Chapter 10
Sexual disorders

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lectures and discussions, students should have an understanding of:

1. The causes and treatments of two problems of sexual function: erectile disorder and genito-pelvic pain/penetration disorder.
2. The nature of unusual sexual desires/behaviours: the paraphilias.
3. The nature and treatment of paedophilia.
4. The psychological experience of a new 'non-disorder': gender dysphoria.

CHAPTER OUTLINE

10.1 Sexual dysfunctions
- Erectile disorder
  - Aetiology of erectile disorder
    - Psychodynamic explanations
    - Psycho-biological explanations
  - Treatment of erectile disorder
    - Anxiety reduction and desensitization
    - Medical approaches
- Genito-pelvic pain/penetration disorder
  - Aetiology of GPDD
    - Psychoanalytic explanations
    - Cognitive behavioural explanations
  - Treatment of GPPD
    - Psychological approaches

10.2 The paraphilias
- Paedophilic disorder
  - Aetiology of paedophilia
    - Neurological models
    - Psychosocial risk factors

Treatment of paedophilic disorder
Social constraints
Treatment programmes
Physical treatments
Behaviour therapy
Relapse prevention

10.3 Transvestic Disorder
Aetiology of transvestic fetishism
Biological factors
Parental relationships
Behavioural condition
Psychoanalytic processes
Treatment of transvestic fetishism

10.4 Gender dysphoria
Aetiology of gender dysphoria
Genetic factors
Biological factors
Psychoanalytic explanations
Early life conditioning
Treatment of gender dysphoria
Physical treatment
Psychological therapies

QUESTIONS FOR DISCUSSION

These may be helpful to include at the beginning of the teaching session to get a sense of where people lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Is transvestic fetishism a sexual disorder as identified by DSM 5?
    a. Yes
    b. No

2. How effective are psychological treatments of paedophilia?
    a. Significantly better than no treatment
    b. Marginally better than no treatment
    c. The same as no treatment
    d. Marginally worse than no treatment

3 Sensate focusing involves:

a) A gradual increase in physical then sexual contact between couples

b) Using masturbation to learn the physical pleasure associated with sex

c) Learning to identify the sensations associated with premature ejaculation in order to prevent its occurrence

4. According to DSM 5, the diagnostic criteria for paedophilia include which of the following:

a. The individual has sexual fantasies involving young children but has not acted on them
b. The individual has sexual fantasies involving young children and has acted on them
c. The individual has sexual fantasies involving young people, has not acted on them, but is distressed by their presence
d. All of the above answers are correct

LECTURE SUGGESTIONS

The sexual disorders considered in the chapter/lecture can be divided into three types:

Disorders of function

- Erectile disorder and genito-pelvic pain disorder/penetration disorder' (GPPD) are male and female disorders involving difficulties during the sexual act associated with anxiety and treated using some form of graded exposure to the sexual act (sensate focusing) plus or minus a range of supportive strategies including relaxation and cognitive challenge.

Disorders of desire

- DSM has adopted a stance in which atypical sexual interests are not considered as 'disorders' unless they result in distress to the individual involved and/or to others involved in the behaviour. In this way, transvestic fetishism is now no longer considered a disorder, but is simply the expression of a range of sexual desires/expressions. It only becomes a disorder when the individual experiences distress as a consequence of their behaviour. This caveat is interesting, in that any distress associated with transvestism is likely to be the result of others' reaction to it: either wider society or others in a more personal relationship with the individual. Some people may internalize these negative responses, but the likelihood is that transvestic disorder could often now be conceptualized as a 'social' disorder rather than a 'psychological' disorder, as distress is a consequence of social responses to the behaviour, not the behaviour *per se.*

- Paedophilia or paedophilic disorder involves a range of behaviours and pathways to these behaviours. It is not a ‘one size fits all’ diagnosis, and the Ward and Siegert (2002) pathways model still provides one of the best multifactorial description of the fundamental processes driving a range of ‘types’ of paedophile, although lacking in detail in their origins. Paedophilia is markedly resistant to treatment. It’s almost impossible to gain accurate outcome measures of any intervention (participants are unlikely to complete post-treatment questionnaires: how many paedophile acts did you engage in during the last week?), so evidence is based on known recidivism (that is, people who have come to the attention of the courts). Despite this potentially problematic measure, the evidence is pretty consistent: people who take part in psychological interventions are marginally more likely to re-offend than those who do not. This may be due to a range of factors including group therapy bringing individuals with pro-paedophilic attitudes together, with a subsequent risk of hidden pro-paedophile exchange of norms and stories. A second explanation may be that paedophilia is a sexual orientation that is rigid and unchangeable. However, this explanation does not account for the overall relatively low levels of recidivism (which suggest some degree of mutability... or perhaps suppression), and why those who engage in treatment programmes fair worse than those who do not.

Gender dysphoria

- Gender dysphoria is not a disorder... although it remains a DSM ‘diagnosis’. However, the desire to change one’s gender is now seen as an atypical, but not a clinically relevant, experience. From a therapeutic perspective, the goals are now largely to support individuals through the time of pre-change dysphoria and transition, the life changes that subsequently occur, and potentially coping with societal reactions to any observable ‘differences’ such as bullying of young gender dysphoric/transgender people.

CLASSROOM ACTIVITIES

Discussion in pairs: Homosexuality is now no longer viewed as a ‘lifestyle choice’ or a product of childhood experiences. It is a sexual orientation. Many would argue that sexual attraction to young people (paedophilia) should have the same shift in societal attitude and be seen as a sexual orientation, and thereby being fixed and not open to change. Do you believe this to be the case, and if so, what are the implications for paedophiles and society in general? The following excerpt from a psych forum may trigger debate:

…. *A preference. Screw you. You have absolutely no idea, and because of this you think it's fine that we continue to be hated. I'm not attracted to adults whatsoever, and you're trivialising this and saying it's a choice? Well, I'd give anything to be able to at least somewhat "normal”. It is most certainly not a "preference" when I have* ***absolutely*** *no choice otherwise. I've tried to be*

with adults, it doesn't work. I am physically turned off by the adult body, I am in no way attracted to the adult personality on a romantic level .For your information, you have to be exclusively or predominantly attracted to children to be considered a pedophile. You are not a pedophile, you do not know how this feels. We deserve to have rights and not to be hated, if we can come out of the shadows then we can have a place to talk, and with more understanding comes less hatred.

Small group discussion: how do we treat paedophiles? If they cannot be treated, do we do what they do in the US, where there is at least one 'super-prison' full of sexual offenders who are released only when there is convincing evidence that they will not commit further offences (almost impossible in reality), or do we support them in the community? Should we try to treat them – and if so, how do we prevent their risk of reoffending actually increasing? Or should we work at other levels, such as: high profile management when released from prison, identifying homes where paedophiles live, safe schools or play areas etc. to prevent their gaining access to children (with the proviso that most offences occur within extended families) and so on?