Chapter 11
Disorders Involving Gender and Sexuality
Sheila K. Grant, Ph.D.
Professor

Gender Identity Disorder

Gender identity - One’s psychological sense of being female or being male.

Gender identity disorder (GID) - A type of psychological disorder characterized by conflict between one’s anatomic sex and one’s gender identity.

Gender identity disorder (also referred to as transsexualism) may begin in childhood.

The Case of Denise

“My earliest memories, back when I was about four years old...I remember crossdressing back then, all the way until really around my puberty.”

Gender Identity Disorder

Although the prevalence rate of GID is unknown, the disorder is certainly uncommon.

It is believed to occur about five times more often in boys than girls (Jones & Hill, 2002).

GID takes many paths. It can end by adolescence, with the child’s becoming more accepting of her or his gender identity, or it may persist into adolescence or adulthood.

What is normal and what is abnormal?

People who undergo sex-reassignment surgery can participate in sexual activity and even reach orgasm, but they cannot conceive or bear children because they lack the internal reproductive organs of their newly reconstructed sex.

Investigators generally find positive postoperative adjustment of transsexuals.

In one study, none of 20 adolescents who underwent sex reassignment surgery later expressed regrets (Smith et al., 2001).

In another recent survey, 85% of male-to-female transsexuals were able to achieve orgasm during sexual activity after reassignment surgery (Lawrence, 2005).
Theoretical Perspectives

Psychodynamic theorists point to extremely close mother–son relationships, empty relationships with parents, and fathers who were absent or detached (Stoller, 1969).

These family circumstances may foster strong identification with the mother in young males, leading to a reversal of expected gender roles and identity.

Girls with weak, ineffectual mothers and strong masculine fathers may overly identify with their fathers and develop a psychological sense of themselves as "little men."

Homophobia - Hatred and fear of lesbians and gay males.

Heterosexism - The culturally based belief system that holds that only reproductive sexuality between men and women is psychologically healthy and morally correct.

GID may develop as the result of an interaction in utero between the developing brain and the release of male sex hormones (Dennis, 2004).

Sexual Dysfunctions

Sexual dysfunctions - Persistent or recurrent problems with sexual interest, arousal, or response.

Sexual dysfunctions may be classified according to two general categories, lifetime versus acquired and situational versus generalized.

Cases of sexual dysfunction that have existed for the individual’s lifetime are called lifetime dysfunctions.

In situational dysfunctions, the problems occur in some situations (for example, with one’s spouse), but not in others (for example, with a lover or when masturbating), or at some times but not others.

Types of Sexual Dysfunctions

The DSM-IV-TR groups most sexual dysfunctions within the following categories:

1. Sexual desire disorders
2. Sexual arousal disorders
3. Orgasm disorders
4. Sexual pain disorders

Sexual Desire Disorders

Sexual desire disorders are disturbances in sexual appetite or an aversion to genital sexual activity.

Hyposexual sexual desire disorder - Persistent or recurrent lack of sexual interest or sexual fantasies.

Typically there is either a virtual or complete absence of sexual fantasies.
**Sexual Desire Disorders**

**Sexual aversion disorder** - A type of sexual dysfunction characterized by aversion to, and avoidance, of genital sexual contact.

**Female sexual arousal disorder** - A type of sexual dysfunction in women involving difficulty becoming sexually aroused or lack of sexual excitement or pleasure during sexual activity.

**Male erectile disorder** - A sexual dysfunction in males characterized by difficulty in achieving or maintaining erection during sexual activity.

**Orgasm Disorders**

**Female orgasmic disorder** - A type of sexual dysfunction involving persistent difficulty achieving orgasm despite adequate stimulation.

**Male orgasmic disorder** - Persistent or recurrent delay in achieving orgasm or inability to achieve orgasm despite a normal level of sexual interest and arousal.

**Premature ejaculation** - A type of sexual dysfunction involving a pattern of unwanted rapid ejaculation during sexual activity.

**Sexual Pain Disorders**

**Dyspareunia** - Persistent or recurrent pain experienced during or following sexual intercourse.

The pain cannot be explained fully by an underlying medical condition and so is believed to have a psychological component.

**Vaginismus** - The involuntary spasm of the muscles surrounding the vagina when vaginal penetration is attempted, making sexual intercourse difficult or impossible.

**Psychological Perspectives**

Physically or psychologically painful sexual experiences may lead the person to respond to sexual contact with anxiety rather than arousal or pleasure.

Conditioned anxiety resulting from a history of sexual trauma or rape plays a role in many women with sexual arousal disorder, sexual aversion disorder, orgasmic disorder, and vaginismus.

Women with problems becoming sexually aroused may harbor deep-seated anger and resentment toward their partners.

Other psychologically based causes of sexual arousal disorder, especially in women, include guilt about sex and ineffective stimulation by the partner.

Cognitive theorists, such as Albert Ellis (1977b), point out that underlying irrational beliefs and attitudes can contribute to sexual dysfunctions.

Consider two such irrational beliefs: (a) we must have the approval at all times of everyone who is important to us; and (b) we must be thoroughly competent at everything we do.

If we cannot accept the occasional disappointment of others, we may catastrophize the significance of a single frustrating sexual episode.

If we insist that every sexual experience be perfect, we set the stage for inevitable failure.

When a source of pleasure becomes a source of misery.
**Biological Perspectives**

Biological factors such as low testosterone levels and disease can dampen sexual desire and reduce responsiveness.

The male sex hormone testosterone plays a pivotal role in energizing sexual desire and sexual activity in both men and women (Davis et al., 2005).

The adrenal glands and ovaries are the sites where testosterone is produced in women.

Cardiovascular problems involving impaired blood flow both to and through the penis can cause erectile disorder—a problem that becomes more common as men age.

Erectile disorder may share common risk factors with cardiovascular disorders (heart and artery diseases) which should alert physicians that erectile dysfunction may be a sign of underlying cardiovascular disorders that need to be medically evaluated.

Erectile dysfunction is also more common in obese men (as are cardiovascular problems).

**Erectile disorder and male orgasmic disorder may also result from multiple sclerosis (MS), a disease in which nerve cells lose the protective coatings that facilitate transmission of neural messages (Rees, Fowler, & Maas, 2007).**

Chronic kidney disease, cancer, and emphysema can also impair erectile response, as can endocrine disorders that impair testosterone production (Ralph & McNicholas, 2000).

Depressant drugs such as alcohol, heroin, and morphine can reduce sexual desire and impair sexual arousal.

Narcotics, such as heroin, also depress testosterone production, which can diminish sexual desire and lead to erectile failure.

**Sociocultural Perspectives**

Investigators find a greater incidence of erectile dysfunction in cultures with more restrictive sexual attitudes toward premarital sex among females, toward sex in marriage, and toward extramarital sex.

Men in these cultures may be prone to develop sexual anxiety or guilt that interferes with sexual performance.

In India, cultural beliefs that link the loss of semen to a draining of the man’s life energy underlie the development of Dhat syndrome, an irrational fear of loss of semen.

**Treatment of Sexual Dysfunctions**

Until the groundbreaking research of the famed sex researchers William Masters and Virginia Johnson in the 1960s, there was no effective treatment for most sexual dysfunctions.

Psychoanalytic therapy approached sexual dysfunctions indirectly.

It was assumed that sexual dysfunctions represented underlying conflicts, so treatment focused on resolving those conflicts through psychoanalysis.

Most contemporary sex therapists assume sexual dysfunctions can be treated by directly modifying the couple’s sexual interactions.

Pioneered by Masters and Johnson (1970), sex therapy uses cognitive-behavioral techniques in a brief therapy format to help individuals enhance their sexual competencies (sexual knowledge and skills) and relieve performance anxiety.

When feasible, both partners are involved in therapy.

In some cases, however, individual therapy may be preferable, as we shall see.
Sexual Desire Disorders

Sex therapists may try to help people with low sexual desire kindle their sexual appetite through the use of self-stimulation (masturbation) exercises together with erotic fantasies.

When working with couples, therapists prescribe mutual pleasuring exercises the couple can perform at home or encourage them to expand their sexual repertoire to add novelty and excitement to their sex life.

When a lack of sexual desire is connected with depression, the treatment focuses on treating the underlying depression.

Disorders of Arousal

Sexual arousal results in the pooling of blood in the genital region, causing erection in the male and vaginal lubrication in the female.

These changes in blood flow occur as a reflexive response to sexual stimulation; they cannot be willed.

Women who have difficulty becoming sexually aroused and men with erectile problems are first educated to the fact that they need not “do” anything to become aroused.

Disorders of Orgasm

Women with orgasmic disorder often harbor underlying beliefs that sex is dirty or sinful.

They may have been taught not to touch themselves.

They feel anxious about sex and have not learned, through trial and error, what kinds of sexual stimulation will arouse them and help them reach orgasm.

Disorders of Orgasm

Masters and Johnson preferred working with the couple in cases of female orgasmic dysfunction, but other sex therapists prefer to work with the woman individually by directing her to practice masturbation in private.

Directed masturbation provides women opportunities to learn about their own bodies at their own pace and has a success rate of 70% to 90%.

It frees women of the need to rely on or please partners. Once women can reliably masturbate to orgasm, couple-oriented treatment may facilitate transfer of training to orgasm with a partner.

Vaginismus and Dyspareunia

Vaginismus is a conditioned reflex involving the involuntary constriction of the vaginal opening.

It represents a psychologically based fear of penetration, rather than a medical problem.

Treatment for vaginismus may include a combination of relaxation techniques, cognitive techniques, and use of methods of gradual exposure in order to desensitize the vaginal musculature to penetration, such as finger insertion of first one and then two fingers by the woman and her partner and use of vaginal dilators (plastic rods) that are inserted, like a tampon, in the vagina by the woman.

Biological Treatments of Sexual Dysfunction

Erectile disorder frequently has organic causes, so it is not surprising that treatment is becoming increasingly medicalized.

Drugs that increase blood flow to the penis, such as Viagra, are successful in producing erections in a majority of men suffering from erectile.

In some cases of erectile disorder, surgical insertion of a penile implant may be performed if drugs or other less invasive techniques fail.
Paraphilias

The word *paraphilia* was coined from the Greek roots *para*, meaning “to the side of,” and *philos*, meaning “loving.”

**Paraphilias** - Sexual deviations or types of sexual disorders in which the person experiences recurrent sexual urges and sexually arousing fantasies involving nonhuman objects (such as articles of clothing), inappropriate or nonconsenting partners (for example, children), or situations producing humiliation or pain to oneself or one’s partner.

Types of Paraphilias

Some *paraphilias* are relatively harmless and victimless.

Among these are fetishism and transvestic *fetishism*.

Others, such as *exhibitionism*, *pedophilia*, and *voyeurism* have unwilling victims.

A most harmful paraphilia is sexual sadism when acted out with a nonconsenting partner.

Exhibitionism

**Exhibitionism** - A type of paraphilia almost exclusively occurring in males, in which the man experiences persistent and recurrent sexual urges and sexually arousing fantasies involving the exposure of his genitals to a stranger and either has acted upon these urges or feels strongly distressed by them.

The person may masturbate while fantasizing about or actually exposing himself (almost all cases involve men).

The victims are almost always women.

Relatively few cases are reported to the police.

Fetishism

The French word *fétiche* is thought to derive from the Portuguese *fétiço*, referring to a “magic charm.”

In this case, the “magic” lies in the object’s ability to arouse sexually.

**Fetishism** - A type of paraphilia in which a person uses an inanimate object as a focus of sexual interest and as a source of arousal.
Transvestic Fetishism

Transvestic fetishism - type of paraphilia in heterosexual males involving sexual urges and sexually arousing fantasies involving dressing in female clothing. Also termed transvestism.

Although other men with fetishes can be satisfied by handling objects such as women's clothing while they masturbate; transvestite men want to wear them.

They may wear full feminine attire and makeup or favor one particular article of clothing, such as women's stockings.

Transvestic Fetishism

Voyeurism

Voyeurism - A type of paraphilia involving sexual urges and sexually arousing fantasies focused on acts of watching unsuspecting others who are naked, in the act of undressing, or engaging in sexual activity.

The voyeur usually masturbates while watching or while fantasizing about watching.

Peeping may be the voyeur's only sexual outlet. Some people engage in voyeuristic acts in which they place themselves in risky situations.

The prospects of being discovered or injured apparently heighten their excitement.

Voyeurism

Frotteurism

The French word frottage refers to the artistic technique of making a drawing by rubbing against a raised object.

Frotteurism - A type of paraphilia involving sexual urges or sexually arousing fantasies involving bumping and rubbing against nonconsenting persons for sexual gratification.

Frotteurism, also called “mashing,” often occurs in crowded places, such as subway cars, buses, or elevators.

The rubbing or touching, not the coercive aspect of the act, sexually arouses the man.

Frotteurism

Pedophilia

The word pedophilia derives from the Greek paidos, meaning “child.”

Pedophilia - A type of paraphilia involving sexual attraction to children.

To be diagnosed with pedophilia, the person must be at least 16 years of age and at least 5 years older than the child or children toward whom the person is sexually attracted or has victimized.

In some cases of pedophilia, the person is attracted only to children. In other cases, the person is attracted to adults as well.

Pedophilia

Effects of Sexual Abuse on Children

An estimated 50,000 children in the United States suffer sexual abuse each year (Villarosa, 2002).

The typical abuser is not the proverbial stranger lurking in the shadows, but a relative or step-relative of the child, a family friend, or a neighbor—someone who has held and then abused the child’s trust.

Sexual abuse can inflict great psychological harm, whether it is perpetrated by a family member, acquaintance, or stranger.

Effects of Sexual Abuse on Children

The effects of childhood sexual abuse tend to be similar in boys and girls (Edwards et al., 2003). Both tend to become fearful and have trouble sleeping. But there are some sex differences.

The most pronounced is that boys more often externalize their problems, often through physical aggression. Girls more often internalize their difficulties, as by becoming depressed (Edwards et al., 2003).
**Sexual Masochism**

Sexual masochism derives its name from the Austrian novelist *Ritter Leopold von Sacher Masoch* (1835–1895), who wrote stories and novels about men who sought sexual gratification from women by inflicting pain on them, often in the form of flagellation (being beaten or whipped).

**Sexual masochism** - A type of paraphilia characterized by sexual urges and sexually arousing fantasies involving receiving humiliation or pain.

**Hypoxophilia** - A paraphilia in which a person seeks sexual gratification by being deprived of oxygen by means of using a noose, plastic bag, chemical, or pressure on the chest.

**Sexual Sadism**

Sexual sadism - A type of paraphilia or sexual deviation characterized by recurrent sexual urges and sexually arousing fantasies involving inflicting humiliation or physical pain on sex partners.

**Sadomasochism** - Sexual activities between partners involving the attainment of gratification by means of inflicting and receiving pain and humiliation.

The clinical diagnosis of sexual masochism or sadism is not brought to bear unless such people become distressed by their behavior or fantasies, or these urges and fantasies lead to problems with other people.

**Other Paraphilias**

Other paraphilias include:

- Making obscene phone calls ("telephone scatologia")
- Necrophilia (sexual urges or fantasies involving contact with corpses)
- Partialism (sole focus on part of the body, such as the breasts)
- Zoophilia (sexual urges or fantasies involving contact with animals)
- Sexual arousal associated with feces (coprophilia), enemas, or urine (urophilia)

In the Controversies in Abnormal Psychology feature, we discuss what may be a new psychological disorder—cybersex addiction.

**Psychological Perspectives**

Psychodynamic theorists see many of the paraphilias as defenses against leftover castration anxiety from the phallic period of psychosexual development.

In Freudian theory, the young boy develops a sexual desire for his mother and perceives his father as a rival.

Castration anxiety—the unconscious fear that the father will retaliate by removing the organ that has become associated with sexual pleasure through masturbation—motivates the boy to give up his incestuous yearnings for his mother and identify with the aggressor, his father.

Learning theorists explain paraphilias in terms of conditioning and observational learning.

Some object or activity becomes inadvertently associated with sexual arousal.

The object or activity then gains the capacity to elicit sexual arousal.

For example, sex researcher June Reinisch (1990) speculates that the earliest awareness of sexual arousal or response (such as erection) may have been connected with rubber pants or diapers.
Biological Perspectives

Investigators find evidence of higher-than-average sex drives in men with paraphilias, as evidenced by a higher frequency of sexual fantasies and urges and a shorter refractory period after orgasm by masturbation (i.e., length of time needed to become rearoused).

Kafka (2003) refers to this heightened sex drive as hypersexual desire—the opposite of hypoactive sexual desire disorder (see the section on sexual dysfunctions).

Other investigators find differences between paraphiliac men and male control subjects in the electrical response patterns in the brain to paraphiliac (fetishistic and sadomasochistic) images and control images (nude women, genital intercourse, oral sex).

Treatment of Paraphilias

A major problem with treating paraphilias is that many people who engage in these behaviors are not motivated to change.

They may not want to alter their behavior unless they believe that treatment will relieve them from serious punishment, such as imprisonment or loss of a family life.

Consequently, they don’t typically seek treatment on their own.

Psychoanalysis

Psychoanalysts attempt to bring childhood sexual conflicts (typically of an Oedipal nature) into awareness so they can be resolved in the light of the individual’s adult personality.

Favorable results from individual case studies appear in the literature from time to time, but there is a dearth of controlled investigations to support the efficacy of psychodynamic treatment of paraphilias.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is briefer and focuses directly on changing problem behavior.

Cognitive-behavioral therapy includes a number of specific techniques, such as aversion therapy, covert sensitization, and social skills training, to help eliminate paraphiliac behaviors and strengthen appropriate sexual behaviors (Krueger & Kaplan, 2002).

In many cases a combination of methods is used.

The goal of aversion therapy is to induce a negative emotional response to paraphiliac stimuli or fantasies.

Biomedical Therapies

SSRIs are often helpful in treating obsessive–compulsive disorder, a psychological disorder characterized by recurrent obsessions and compulsions.

Antiandrogen drugs reduce levels of testosterone in the bloodstream (Bradford, 2001).

The most widely used antiandrogen is medroxyprogesterone acetate (MPA) (trade name Depo-Provera), which is usually administered in weekly injections.

Antiandrogens do not completely eliminate paraphiliac urges, nor do they change the types of erotic stimuli to which the man is attracted.

Overview of Paraphilias
**Rape**

Rape - Forced sexual intercourse with a nonconsenting person. Note that the legal definition of rape varies from state to state.

Victims of rape have trouble sleeping and cry frequently.

They report eating problems, cystitis, headaches, irritability, mood changes, anxiety and depression, and menstrual irregularity.

Survivors may become withdrawn, sullen, and mistrustful.

---

**Types of Rape**

The main types of rape include stranger rape, acquaintance rape, marital rape, and male rape.

Stranger rape is committed by an assailant (or assailants) who is not acquainted with the victim.

Acquaintance rapes - rapes committed by people known by the victim.

Marital rapes may be even more common than date rapes because the sexual relationship has already been established in the context of marriage.

---

**Relative percentages of stranger rapes and acquaintance rapes.**

- **Stranger Rape**
  - Percentage of Total Rapes
    - Stranger Rape: 30%
    - Non-consensual Acquaintances: 25%
    - Casual Dates: 15%
    - Street Rape: 10%
    - Survivors and Other Family Members: 5%

- **Acquaintance Rape**
  - Percentage of Total Rapes
    - Acquaintance Rape: 40%

---

**QUESTIONS?**