

# Sexual Disorders

## Background

### First heterosexual intercourse

- fallen in the last four decades from 21 to 17 for both men and women
- fewer than 1% of women aged 55 or over report heterosexual intercourse before the age of 16, compared with 20% of those in their teens
- early intercourse is associated with:
  - lower social class
  - lower educational level
  - less likely to use contraception

### Heterosexual partnerships

- age and marital status are associated with multiple partnerships
- increasing partner change with increasing social class
- serial monogamy is more common in those aged 16-34, concurrent partnerships are more common in those over 35

### Heterosexual practices

- age related to number of acts, with frequency peaking in mid-twenties, then gradually declining
- highest frequency in married and cohabiting groups of all ages
- strong association in all age groups between length of relationship and frequency of sex – lower frequency in longer relationships
- type of intercourse:
  - vaginal intercourse predominates
  - 75% have experience of non-penetrative sex
  - 70% have experience of oral sex
  - 14% of men, and 13% of women report experience of anal sex
- those not married have wider repertoire of sexual practice
- prevalence of oral, anal and non-penetrative sex increases with increasing numbers of partners

### Sexual diversity and homosexual behaviour

- no sexual attraction of any kind is reported by 0.4% of men, and 0.5% of women
- 90% of men, and 92% of women are exclusively heterosexual
- 1% of men, and 0.25% of women are mostly or exclusively homosexual
- 6% of men and 3% of women report some form of homosexual experience
- lifetime experience of homosexuality is higher in higher social classes
- the majority of those with homosexual experience have had sex with both men and women
- men reporting anal sex do so usually as both the receptive and insertive partner
- highest levels of homosexual activity reported by 25-34-year-olds

## Physical health

- multiple sexual partners are significantly associated with:
  - smoking
  - increasing levels of alcohol consumption
- attendance at STD clinic is associated with:
  - number of heterosexual partners
  - history of homosexual partnership
- likelihood of termination increases with the numbers of heterosexual partners

## Sexual dysfunction

### The sexual response cycle

1. desire
2. arousal, mediated by the parasympathetic nervous system
3. plateau
4. orgasm, mediated by the sympathetic nervous system
5. resolution, longer in males and increases with age

### Sensate focus: Masters and Johnson (1970)

- behavioural psychotherapy involving the couple in graded assignments which may be modified according to the particular problem
- divided into six stages:
  1. touching partner without genital contact for subject's own pleasure
  2. touching partner without genital contact for both partners' pleasure
  3. touching partner with genital contact, but intercourse not permitted
  4. simultaneous touching of partner and being touched by partner with genital contact, but intercourse not permitted
  5. intercourse, but without male thrusting; initial containment brief, with lengthening periods of containment with each session
  6. vaginal containment with movement; couple practice stopping before climax

### F52 Behavioural syndromes associated with psychological disturbances and physical factors

F52 Lack or loss of sexual desire

F52.1 Sexual aversion (.10) and lack of sexual enjoyment (.11)

F52.2 Failure of genital response

F52.3 Orgasmic dysfunction

F52.4 Premature ejaculation

F52.5 Nonorganic vaginismus

F52.6 Nonorganic dyspareunia

F52.7 Excessive sexual desire

F52.8 Other sexual dysfunction, not caused by organic disorders or disease

F52.9 Unspecified sexual dysfunction, not caused by organic disorders or disease

### Lack or loss of sexual desire

- not secondary to other sexual difficulties
- does not preclude sexual enjoyment or arousal, but makes initiation of sexual activity less likely

### Sexual aversion

- sexual interaction is associated with strong negative feelings of sufficient intensity that sexual activity is avoided

### Lack of sexual enjoyment

- sexual responses and orgasm occur normally but there is lack of pleasure
- more common in women

## F52.2 Failure of genital response (erectile dysfunction)

- in men, primarily erectile dysfunction
- in women, primarily vaginal dryness

### Biology

- erection depends on:
  - intact arterial supply
  - intact venous valves
- vascular changes caused by parasympathetic nervous system
- psychic erections are mediated by thoracic sympathetic outflow
- reflex erections result from sacral parasympathetic outflow
- androgens also influence erection, particularly those during sleep, via the limbic system

### Epidemiology

- prevalence of 4-9%
- makes up 50% of male cases presenting to sexual problems service
- incidence rises with age (1.3% at 35 years, to 55% at 75 years)

### Aetiology

- organic in 50%
- 1. *Local:*
  - a) Peyronie's disease – progressive fibrosis in the tunica albuginea, resulting in curvature of the penis upon erection
  - b) Congenital abnormalities, such as hypospadias, epispadias, absence of suspensory ligaments
  - c) Priapism – may result in impotence if not properly treated within 24 hours
- 2. *Endocrine:*
  - a) Diabetes – causes a combination of arteriopathy and neuropathy
    - i) 2/3 of diabetic males are impotent
  - b) Hypogonadism – nocturnal erections are androgen dependent
  - c) Hyperprolactinaemia secondary to hypothalamic/ pituitary disease, phenothiazines, sometimes in alcoholics
  - d) Endorphins – naltrexone can improve impotence
- 3. *Neurological:*
  - a) Peripheral or autonomic neuropathy, e.g. diabetes, alcoholism
  - b) Radical pelvic surgery causing autonomic disruption
  - c) Spinal cord lesion, e.g. transection, multiple sclerosis
- 4. *Vascular:*
  - a) arterial disease interfering with blood supply to pelvic organs
  - b) incompetent venous valves
- 5. *Pharmacological:*
  - a) alcohol
  - b) antihypertensives – ganglion blockers interfere with both sympathetic and parasympathetic systems and cause both impotence and ejaculatory failure
- 6. *Psychological:*
  - a) classical history of lack of sexual interest, but continued morning erections suggests psychological cause

7. *Psychoanalytical:*
  - a) anxiety about the persecutory object
  - b) unresolved Oedipal conflict
    - i) in younger men with primary impotence
  - c) deep ambivalence about the intimate object leading to fear of sexual failure
  - d) narcissistic crisis
    - i) in middle-aged men with secondary impotence
8. *Cognitive:*
  - a) due to negative self-image within a depressive view of the relationship, and is linked to abandonment fear
  - b) anxiety plays a key role
  - c) fear of hurting female/ fear of pregnancy/ distaste for female genitalia/ trying too hard

## Management

### 1. Assessment

- a) full sexual history
- b) physical examination
- c) penile-brachial artery pressure index of less than 0.6 is indicative of arterial disease to penis; angiography may be necessary in younger patients
- d) nocturnal penile tumescence monitoring can distinguish organic (no nocturnal erections) from psychogenic causes
- e) dynamic cavernometry (normal saline infused into corpus cavernosum) can detect venous incompetence
- f) intracorporeal injection of PAPAVERINE or PHENTOLAMINE can be diagnostic to establish the capacity for erection

### 2. Treatment

- a) *Physical*
  - i) intra-cavernosal injection of vasoactive drugs:
    - (1) PAPAVERINE, self-injected can give an erection lasting about an hour, and can be used up to twice a week
    - (2) complications include priapism, fibrosis, haematomas, and bruising
  - ii) suction devices:
    - (1) provide a safe method of obtaining an erection in up to 90% of patients
    - (2) problems include lack of spontaneity, decreased sensation, and delayed or absent ejaculation
  - iii) vascular surgery
  - iv) penile prosthetic implants:
    - (1) three types – malleable, self-contained inflatable, and multipart inflatable
    - (2) few problems with those with organic cause, but for those with psychogenic impotence, it can exacerbate pre-existing marital difficulties
- b) *Psychological*
  - i) counselling
  - ii) psychotherapy
    - (1) CBT reports success rates of 70%
    - (2) couple therapy seems more effective than surrogate or individual therapies
    - (3) factors associated with better outcome include:

- (a) good marriage
- (b) better pre-treatment communication
- (c) better general sexual adjustment
- (d) female partners interest and enjoyment of sex
- (e) absence of psychiatric history in female partner
- (f) early engagement in homework assignments

### **F52.3 Orgasmic dysfunction (anorgasmia)**

- orgasm does not occur or is delayed
- more common in women

#### **Biology**

- orgasm involves local spinal mechanisms as well as CNS activity
- EEG shows changes akin to epileptic seizures
- orgasm is similar in both sexes:
  - HR and blood pressure increase
  - sudden increase in skeletal muscle activity involving almost all parts of the body
  - in females, there is transient rhythmical contraction of the uterus and vagina

#### **Epidemiology**

- prevalence = 5-10% in females, 4-10% in males
- in females, the prevalence of anorgasmia reduces with increasing age

#### **Aetiology**

1. *Physical*
  - a) in both sexes, the bulbocavernosus reflex has been reported to be absent in some people – this is strongly correlated with treatment failure
  - b) sometimes, local pain can create fear of orgasm
  - c) Drugs:
    - i) opiates have a direct inhibitory effect
    - ii) antiserotonergic drugs inhibit orgasm
    - iii) SSRIs, MAOIs, and TCAs are all associated with female anorgasmia
2. *Psychological*
  - a) anxiety inhibits orgasm in females, but hastens it in men
  - b) there may be fear of pregnancy or STDs

#### **Management**

- direct masturbation training is the treatment of choice
- tasks include relaxation, fantasizing, and masturbation

## **F52.4 Premature ejaculation**

- the inability to control ejaculation sufficiently for both partners to enjoy sex
- primary premature ejaculation is always present
- secondary premature ejaculation develops after a period of satisfactory sexual functioning

### **Biology**

- if semen is released from the urethra without force, it is termed emission
- ejaculation and emission are mediated by the alpha-adrenergic sympathetic nervous system
- androgens have a role

### **Epidemiology**

- prevalence = 36-38%
- 13% of attendees and sexual disorders clinic have premature ejaculation

### **Aetiology**

1. *Psychological*
  - a) anxiety promotes emission but inhibits orgasm
  - b) those with primary PE are more impaired in sexual functioning and are more anxious
  - c) those with secondary PE are more likely to have coexisting erectile dysfunction, and reduction in sex drive, and a reduction in arousal
2. *Learning*
  - a) many factors may interfere with the learning of the ability to identify the point of impending ejaculation
3. *Physical*
  - a) drugs do not cause PE
  - b) those with PE do not have penile hypersensitivity

### **Management**

- education in ejaculatory control using the 'pause' technique
- sensate focus therapy
- if difficulty is experienced with these methods, the 'squeeze technique' can be used
- some antidepressants (e.g. FLUOXETINE) have a beneficial effect on PE

## **F52.5 Non-organic vaginismus**

- occlusion of the vaginal opening caused by spasm of the surrounding muscles
- penile entry is impossible or painful

### **Biology**

- when sexually aroused the upper 2/3 of the vagina are lax and capacious, whereas the lower 1/3 is closely invested by the surrounding musculature of the pelvic floor – the strongest is the levator ani
- if these muscles are too tense then penile entry is occluded
- pain or anticipation of pain can cause further muscle contraction

### **Epidemiology**

- prevalence is around 10%

### **Aetiology**

- the majority are primary
- onset can sometimes be related to a traumatic episode (painful examination, rape)
- sometimes vaginismus results from ambivalence about the relationship, or it may be due to reluctance to assume the mature adult's role

### **Management**

- exploration of own genitalia – finger insertion, combined with sensate focus techniques
- additional dilatation may be required using graded dilators

### **Non-organic dyspareunia**

- pain during intercourse may occur in both sexes

### **Excessive sexual drive**

- usually occurs in men or women during late teenage or early adult years
- if secondary to mental illness (e.g. mania) the underlying disorder is coded

## Disorders of Gender Identity

### Transsexualism

- the desire to live as a member of the opposite sex
- there is discomfort with anatomical sex, and a wish to change the body into that of the preferred sex
- it must have been persistently present for at least 2 years, and not due to another mental disorder (such as schizophrenia) or intersex, genetic, or sex-chromosomal abnormality
- the majority of transsexuals experience a successful outcome after sex-reassignment treatment

### Dual role transvestism

- includes the wearing of clothes of the opposite sex for part of the time to enjoy the temporary experience of membership of the opposite sex
- there is no desire for permanent sex change
- no sexual excitement accompanies this cross-dressing, distinguishing it from fetishistic transvestism

### Gender identity disorder of childhood

- persistent, intense distress about assigned sex, together with the desire to be of the other sex – there is a profound disturbance of the sense of maleness or femaleness
- usually manifest during early childhood, and always before puberty
- more common in boys
- between 1/3-2/3 of boys show homosexual orientation during and after adolescence – very few exhibit transsexualism in later life
- some girls show homosexual tendencies in later life, and retain male gender identification, although most do not

## Sexual Deviation

### Fetishism

- sexual preoccupation and excitement with non-living objects, which take central importance in achieving orgasm
- to be regarded as deviant, fetishism must be essential for orgasm, and causing problems

### Exhibitionism

- sexual pleasure and gratification is derived from exposure of the genitals to a person of the opposite sex
- predominantly male, aged 15-25
- the victim is usually female, and there is often an intention to surprise, shock, or insult – a reaction in the victim heightens the excitement in the perpetrator
- the victim is usually unknown
- often compulsive in nature
- often passive, inadequate men with problems in relationships and low self-esteem
- may show personality disorder of asthenic or inadequate type

### Voyeurism

- no sexual contact is attempted, though masturbation may occur during or after
- the voyeur often has fantasies of humiliating or embarrassing the victims with the knowledge that they have been observed
- the victim is usually unaware

### Paedophilia

- where the child is an older girl (over 12), the offender is often a young male but is unlikely to be consistently deviant or psychiatrically ill
- for younger children, the adult is likely to be substantially older and more likely to show psychiatric illness such as:
  - schizophrenia
  - hypomania
  - alcoholism
  - dementia
  - mental handicap

### Sadomasochism

- sexual arousal in response to the infliction of pain, psychological humiliation or ritualized dominance or submission
- sadomasochistic fantasies occur during intercourse or masturbation in both sexes, often in stable relationships
- more common in homosexuals

### Polymorphously perverse

- multiple disorders of sexual preference

### Other disorders of sexual preference

- obscene telephone calls
- frotteurism
- bestiality:
  - low intellect
  - restricted social outlets
  - access to animals
- anoxophila
- necrophilia

## Antisocial Sexual Behaviour

### Rape

- this is unlawful sexual intercourse with a woman by force or against her will
- Classification of rapists (Trick and Tennant 1981):
  1. *Situational stress rapist*
    - a) otherwise sexually normal, these individuals commit rape when under extreme situational stress
    - b) there is much guilt and remorse afterwards
  2. *Sociopathic rapist*
    - a) poor social adjustment with criminality, poor work record, substance abuse, unstable relationships
    - b) rape is often impulsive, with immediate gratification and little regard to the consequences
    - c) threats of violence are common
  3. *Sexually inadequate rapists*
    - a) shy, timid, and insecure, lacking social skills
    - b) they often plan a rape against an attractive or sexually threatening woman
  4. *Sadistic rapist*
    - a) deep-rooted hatred of women arising from early relationships
    - b) the object of the rape is the infliction of humiliation and suffering
    - c) the rape is often planned, with precautions to avoid detection
  5. *Psychotic rapist*
    - a) the rape is often bizarre, violent, and terrifying for the victim

### Indecent exposure

- an offence under the 1824 Vagrancy Act: 'openly, lewdly and obscenely exposing his person with intent to insult any female'
- two main groups:
  - **Type I**
    - inhibited young men of relatively normal personality and good character who struggle against the impulse but find it irresistible
    - they expose with a flaccid penis and do not masturbate
    - the frequency of exposure is often related to other sexual stresses and anxieties, such as marital conflict or a pregnant spouse
  - **Type II**
    - less inhibited, more sociopathic
    - expose with an erect penis in a state of excitement, and may masturbate
    - obtain pleasure and show little guilt
    - more likely to expose to a group of women or girls, and may return repeatedly to the same place
    - associated with other psychosexual disorders and other types of offences
    - may lead on to more serious sexual offences
- 80% do not offend again if they are charged with the first offence
- the chances of recidivism rise dramatically with the second offence
- treatment:
  - antilibidinal drugs
  - psychotherapy – cognitive and behavioural