, paraphilic behaviors should not be considered disorders at all

XII. GENDER IDENTITY DISORDER

- A. The DSM-IV-TR categorization of this disorder has become controversial in recent years
 - 1. Many people believe that transgender experiences reflect alternative—not pathological—ways of experiencing one's gender identity
 - 2. Others argue that gender identity is in fact a medical problem that may produce personal unhappiness
- B. According to current DSM-IV-TR criteria, people with this disorder persistently feel that they have been assigned to the wrong biological sex and experience gender dysphoria
 - 1. They would like to remove their primary and secondary sex characteristics and acquire the characteristics of the opposite sex
- C. Men with GID outnumber women 2 to 1
- D. People with this problem often experience anxiety or depression and may have thoughts of suicide
- E. The disorder sometimes emerges in childhood and disappears with adolescence
 - 1. In some cases it develops into adult gender identity disorder
- F. Various theories have been proposed to explain this disorder but research is limited and generally weak

1. Some clinicians suspect biological—perhaps genetic or prenatal—factors
 - a. Abnormalities in the hypothalamus (particularly the bed nucleus of stria terminalis) are a potential link
- G. In order to more effectively assess and treat those with the disorder, clinical theorists have tried to distinguish the most common patterns of gender dysphoria:
 1. Female-to-male
 2. Male-to-female: androphilic type
 3. Male-to-female: autogynephilic type
- H. Some adults with this disorder change their sexual characteristics by way of hormones; others opt for sexual reassignment (sex-change) surgery

LEARNING OBJECTIVES

1. Describe each of the four phases of the sexual response cycle: desire, arousal, orgasm, and resolution.
2. Explain the two most common dysfunctions of the desire phase, hypoactive sexual desire and sexual aversion; then describe dysfunctions of the arousal phase, male erectile disorder; and female arousal disorder.
3. Discuss the orgasmic sexual dysfunctions of premature ejaculation, male orgasmic disorder, and female orgasmic disorder.
4. Discuss the sexual pain disorders of vaginismus and dyspareunia.
5. Discuss therapy for the sexual dysfunctions.
6. Define paraphilias and describe behavioral treatment for them.
7. Define, compare, and contrast the major paraphilic diagnoses.
8. Define and discuss gender identity disorder.

KEY TERMS

aversion therapy
 bed nucleus of stria terminalis (BST)
 cross-dressing
 desire phase
 directed masturbation training
 dyspareunia
 erectile disorder
 excitement phase
 exhibitionism
 female orgasmic disorder
 female sexual arousal disorder
 fetishism
 frotteurism
 gender identity disorder

hypoactive sexual desire disorder
 male erectile disorder
 male orgasmic disorder
 masturbatory satiation
 mutual responsibility
 nocturnal penile tumescence (NPT)
 orgasm phase
 orgasmic reorientation
 paraphilias
 pedophilia
 performance anxiety
 rapid ejaculation
 relapse-prevention training
 sensate focus

sex therapy
 sex-change surgery
 sexual addiction
 sexual aversion disorder
 sexual dysfunction
 sexual masochism
 sexual response cycle
 sexual sadism
 spectator role
 stop-start technique
 transsexualism
 transvestic fetishism
 transvestism
 vaginismus
 voyeurism

MEDIA RESOURCES

Abnormal Psychology Student Tool Kit

Produced and edited by Ronald J. Comer, Princeton University and Gregory Comer, Princeton Academic Resources. Tied directly to the CyberStudy sections in the text, this Student Tool Kit offers 57 intriguing Video Cases running three to seven minutes each. The Video Cases focus on persons affected by disorders discussed in the text. Students first view the video and then answer a series of thought-provoking questions. Additionally, the Student Tool Kit contains multiple-choice practice test questions with built-in instructional feedback for every option.

PowerPoint Slides

Available at the Instructor's site on the companion Web site are comprehensive PowerPoint slide presentations and supplemental student handouts for Chapter 13. The slide files reflect the main points of the chapter in significant detail. Student handouts were created using the instructor slides as a base, with key points replaced as "fill-in" items. Answer keys and suggestions for use also are provided.

DSM-IV-TR Masters

- B-38, DSM-IV-TR Diagnostic Criteria for Hypoactive Sexual Desire Disorder
- B-38, DSM-IV-TR Diagnostic Criteria for Sexual Aversion Disorder
- B-39, DSM-IV-TR Diagnostic Criteria for Female Sexual Arousal Disorder
- B-39, DSM-IV-TR Diagnostic Criteria for Male Erectile Disorder
- B-40, DSM-IV-TR Diagnostic Criteria for Female Orgasmic Disorder
- B-40, DSM-IV-TR Diagnostic Criteria for Male Orgasmic Disorder
- B-41, DSM-IV-TR Diagnostic Criteria for Premature Ejaculation
- B-41, DSM-IV-TR Diagnostic Criteria for Dyspareunia
- B-41, DSM-IV-TR Diagnostic Criteria for Vaginismus
- B-42, DSM-IV-TR Diagnostic Criteria for Exhibitionism
- B-42, DSM-IV-TR Diagnostic Criteria for Fetishism
- B-42, DSM-IV-TR Diagnostic Criteria for Frotteurism
- B-42, DSM-IV-TR Diagnostic Criteria for Pedophilia
- B-43, DSM-IV-TR Diagnostic Criteria for Sexual Masochism
- B-43, DSM-IV-TR Diagnostic Criteria for Sexual Sadism

- B-43, DSM-IV-TR Diagnostic Criteria for Transvestic Fetishism
- B-43, DSM-IV-TR Diagnostic Criteria for Voyeurism
- B-44, DSM-IV-TR Diagnostic Criteria for Gender Identity Disorder

Internet Sites

Please see Appendix A for full and comprehensive references.

Sites relevant to Chapter 13 material are:

<http://www.sca-recovery.org> (Sexual Compulsives Anonymous)

SCA is a fellowship of men and women who share their experience, strength, and hope with each other, that they may solve their common problem and help others to recover from sexual compulsion.

<http://www.aasect.org/>

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

<http://www.siecus.org/>

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

<http://www.agi-usa.org/>

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

<http://www.ifge.org/>

The International Foundation for Gender Education (IFGE), founded in 1987, is a leading advocate and educational organization for promoting the self-definition and free expression of individual gender identity.

Mainstream Films

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

Key to Film Listings:

P = psychopathology focus

T = treatment focus

E = ethical issues raised

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

Adventures of Priscilla, Queen of the Desert

This Australian film from 1994 follows three cabaret drag queens who trek across the outback. **P, comedy**

Belle de Jour

Scandalous when first released in 1965, this film is Luis Bunuel's story of an affluent housewife (Catherine Deneuve) who acts out her sexual fantasies by taking a job at a Paris brothel. **P, serious film**

The Birdcage

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

Boys Don't Cry

From 1999, this powerful film stars Hilary Swank as Teena Brandon, a young woman who claims a new male identity in the rural town of Falls City, Nebraska. Based on a true story. **P, E, serious film**

A Clockwork Orange

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

The Crying Game

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

Damage

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

Kinsey

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

Kiss of the Spider Woman

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

Lolita

From 1962, this Stanley Kubrick adaptation of Nabokov's book is set in 1947 and details a troubled man in

a troubled relationship with a very young girl. **P, E, comedic/serious film**

Looking for Mr. Goodbar

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

Ma vie en rose

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

My Own Private Idaho

In this moving film from 1991, River Phoenix plays a narcoleptic, psychologically scarred street prostitute, working and traveling with his best friend (Keanu Reeves). **P, serious film**

Secretary

From 2002, this film depicts Maggie Gyllenhall as a smart, quirky masochistic woman having an unorthodox relationship with her boss. **P, E, serious film**

sex, lies, and videotape

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

Transamerica

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

The World According to Garp

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

Other Films:

Auto-Focus (2002) exhibitionism and sexual addiction. **P, serious film**

Body Double (1984) voyeurism. **P, commercial/serious film**

Crash (1996) paraphilia. **P, serious film** (Note: Graphic sexual content)

Happiness (1998) paraphilia. **P, T, serious film**

M (1931) paraphilia. **P, serious film**

Comer Video Segments

Available as a supplement, this revised set of videotapes contains short clips depicting various topics related to abnormal psychology. Please see the accompanying Video Guide for specific clips linked to Chapter 13.

Recommendations for Purchase or Rental

The Comer Video Segments include excerpts from many superb clinical documentaries. While the segments alone are ideal for use in lectures, it often is useful to assign the entire documentary for special class screenings or library use by students. The following videos and other media are available for purchase or

rental and appropriate for use in class or for assignment outside of class.

Phallacies

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

Sex: Unknown

WGBH
P.O. Box 200
Boston, MA 02134
Tel: 617-300-5400
<http://main.wgbh.org/wgbh/shop/>

CLASS DEMONSTRATIONS AND ACTIVITIES

Case Study

Present a case study to the class.

Panel Discussion

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

“It’s Debatable: Is Sexual Activity in Video Games Appropriate?” (see Preface instructions for conducting this activity)

Have students volunteer (or assign them) in teams to opposite sides of the debate topic—use the textbox on page 425 as a starting point. Have students present their case in class, following standard debate guidelines.

“It’s Debatable: Is Sexual Activity in a Casual Relationship Acceptable?” (see Preface instructions for conducting this activity)

Have students volunteer (or assign them) in teams to opposite sides of the debate topic—use the textbox on

page 426 as a starting point. Have students present their case in class, following standard debate guidelines.

The Anonymous Five-Minute Essay

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

Group Work: Childhood Misconceptions

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

Childhood Sexual Abuse Controversies

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

A. Discrepancies

Discrepancies are often noted between the stories told by children and those told by their accused offenders. Although denial or minimization can play a role in the

offender's account, differences are also found in the types of sexual behavior described in events and their sequences, as well as in timing. One big problem is that young children's sequencing abilities are not adequate to enable them to encode some facts accurately. The feelings they express are likely to reflect their experiences more accurately than the details of the events they describe.

B. Leading Questions

Leading questions, such as "Did he touch your private parts?" can influence what children say and come to

believe. Such questions are inadmissible as evidence in the courtroom, and they are ill-advised in therapy, too.

C. Anatomically Correct Dolls

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

SUGGESTED TOPICS FOR DISCUSSION

Sex-Role Myths

Using A Closer Look on p. 427 in the text as a starting point, lead a discussion on the MYTHS of male and female sexuality. Be sure to correct these misconceptions and discuss the realities. A related discussion point is the impact of shows like *Sex and the City* on beliefs and perceptions about sexuality.

Open Discussion: Cultural and Sexual Behavior

Point out how cultural norms, beliefs, and values influence what is considered healthy sexuality. For example, homosexual intercourse is not only permitted but encouraged in some cultures. Discuss how cultural norms change. For example, homosexuality was considered a mental illness in early versions of the DSM (students are fascinated by overheads of these particular pages from the manual). Outmoded terms such as "nymphomania" (which in the Victorian era applied to women who were regularly orgasmic and enjoyed sex) and "masturbatory insanity" (in the 1930s physicians

believed that masturbation could cause fatigue, physical illness, and mental illness) can be used for illustration. Some of these ideas persist today without scientific evidence to support them. For example, many varsity coaches insist that college players not have sex prior to a game because having it will reduce their athletic ability.

Open Discussion: Sexual Fantasies

Ask students to define "sexual fantasy." Ask them to then determine at what point normal fantasy becomes abnormal.

Open Discussion: False Memory Syndrome

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

ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

"Write a Pamphlet"

With the use of a software program like Microsoft Publisher or simply paper and markers, students can create a pamphlet on one or all of the sexual disorders or general identity disorder. Students should be encouraged to be as accurate and up-to-date as possible and

also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal

In addition to helping students synthesize material, this activity is helpful in developing writing skills.

Have students keep a journal of their thoughts on course material through the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Faculty generally should have students submit their journals for review on an on-going basis as students can tend to delay writing until the end of the semester. Some suggestions for journal topics include: reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, etc.

Abnormal Psychology Student Tool Kit Video Questions

As a homework assignment, have students watch a video clip and answer the accompanying questions. Students can answer the questions directly into the on-line assessment feature. The results of these quizzes report to the site's built-in grade book.

Web Site Quiz

For homework or extra credit, have students complete the quiz for Chapter 13 located on the companion Web site. Students can complete an on-line test of the key chapter material (using questions NOT from the test bank) and have their scores e-mailed directly to the course instructor.

Essay Topics

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

- (1) Discuss the sex-role myths listed in A Closer Look on p. 427 in the text. Are these myths to which you have been exposed? Do you yourself hold these beliefs? What are the sociocultural influences on these beliefs? What are the implications for sexual dysfunction?
- (2) Where do you stand on the topic of Viagra vs. the Pill (Eye on Culture, p. 432 in the text)? What are the differences between the two medications that support the disparate policies? What are the similarities that refute it?
- (3) Discuss the implications of the recent change to the DSM-IV-TR (2000) criteria for pedophilia (as explained in Psych Watch, p. 440 in the text). With which side of the argument do you most agree?
- (4) Discuss the implications of homosexuality being listed as a DSM disorder and being removed from the DSM (see Eye on Culture, p. 444 in text).

Research Topics

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

- (1) Conduct a "Psych Info" search and write an annotated bibliography on treatments for three of the sexual dysfunctions described in the text. Which treatments are proving most effective?
- (2) Research and review the literature on "cybersex"—what are the research findings on Internet pornography as it relates to sexual dysfunction? Are there any positive findings?
- (3) Research and review the literature on Internet chat rooms for children and teens and the link to pedophilia.

Film Review

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

Case Study Evaluations

To complement the Comer and Gorenstein supplemental case study text, case study evaluations have been created. Students can be assigned the appropriate case study and evaluation as homework or for class discussion. While case study evaluation questions are listed in their entirety on the companion Web site at www.worthpublishers.com/comer, the relevant case studies follow.

Case Study 11: Sexual Dysfunction: Male Erectile Disorder

Crossword Puzzles

As a homework assignment or for extra credit, have students complete and submit Crossword Puzzle #13.

Word Searches

As a homework assignment or for extra credit, have students complete and submit Word Search #13.