Gender Identity Disorder, Paraphilias, and Sexual Dysfunctions

PSYCH 239

Did You Know That...

- Unlike people with gender dysphoria, gay and lesbian people do not perceive themselves as members of the opposite sex?
- Homosexuality was once considered a psychological disorder?
- Professional strippers are not classified as exhibitionists?

Did You Know That...

- Becoming sexually aroused by watching your partner disrobe or viewing porn is not a form of voyeuristic disorder?
- Some people cannot become sexually aroused unless others subject them to pain or humiliation?
- In most cases of sexual assault, the woman was acquainted with the assailant?

Did You Know That...

- Orgasm is a reflex?
- Premature ejaculation affects about one out of three men?
- Both men and women have the male sex hormone testosterone circulating in their bodies?
- The drug Viagra, used in the treatment of erectile dysfunction, became the fastest-selling drug in history when it was introduced?

GENDER IDENTITY DISORDER, PARAPHILIA, & SEXUAL DYSFUNCTION

- Attitudes towards sexual activity are incredibly diverse.
- What is ‘normal’ is clearly influenced by sociocultural factors.
- Sexual behaviour may be labeled as abnormal if it:
  - deviates from the norms of one’s society.
  - is self-defeating/causes personal distress
  - harms others
  - interferes with one’s ability to function
    - Examples of each?

Transgender

Gender reassignment. Chastity Bono, left; Chaz Bono, right, in 2011. Bono had Gender Dysphoria and underwent hormone and surgical procedures to transition from anatomical female to male.

DSM-5 Criteria: GD (Adult & Adolescent)

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
- 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
- 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

- 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Specify if: Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natural female).

GENDER IDENTITY DISORDER

- **Gender Expression:**
  - The way one presents their gender outwardly.
- **Gender Identity:**
  - One's psychological sense of being female or male.
- **Gender Dysphoria**
  - A disorder in which the individual believes that her or his anatomic gender is inconsistent with his or her psychological sense of being male or female.

Treatment

- Hormone therapy
- Living as the identified gender ≈ 1 year (RLE; Real Life Experience)
- Sex reassignment surgery
  - tracheal shave
  - Breast removal/construction
  - Vaginoplasty
    - Surgical removal of the penis and creation of a vagina
  - Phalloplasty
    - Clitoris embedded in shaft of penis created from skin taken from thigh or forearm
    - Normal size penis, erection achieved via prosthesis

- Metoidioplasty
  - Vaginal lining is scraped and allowed to heal together to seal closed
  - Alternative to phalloplasty
  - Starts with hormone therapy to enlarge clitoris to about 5 cm
  - Labia are fashioned into a scrotum, usually with prosthetic testicles
  - Clitoris located at end; maintains orgasmic capacity

- **Psychotherapy**
  - Necessary throughout
  - Important to screen for other conditions motivating the desire for gender change
  - Since these are major, and partly irreversible surgeries, the decision to move forward should be made cautiously
  - Excessive delays/refusal can also be risk factors

Please be aware…

- Gender transformation is a lifelong process: It neither begins nor ends with surgery
- Not every transgendered person will opt for the full range of affirming surgeries. They could conceivably choose whatever subset they feel best resolves their gender dysphoria.
  - For many, this may mean *no* surgeries or hormones at all.

An early and famous example

Dr. Richard Raskind (left) underwent GRS to become Dr. Renee Richards (right) in 1975.

PARAPHILIC DISORDERS: Too many to count…

- Exhibitionistic
- Fetishistic
- Transvestic
  - Not to be confused with GD
- Voyeuristic
- Frotteuristic
- Toucheristic
- Klismaphilic
- Pedophilic

PARAPHILIC DISORDER

The Development of Persistent Sexual Offending Against Children

- 2 components: - Antisociality
  - Sexual attraction to prepubescent children (pedophilia)

- The presence of both significantly increases likelihood that a person will offend against children

DSM-5 Criteria

Eg., Exhibitionistic Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

   Specify whether:

   Sexually aroused by exposing genitals to prepubertal children

   Sexually aroused by exposing genitals to physically mature individuals

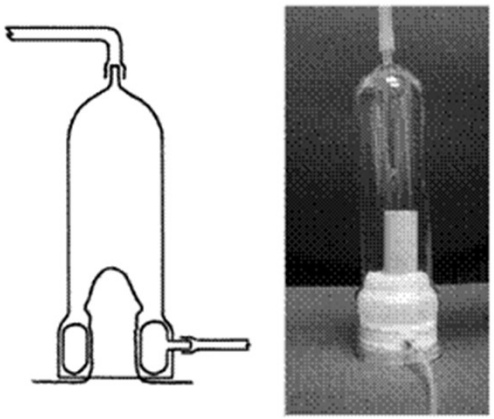
   Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

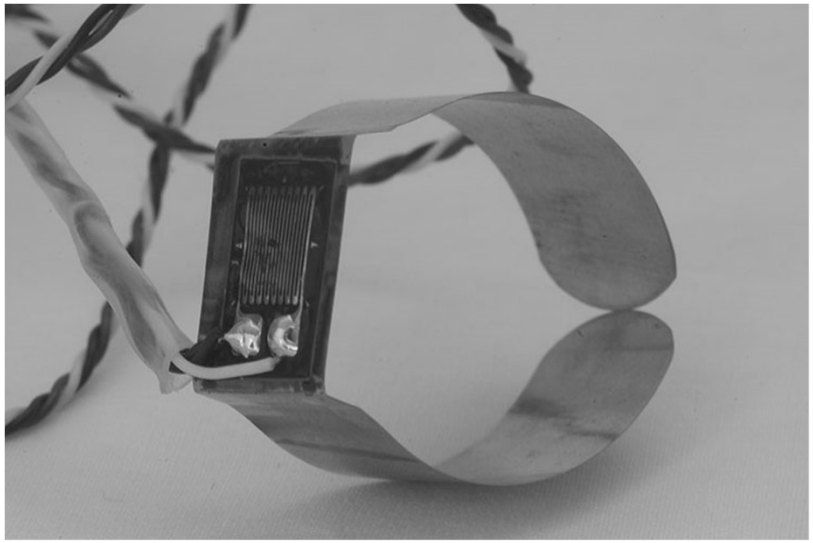
- Specify if;
- In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted.
- In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

ASSESSMENT OF EROTIC PREFERENCE

- Primary means is by patient self-report, though this is highly prone to distortion, especially when motivated by shame or possible legal censure.
- Examining web browsing history.
- VRT
  - Indirect. Based on viewing times and pattern
  - Abel battery:
    - Also elicits a subjective rating from 1 (disgusting) to 7 (highly arousing)
    - Not always accepted in court
- Plethysmographic studies
  - More direct. Measurement of arousal while watching/hearing stimuli in several categories.

Penile Plethysmographs





Vaginal Photoplethysmograph

Theoretical Perspectives

- Psychodynamic theory
  - Castration anxiety leads to projection of sexual desires onto “safer” targets
  - The penis vanishing into a vagina is symbolic of castration in this view
  - Masochism is symbolic aggression toward the internalized father
- Learning theory
  - Learned associations between sexual pleasure and contextual stimuli
  - Implications for partner intimacy/sustained attraction?
    - Fails to explain why paraphilias (esp fetishes) aren’t *more* common
  - Observational (vicarious) learning

Treatment of Paraphilias

- Psychodynamic: Resolution of the Oedipal complex (and corresponding castration anxiety) allows the emergence of non-paraphilic interests.
  - Little empirical support
- Behaviour Therapy: Aversive conditioning
  - Prone to extinction
  - No promotion of alternate interests

- CBT: Development of adaptive thoughts and social skills
- Pharmacological: SSRIs are sometimes helpful
  - Could paraphilias be a subtype of OCD?

SEXUAL ASSAULT

- Forcible Rape & “Statutory Rape”
- Incidence of Rape & Other Forms of Sexual Assault
- Theoretical Perspectives
- Possible Effects of Sexual Assault
  - Post Traumatic Stress Disorder (PTSD)
  - Depression
  - Impaired intimate relationships
  - Increased substance abuse
  - Lower sexual drive/enjoyment
  - Physical symptoms (eg, headache, disrupted menses)
- Treatment of Rape Survivors

Sexual Assault

- Level 1: non-consensual bodily contact for sexual purpose
- Level 2: assault with a weapon
- Level 3: aggravated; physical harm and/or threat of death

Incidence

Effects on Survivors (eg. PTSD)

Treatment

SEXUAL DYSFUNCTION

- **Sexual Dysfunction**

- **Types of Sexual Dysfunction**
  - Sexual Interest Disorder
  - Sexual Arousal Disorder
  - Orgasm Disorder
  - Sexual Pain Disorder

SEXUAL DYSFUNCTION

DSM-5 groups most sexual dysfunctions into the following categories:

1. Sexual interest/arousal disorders
2. Orgasm disorders
3. Sexual pain disorders

The first three categories correspond to the first three phases of the sexual response cycle.

SEXUAL DYSFUNCTION

- **Sexual Desire Disorders**
  - Hypoactive Sexual Desire Disorder
  - Sexual Aversion Disorder
- **Sexual Arousal Disorders**
  - Female Sexual Interest/Arousal Disorder
  - Male Erectile Disorder
  - Orgasm Disorders
    - Female Orgasmic Disorder
    - Male Orgasmic Disorder
    - Premature Ejaculation

SEXUAL DYSFUNCTION

- **Sexual Pain Disorders**
  - Genito-pelvic pain/penetration disorder
    - Dysparenuria
    - Vaginismus

SEXUAL DYSFUNCTION

Theoretical Perspectives

- Biological Perspectives
  - Testosterone: Men and Women
- Psychodynamic Perspectives
  - Castration anxiety
  - Guilt

SEXUAL DYSFUNCTION

Theoretical Perspectives

- Learning Perspectives
  - Cognitive Perspectives
    - Expectations / self-fulfilling prophecies
- Problems in Relationships
- Sociocultural Factors
  - Performance anxiety

TREATMENT

- Sexual Desire Disorders
- Disorders of Arousal
- Disorders of Orgasm
- Vaginismus & Dysparenuria
- Evaluation of Sex Therapy
- Biological Treatments of Male Sexual Dysfunction
  - Phosphodiesterase 5 (PDE-5) Inhibitors: Viagra, Cialis, Levitra
  - SSRIs: delay ejaculation