19 - Chapter 16 Sexual Dysfunctions and Paraphilic Diso

- 01 - Chapter 16 Sexual Dysfunctions and Paraphilic

01 - Chapter 16 Sexual Dysfunctions and Paraphilic

Chapter 16 Sexual Dysfunctions and Paraphilic Disorders

Sexual Response Cycle...176
Sexual Changes with Aging...176
Differential Diagnosis of Sexual Dysfunctions..176
Sexual Dysfunctions...177
Treatment of Sexual Disorders...178 Sex Therapy...178 Cognitive-Behavioral Therapy..179 Group Therapy...179 Analytically Oriented (Psychodynamic) Psychotherapy...179 Pharmacologic Treatment...179 Mechanical Therapies...179 Gender Dysphoria...180 Diagnosis and DSM-5 Criteria...180
Treatment..180
Paraphilias...181
Examples of Paraphilic Disorders...181 Course and Prognosis..181
Treatment..181
PARAPHILIC DISORDERS S EX UAL DYSFU NC T I O NS A ND CHAPTER 16

176 SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS Sexual Response Cycle WARDS QUESTION Q: Which class of antidepressants is most likely to cause sexual dysfunction? A: Selective serotonin reuptake inhibitors (SSRIs). ■ Depression. ■ Substance use. Sexual dysfunctions include clinically significant disturbances in individuals’ ability to respond sexually or to experience sexual pleasure. There are several stages of normal sexual response in men and

women:

1. Desire: The motivation or interest in sexual activity, often reflected by sexual fantasies.
2. Excitement/Arousal: Begins with either fantasy or physical contact. It is characterized by erections and testicular enlargement in men and by vaginal lubrication, clitoral erection, labial swelling, and elevation of the uterus in the pelvis (tenting) in women. Both men and women experience flushing, nipple erection, and increased respiration, pulse, and blood pressure.
3. Orgasm: In men just prior there is tightening of the scrotal sac and secretion of a few drops of seminal fluid. Women experience contraction of the outer one-third of the vagina and enlargement of the upper one-third of the vagina. Men ejaculate and women have contractions of the uterus and lower onethird of the vagina. There is facial grimacing, release of tension, slight clouding of consciousness, involuntary anal sphincter contractions, and acute increase in blood pressure and pulse in both men and women.
4. Resolution: Muscles relax and cardiovascular state returns to baseline. Detumescence of genitalia in both sexes. Men have a refractory period lasting minutes to hours during which they cannot reexperience orgasm; women have little or no refractory period. Sexual Changes with Aging The desire for sexual activity does not usually change as people age. However, men usually require more direct stimulation of genitals and more time to achieve orgasm, with less reliable/strong erections. The intensity of ejaculation usually decreases, and the length of refractory period increases. After menopause, women experience vaginal dryness and thinning due to decreased levels of estrogen and lubrication. They may also have decreased libido and reduced nipple/clitoral/vulvar sensitivity. These conditions can be treated with hormone replacement therapy or vaginal creams. Differential Diagnosis of Sexual Dysfunctions Problems with sexual functioning may be due to any of the following: ■ Medical conditions: Examples include atherosclerosis (causing erectile dysfunction from vascular occlusion), diabetes (causing erectile dysfunction from vascular changes and peripheral neuropathy), and pelvic adhesions (causing dyspareunia in women). ■ Medication side effects: Antihypertensives, anticholinergics, antidepressants (especially selective serotonin reuptake inhibitors [SSRIs]), and antipsychotics.

■ Abnormal levels of gonadal hormones: • Estrogen: Decreased levels after menopause cause vaginal dryness and thinning in women (without affecting desire). • Testosterone: Promotes libido (desire) in both men and women. • Progesterone: May inhibit libido in both men and women by blocking androgen receptors; found in oral contraceptives, hormone replacement therapy, and, occasionally, treatments for prostate cancer. ■ Presence of a sexual dysfunction (see below). Sexual Dysfunctions Sexual dysfunctions are problems involving any stage of the sexual response cycle. They all share the following Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5) criteria: ■ The disorder causes clinically significant distress. ■ The dysfunction is not better explained by a nonsexual mental disorder, as a consequence of severe relationship distress or other stressors, and not attributable to the effects of a substance/medication or another medical condition. Mr. Jones is a 58-year-old married man with a history of major depressive disorder who arrives at your outpatient clinic for a yearly follow-up visit. He complains of recent marital problems with his wife of 30 years. He is being treated with an SSRI, and his depressive symptoms have been stable for over 3 years on his current dose. Upon further questioning, he reveals that he has been

having sex with his wife less often than usual, only once or twice a month. He states that this is a marked decrease since his last visit with you. He feels that lately they have been arguing more and feels that their decrease in sexual activity has adversely affected their relationship. He also reports a mild decrease in his energy. Mr. Jones denies having urges to masturbate in the times between sexual intercourse with his wife. He also denies having any affairs, laughing nervously while saying, “I can barely satisfy my own wife.” He appears sad and states that he is beginning to feel “down” about this. When he does have sex, he reports that it is initiated by his wife, and he is initially reluctant to engage in sexual activity. However, once he does, he denies any problems with having or sustaining an erection and denies any difficulties in reaching orgasm. Mr. Jones reports that he drinks two or three drinks per day on the weekends, and he does not use any recreational drugs. What is his most likely diagnosis? What other considerations should be made? The patient’s most likely diagnosis is male hypoactive sexual desire disorder. Although decreased sexual interest is more prevalent in women, it should not be overlooked in men. As this clinical case shows, the patient does not seem to fantasize or desire sexual activity despite prior history of doing so. He appears distressed by this and reports that it is causing interpersonal dysfunction. Although his depression has remained stable during the past 3 years and the patient does not report symptoms that would suggest a current depressive episode, his sexual complaints and fatigue symptoms might suggest a relapse of depressive symptoms and should be monitored closely. It is also very important to consider if his treatment with an SSRI is affecting his sexual functioning. SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS KEY FACT Dopamine enhances libido. Serotonin inhibits sexual function. WARDS TIP Causes of sexual dysfunctions may be physiological, psychological, or both. Psychological causes of sexual dysfunctions are often comorbid with other psychiatric disorders, such as depression or anxiety. WARDS TIP Problems with sexual desire may be due to stress, relationship difficulties or conflict, poor selfesteem, or unconscious fears about sex.

178 SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS WARDS QUESTION Q: What are the most common sexual dysfunctions in men? A: Erectile disorder and premature ejaculation. KEY FACT Other DSM-5 categories of sexual dysfunction include substance/ medication-induced sexual dysfunction and other specified/ unspecified sexual dysfunction. SEX THERAPY What should you consider in the initial management of this patient’s complaints? His initial management should consist of a thorough history, a physical examination, and laboratory tests (complete metabolic profile, testosterone levels, thyroid-stimulating hormone levels) that might rule out medical (e.g., endocrine) abnormalities. If another medical disorder, mental disorder, or substance is not believed to be responsible, treatment considerations should include outpatient psychotherapy, sex therapy, cognitive-behavioral therapy, or group therapy. ■ Male hypoactive sexual desire disorder: Absence or deficiency of sexual thoughts, desire, or fantasies for more than 6 months (self-reported in approximately 5% of men). ■ Female sexual interest/Arousal disorder: Absence or reduced sexual interest, thoughts/fantasies, initiation of sex, sexual excitement/pleasure, sexual arousal, and/or genital/nongenital sensations during sex for more than 6 months (unclear prevalence of DSM-5 disorder, but self-reported in 26–43% of women). ■ Erectile disorder: Marked difficulty obtaining or maintaining an erection, or marked decreased in erectile rigidity for more than 6 months. Commonly referred to as erectile dysfunction (ED) or impotence. May be lifelong (always had difficulty) or acquired (after previous ability to maintain erections). ED is the most common sexual disorder diagnosed in men; the prevalence is age dependent, from 5% at age 40 to 15% at age 70. ■ Premature (early) ejaculation: Recurrent pattern of ejaculation during sex within 1 minute and

before the individual wishes it for more than 6 months. Likely the most common sexual disorder in men, but underreported. Worldwide prevalence up to 30%. ■ Female orgasmic disorder: Marked delay in infrequency/absence/reduced intensity of orgasm for more than 6 months. The international prevalence ranges from 20% to 40%. ■ Delayed ejaculation: Marked delay in infrequency/absence of ejaculation for more than 6 months. Worse as men age and likely underreported, approximately 6% of men over 50 years report ejaculatory difficulty. ■ Genito-pelvic pain/Penetration disorder: Persistent or recurrent difficulties in one of the following: vaginal penetration during intercourse, marked vulvovaginal or pelvic pain during intercourse or penetration, marked anticipatory fear or anxiety about vulvovaginal or pelvic pain, or marked tensing or tightening of pelvic floor muscles during attempted vaginal penetration for more than 6 months. Prevalence unknown but 10–20% of American women complain of pain during intercourse. Prior sexual/physical abuse is considered to be a risk factor. Treatment of Sexual Disorders Sex therapy utilizes the concept of the couple, rather than the individual, as the target of therapy. Couples meet with a therapist together in sessions to identify and discuss their sexual problems. The therapist recommends sexual exercises

for the couple to attempt at home; activities initially focus on heightening sensory awareness (sensate focus exercises) and progressively incorporate increased levels of sexual contact. Treatment is short term. This therapy is most useful when no other psychopathology is involved. COGNITIVE-BEHAVIORAL THERAPY Cognitive-behavioral therapy (CBT) approaches sexual dysfunction as a learned maladaptive behavior. It utilizes traditional therapies such as cognitive restructuring, partner communication training, systematic desensitization, and exposure, where patients are progressively exposed to increasing levels of stimuli that provoke their anxiety. Eventually, patients are able to respond appropriately to the stimuli. Other forms of therapy may include muscle relaxation techniques, assertiveness training, and prescribed sexual exercises to try at home. It is also a short-term therapy. GROUP THERAPY May be used as a primary or adjunctive therapy. ANALYTICALLY ORIENTED (PSYCHODYNAMIC) PSYCHOTHERAPY Individual, long-term therapy that focuses on feelings, past relationships (including familial), fears, fantasies, dreams, and interpersonal problems that may be contributing to the sexual disorder. PHARMACOLOGIC TREATMENT ■ Erectile disorder: Phosphodiesterase-5 inhibitors (e.g., sildenafil) are given orally, which enhance blood flow to the penis; they require psychological or physical stimulation to achieve an erection. A second-line treatment is alprostadil, either injected into the corpora cavernosa or transurethral, which acts locally; it produces an erection within 2–3 minutes and works in the absence of sexual stimulation. ■ Premature ejaculation: SSRIs and the serotonergic tricyclic antidepressant (TCA) clomipramine prolong the time from stimulation to orgasm. Topical aesthetics are also occasionally used. ■ Male hypoactive sexual desire disorder/female sexual interest/arousal disorder: Testosterone is used as replacement therapy for men with low levels. Low doses may also improve libido in women, especially in postmenopausal women. Medications that increase dopamine and norepinephrine, such as Flibanserin and bupropion, may also be used. Low-dose vaginal estrogen replacement may improve vaginal dryness and atrophy in postmenopausal women. MECHANICAL THERAPIES ■ Erectile disorder: Vacuum-assisted erection devices, penile prostheses, or surgical insertion of semirigid or inflatable tubes into the corpora cavernosa (used only for end-stage impotence). ■ Female orgasmic disorder: Directed masturbation (education and selfawareness exercises to reach orgasm through self-stimulation). SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS

180 ■ Premature ejaculation: SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS Gender Dysphoria DIAGNOSIS AND DSM-5 CRITERIA ■ At least two of the following: KEY FACT Gender-expansive patients may use a wide range of terms to self-identify, such as transgender, nonbinary, or genderqueer. Transitioning is different for every individual, and may involve psychosocial changes, medications, or gender-affirming surgeries. TREATMENT • The squeeze technique is used to increase the threshold of excitability. When the man is excited to near ejaculation, he or his sexual partner is instructed to squeeze the glans of his penis in order to prevent ejaculation. Gradually, he gains awareness about his sexual sensations and learns to achieve greater ejaculatory control. • The stop-start technique involves cessation of all penile stimulation when the man is near ejaculation. This technique functions in the same manner as the squeeze technique. ■ Genito-pelvic pain/Penetration disorder: Gradual desensitization to achieve intercourse, starting with muscle relaxation techniques, progressing to erotic massage, and finally achieving sexual intercourse. Previous versions of the DSM included the diagnosis of gender identity disorder. This was revised to gender dysphoria in DSM-5 to emphasize that the pathology is not gender diversity itself, but rather the distress caused by incongruence between the gender a person was assigned at birth and their identified gender. Gender-expansive people experience disproportionately high rates of harassment, violence, and discrimination. One-third of transgender adults have had negative experiences related to their gender in healthcare settings, and nearly one-third are not “out” to any of their medical providers; therefore, clinicians should ask, not assume, a patient’s gender, and use the patient’s identified pronouns in all communication and documentation. Common psychiatric comorbidities include suicidal ideation, mood/anxiety disorders, PTSD, substance use, and eating disorders. • A marked incongruence between one’s experienced gender and primary/ secondary sex characteristics. • A strong desire to be rid of one’s primary/secondary sex characteristics because of the above. • A strong desire for the primary/secondary sex characteristics of the other gender. • A strong desire to be of the other gender. • A strong desire to be treated as the other gender. • A strong conviction that one has the typical feelings/reactions of the other gender. ■ Clinically significant distress or impairment in functioning. Gender-affirming psychotherapy, and engagement of family support especially for children or adolescents. Transitioning may be social (e.g., changes to name, clothing, or hairstyle), medical (hormone therapy), or surgical. Surgical sex reassignment surgery can be performed after living 1 year in the desired gender role and 1 year of continuous hormone therapy. It’s essential to screen carefully for comorbid psychiatric conditions and treat these as usual.

Paraphilias Paraphilic disorders are characterized by engagement in unusual sexual activities and/or preoccupation with unusual sexual urges or fantasies for at least 6 months that either are acted on with a nonconsenting person or cause significant distress or impairment in functioning. Paraphilic fantasies alone are not considered disorders unless they are intense, recurrent, and interfere with daily life; occasional fantasies are considered normal components of sexuality (even if unusual). Only a small percentage of people suffer from paraphilic disorders. Most paraphilic disorders occur almost exclusively in men, but sadism, masochism, and pedophilia may also occur in women. Voyeuristic and pedophilic disorders are the most common paraphilic disorders. EXAMPLES OF PARAPHILIC DISORDERS ■ Pedophilic disorder: Sexual fantasies/urges/behaviors involving sexual acts with prepubescent children (age 13 years or younger). DSM-5 specifies that the person is at least age 16 and at least 5 years older than the child. ■ Frotteuristic disorder: Sexual arousal from touching or rubbing against a nonconsenting person. ■ Voyeuristic disorder: Sexual arousal from observing an unsuspecting nude, or disrobing individual (often with

binoculars). ■ Exhibitionistic disorder: Sexual arousal from exposure of one's genitals to an unsuspecting person. ■ Sexual masochism disorder: Sexual arousal from the act of being humiliated, beaten, bound, or made to suffer. ■ Sexual sadism disorder: Sexual arousal from the physical or psychological suffering of another person. ■ Fetishistic disorder: Sexual arousal from either the use of nonliving objects (e.g., shoes or pantyhose) or nongenital body parts. ■ Transvestic disorder: Sexual arousal from cross-dressing (e.g., man wearing women's clothing such as underwear). COURSE AND PROGNOSIS ■ Poor prognostic factors are having multiple paraphilias, early age of onset, comorbid substance use, high frequency of behavior, and referral by law enforcement agencies (i.e., after an arrest). ■ Good prognostic factors are having only one paraphilia, self-referral for treatment, sense of guilt associated with the behavior, and history of otherwise normal sexual activity in addition to the paraphilia. TREATMENT ■ Difficult to treat; studied mostly in pedophilia. ■ Psychotropic medication if associated with a comorbid psychiatric illness. SEXUAL DYSFUNCTIONS AND PARAPHILIC DISORDERS WARDS QUESTION Q: What are the three most common types of paraphilia? A: Pedophilia, voyeurism, and exhibitionism. KEY FACT Patients often have more than one paraphilia. KEY FACT An example of fetishistic disorder is a man being primarily sexually aroused by women's shoes resulting in significant distress and marital problems. KEY FACT An example of transvestic disorder is a person significantly distressed by being sexually aroused when dressing up as a member of the opposite gender. This is not the same as homosexuality or gender dysphoria.

 KEY FACT Rape is a violent crime and not a paraphilia. ■ Social skills training. ■ Twelve-step programs. ■ Group therapy. ■ Although controversial, antiandrogens, long-acting gonadotropin-releasing hormones, SSRIs, and naltrexone have been used to decrease sex drive and fantasies. ■ Cognitive-behavioral therapy can be used to disrupt learned patterns and modify behavior.