Chapter 9
Sexual and Gender Identity Disorders
Sexual and Gender Identity Disorders: An Overview

• What Is “Normal” vs. “Abnormal” Sexual Behavior?
  – Normative facts and statistics
  – Extent of gender differences in sexual behavior and attitudes
  – Cultural considerations

• The Development of Sexual Orientation
  – Complex interaction of bio-psycho-social influences
  – The example of homosexuality

• DSM-IV Sexual and Gender Identity Disorders
  – Gender identity disorder
  – Sexual dysfunctions
  – Paraphilias
Results of a survey of male sexual practices

Figure 19.1

Percentage of men, ages 20–39, who have ever had vaginal intercourse, had anal intercourse, performed oral sex, or received oral sex.

- Had vaginal intercourse: 95.4% (n = 3,317)
- Had anal intercourse: 20.1% (n = 3,298)
- Performed oral sex: 74.6% (n = 3,286)
- Received oral sex: 78.8% (n = 3,290)
Results of a survey of male sexual practices

![Bar chart showing percentages of men with different sexual histories](Image)

**Figure 19.1a**

- Percentage of men, ages 20–39, who engaged in vaginal intercourse with either 1–3 partners or 20 or more partners.

- 1–3 partners ever: 28.2%
- 20 partners ever: 23.3%

*Note: *(n = 3,111)
Sequence of events leading to sexual orientation

A. Biological variables (e.g., genes, prenatal hormones)

B. Childhood temperaments (e.g., aggression, activity level)

C. Sex-typical or atypical activity & playmate preferences (gender conformity/nonconformity)

D. Feeling different from opposite or same-sex peers (dissimilar, unfamiliar, exotic)

E. Nonspecific autonomic arousal to opposite or same-sex peers

F. Erotic or romantic attraction to opposite or same-sex persons (sexual orientation)
Defining Gender Identity Disorder

• Clinical Overview
  – Person feels trapped in the body of the wrong sex
  – Assume the identity of the desired sex, but the goal is not sexual

• Causes are Unclear
  – Gender identity develops between 18 months and 3 years of age

• Sex-Reassignment as a Treatment of Gender Identity Disorder
  – Who is a candidate? – Some basic prerequisites before surgery
  – 75% report satisfaction with new identity
  – Female-to-male conversions adjust better than male-to-female

• Psychosocial Treatment of Gender Identity Disorder
  – Involve realigning the persons psychological gender with their biological sex
  – Few large scale studies
Overview of Sexual Dysfunctions

- Sexual Dysfunctions Involve Desire, Arousal, and/or Orgasm
- Males and Females Experience Parallel Versions of Most Dysfunctions
  - Affects about 43% of all females and 31% of males
  - Most prevalent class of disorder in the United States
- Classification of Sexual Dysfunctions
  - Lifelong vs. acquired
  - Generalized vs. situational
  - Due to psychological factors alone or in combination with a medical condition
The human sexual response cycle

Desire phase
Sexual urges occur in response to sexual cues or fantasies.

Arousal stage
A subjective sense of sexual pleasure and physiological signs of sexual arousal: in males, penile tumescence (increased flow of blood into the penis); in females, vasocongestion (blood pools in the pelvic area) leading to vaginal lubrication and breast tumescence (erect nipples).

Resolution phase
Decrease in arousal occurs after orgasm (particularly in men).

Orgasm phase
In males, feelings of the inevitability of ejaculation, followed by ejaculation; in females, contractions of the walls of the lower third of the vagina.

Plateau phase
Brief period of time before orgasm.

Figure 9.3
Sexual Desire Disorders: An Overview

• Hypoactive Sexual Desire Disorder
  – Little or no interest in any type of sexual activity
  – Accounts for half of all complaints at sexuality clinics
  – 22% of women and 5% of men suffer from this disorder
  – Masturbation, sexual fantasies, and intercourse are rare in this disorder

• Sexual Aversion Disorder
  – Little interest in sex
  – Extreme fear, panic, or disgust related to physical or sexual contact
  – 10% of males report panic attacks during attempted sexual activity
Sexual Arousal Disorders

- Male Erectile Disorder
  - Difficulty achieving and maintaining an erection
- Female Sexual Arousal Disorder
  - Difficulty achieving and maintaining adequate lubrication
- Associated Features of Sexual Arousal Disorders
  - Problem is arousal, not desire
  - Problem affects about 5% of males, 14% of females
  - Males are more troubled by the problem than females
  - Erectile problems are the main reason males seek help
Estimated prevalence and severity of erectile dysfunction

Figure 9.4
Orgasm Disorders

• Inhibited Orgasm: Female and Male Orgasmic Disorder
  – Inability to achieve orgasm despite adequate sexual desire and arousal
  – Rare condition in adult males, but is the most common complaint of adult females
  – 25% of adult females report significant difficulty reaching orgasm
  – 50% of adult females report experiencing regular orgasms during intercourse

• Premature Ejaculation
  – Ejaculation occurring before the man or partner wishes it to
  – 21% of all adult males meeting criteria for premature ejaculation
  – Most prevalent sexual dysfunction in adult males
  – How soon is too soon?
  – Most common in younger, inexperienced males, but declines with age
Sexual Pain Disorders

• Defining Feature: Marked Pain During Intercourse

• Dyspareunia
  – Extreme pain during intercourse
  – Adequate sexual desire, and ability to attain arousal and orgasm
  – Must rule out medical reasons for pain
  – Affects 1% to 5% of men and about 10% to 15% of women

• Vaginismus
  – Limited to females
  – Outer third of the vagina undergoes involuntary spasms
  – Complaints include feeling of ripping, burning, or tearing
  – Affects over 5% of women seeking treatment in the United States
  – Prevalence rates are higher in more conservative countries and subgroups
Assessing Sexual Behavior

• Comprehensive Interview
  – Include a detailed history of sexual behavior, lifestyle, and associated factors

• Medical Examination
  – Must rule out potential medical causes of sexual dysfunction

• Psychophysiological Evaluation
  – Exposure to erotic material
  – Determine extent and pattern of physiological and subjective sexual arousal
    – Males – Penile strain gauge
    – Females – Vaginal photoplethysmograh
Causes and Treatment of Sexual Dysfunction

• Biological Contributions
  – Physical disease and medical illness
  – Prescription medications
  – Use and abuse of alcohol and other drugs

• Psychological Contributions
  – The role of “anxiety” vs. “distraction”
  – The nature and components of performance anxiety
  – Psychological profiles associated with sexual dysfunction

• Social and Cultural Contributions
  – Erotophobia – Learned negative attitudes about sexuality
  – Negative or traumatic sexual experiences
  – Deterioration of interpersonal relationships, lack of communication
A model of functional and dysfunctional sexual arousal

**Figure 9.5**

- **Functional (positive feedback loop):**
  - Positive affect and expectancies, accurate reporting of arousal, perception of control
  - Attentional focus on erotic cues
  - Increased autonomic arousal
  - Increasingly efficient attentional focus on erotic cues
  - Functional performance

- **Approach**

- **Avoidance**

- **Dysfunctional (negative feedback loop):**
  - Negative affect and expectancies, inaccurate and underreporting of arousal, perceived lack of control
  - Attentional focus on public consequences of not performing or other nonerotic issues
  - Increased autonomic arousal
  - Increasingly efficient attentional focus on consequences of not performing (etc.)
  - Dysfunctional performance

Explicit or implicit demands for sexual performance; e.g., a responsive partner or other contexts leading to public expectation of performance.
Treatment of Sexual Dysfunction

• Education Alone
  – Is surprisingly effective

• Masters and Johnson’s Psychosocial Intervention
  – Education
  – Eliminate performance anxiety – Sensate focus and nondemand pleasuring

• Additional Psychosocial Procedures
  – Squeeze technique – Premature ejaculation
  – Masturbatory training – Female orgasm disorder
  – Use of dilators – Vaginismus
  – Exposure to erotic material – Low sexual desire problems
Medical Treatment of Sexual Dysfunction

• Erectile Dysfunction
  – Viagra – Is it really the wonder drug?
  – Injection of vasodilating drugs into the penis
  – Penile prosthesis or implants
  – Vascular surgery
  – Vacuum device therapy

• Few Medical Procedures Exist for Female Sexual Dysfunction
Paraphilias: Clinical Descriptions and Causes

• Nature of Paraphilias
  – Sexual attraction and arousal to inappropriate people, or objects
  – Often multiple paraphilic patterns of arousal
  – High comorbidity with anxiety, mood, and substance abuse disorders

• Main Types of Paraphilias
  – Fetishism
  – Voyeurism
  – Exhibitionism
  – Transvestic fetishism
  – Sexual sadism and masochism
  – Pedophilia
Voyeurism and Exhibitionism

• Voyeurism
  – Practice of observing an unsuspecting individual undressing or naked
  – Risk associated with “peeping” is necessary for sexual arousal

• Exhibitionism
  – Exposure of genitals to unsuspecting strangers
  – Element of thrill and risk is necessary for sexual arousal
Fetishism and Transvestic Fetishism

- Fetishism
  - Sexual attraction to nonliving objects (i.e., inanimate and/or tactile)
  - Numerous targets of fetishistic arousal, fantasy, urges, and desires
- Transvestic Fetishism
  - Sexual arousal with the act of cross-dressing
  - Males may show highly masculinized compensatory behaviors
  - Most do not show compensatory behaviors
  - Many are married and the behavior is known to spouse/partner
Sexual Sadism and Sexual Masochism

• Sexual Sadism
  – Inflicting pain or humiliation to attain sexual gratification

• Sexual Masochism
  – Suffer pain or humiliation to attain sexual gratification

• Relation Between Sadism and Rape
  – Some rapists are sadists, but most do not show paraphilic patterns of arousal
  – Rapists show sexual arousal to violent sexual and non-sexual material
A model of the development of paraphilia

- Early inappropriate sexual associations or experiences (some accidental and some vicarious)
- Possible inadequate development of consensual adult arousal patterns
- Possible inadequate development of appropriate social skills for relating to adults
- Inappropriate sexual fantasies repeatedly associated with masturbatory activities and strongly reinforced
- Repeated attempts to inhibit undesired arousal and behavior resulting in (paradoxical) increase in paraphilic thoughts, fantasies, and behavior

Figure 9.6
Pedophilia

• Overview
  – Pedophiles – Sexual attraction to young children
  – Incest – Sexual attraction to one’s own children
  – Both may involve male and/or female children or very young adolescents
  – Pedophilia is rare, but not unheard of, in females

• Associated Features
  – Most pedophiles and incest perpetrators are male
  – Incestuous males may be aroused to adult women; not true for pedophiles
  – Most rationalize the behavior and engage in other moral compensatory behavior
Pedophilia: Causes and Assessment

- Causes of Pedophilia
  - Pedophilia is associated with sexual and social problems and deficits
  - Patterns of inappropriate arousal and fantasy may be learned early in life
  - The role of high sex drive, coupled with suppression of urges

- Psychophysiological Assessment of Pedophilia
  - Assess extent of deviant patterns of sexual arousal
  - Assess extent of desired sexual arousal to adult content
  - Assess social skills and the ability to form relationships
Pedophilia: Psychosocial Treatment

• Psychosocial Interventions
  – Most are behavioral and target deviant and inappropriate sexual associations
  – Covert sensitization – Imaginal procedure involving aversive consequences
  – Orgasmic reconditioning – Associate masturbation with appropriate stimuli
  – Family/marital therapy – Address interpersonal problems
  – Coping and relapse prevention – Teaches self-control and coping with risk

• Efficacy of Psychosocial Interventions
  – About 70% to 100% of cases show improvement
  – Poorest outcomes are for rapists and persons with multiple paraphilias
Pedophilia: Drug Treatments

• Medications: The Equivalent of Chemical Castration
  – Often used for dangerous sexual offenders

• Types of Available Medications
  – Cyproterone acetate – Anti-androgen, reduces testosterone, sexual urges and fantasy
  – Medroxyprogesterone acetate – Depo-provera, also reduces testosterone
  – Triptoretin – A newer and more effective drug that inhibits gonadotropin secretion

• Efficacy of Medication Treatments
  – Drugs work to greatly reduce sexual desire, fantasy, arousal
  – Relapse rates are high with medication discontinuation
Summary of Sexual and Gender Identity Disorders

- Gender Identity and Gender Identity Disorder
  - Problem is not sexual; the problem is feeling trapped in body of wrong sex

- Sexual Dysfunctions are Common in Men and Women
  - Problems with desire, arousal, and/or orgasm
  - Require comprehensive assessment and treatment approaches

- Paraphilias Represent Inappropriate Sexual Attraction
  - Desire, arousal, and orgasm gone awry
  - Require comprehensive assessment and treatment approaches

- Available Psychosocial and Medical Treatment Options are Generally Efficacious
Discussion Group 8 – Sexual and Gender Identity Disorders

• Does someone who dresses like the opposite sex automatically meet the DSM-based criteria for Gender Identity Disorder? Why or why not?

• What kinds of questions would you want to ask a male client who is complaining regarding “difficulties in the bedroom”? That is, what kind of information would you want to know to try and figure out whether or not this client has a disorder, and if so which type?

• Describe a psychosocial intervention for a sexual dysfunction.