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Chapter 13

Sexual and Gender Identity Disorders

LEARNING OBJECTIVES

AFTER READING THIS CHAPTER, STUDENTS WILL BE ABLE TO:

1. List and provide examples of each phase of the sexual response cycle as developed by Masters and Johnson.
2. Compare and contrast lifelong versus acquired sexual dysfunction, and generalized versus situational sexual dysfunction. Provide one example of each of the following: a lifelong generalized male sexual dysfunction, a lifelong situational female sexual dysfunction, an acquired generalized male sexual dysfunction, and an acquired situational female sexual dysfunction.
3. Describe the rationale for sensate focus, and describe the stages of this treatment tool for a couple in which the male partner has been diagnosed with erectile dysfunction.
4. Identify the different dimensions of gender and explain how inconsistencies among them can result in sexes other than male or female.
5. Compare and contrast the following: paraphilic disorders, exhibitionistic disorder, voyeuristic disorder, and frotteuristic disorder. Provide an example of each.
6. Explain how a clinician currently makes a diagnosis of “rapist” using the DSM-5.

When David phoned for an appointment, he asked whether he could arrange to arrive at the office unseen by other clients to avoid recognition. He said that his problem was "impotence," so the therapist encouraged him to bring his wife to the initial interview.

David had always doubted the adequacy of his sexual responsiveness. He had first tried to have intercourse at age 20 while on a road tour with his university football team. After a night of drunken revelry, some of the guys hired a prostitute for the night. Rather than admit to being a virgin, David went along, despite his anxiety. He tried to take his turn with the woman, but could not. He was so ashamed that he begged the prostitute not to tell anyone, but later he boasted about his prowess.

Although he could masturbate to orgasm and develop an erection when he did so, David believed that he wasn't "highly sexed" like most guys, because he did not share his classmates' fascination with pornography and ribald jokes. He became upset by his continued masturbation, believing that it was an abnormal sexual outlet, and worried about whether he could have intercourse. The episode with the prostitute confirmed David's worst fears. To avoid facing such embarrassment again, he broke off relations with women as soon as they made any sexual overtures. Eventually, he stopped dating entirely.

David had graduated and was working as an engineer when he began to develop a strong friendship with Alicia, a colleague in his office. He admired her for bucking the establishment in a male-dominated field, and they often talked over coffee or lunch. Eventually, she made it clear that she was interested in more than friendship. Before he knew it, David had agreed to marriage. He felt that he had led her on by allowing such a close bond to develop and hoped that in the security of a caring relationship, his capacity for a sexual relationship with a woman would grow.

David was nevertheless panicked by the thought of meeting his wife's sexual demands. Alicia did not seem to expect sex before marriage and, to his relief, when he finally admitted his problem to her the week before their marriage, she understood and was calm, stating that they would work it out together. On their honeymoon, David found that he was able to have intercourse on several occasions. Many more times, however, Alicia was interested but David could not get an erection and quickly backed out of the encounter.

As the years passed, Alicia remained the sexual initiator, and David grew more and more anxious. He began to stay up late, working until Alicia was asleep. Gradually, conflict between them increased. Alicia, who was thinking about having children, began to press David "to do something about [his] impotence." David became more anxious about failure with each unsuccessful attempt, and he would sometimes try to satisfy Alicia with oral sex. This always left him feeling inadequate, and he withdrew emotionally, leaving her upset.

By the time they sought therapy, David and Alicia felt quite hopeless. They saw therapy as a last-ditch effort to save their marriage, but they were also motivated by the joint desire to have children.

This case illustrates a particular type of sexual dysfunction (i.e., erectile disorder) that represents a persistent failure to achieve satisfaction in sexual relations. Other sexual dysfunctions will be described, as will specific paraphilias (i.e., a redirection of sexual desires toward inappropriate objects, people, or behaviours). This chapter will also describe *gender dysphoria:* the condition of people who feel ill at ease with their biological sex.

Historical Perspective

Conceptions of the appropriateness or deviance of human sexual behaviours have varied considerably throughout history (Bullough, 1976). Sex is one of the most discussed human behaviours, although these discussions are often superficial and skirt substantive issues. For example, sex education often takes the form of a recitation of knowledge

about physiological functioning and anatomical facts rather than a discussion of actual behaviours and their associated thoughts and feelings.

Brown (1985) suggests that the Judeo-Christian tradition has had a significant influence on notions about appropriate and inappropriate sexual behaviours within our society. He contends that the prevailing attitudes at the time the Bible and the Talmud were written condoned "sex between men and very young girls in marriage, concubinage, and slavery" (p. 23). Not surprisingly, some of the remarks in these historical documents are in conflict with today's values. Christian notions of acceptable sexual behaviour evolved in the West primarily through the teachings of St. Augustine, who declared that sexual intercourse was permissible only for purposes of procreation, only when the male was on top, and only when the penis and vagina were involved. Thus, oral-genital sex, masturbation, anal sex, and presumably all forms of precoital activities were considered sinful, as were sexual activities with someone who could not conceive, such as a child or a same-sex partner.

Science in the sixteenth and seventeenth centuries offered support for these Christian teachings by attributing all manner of dire consequences to so-called excessive sexual activity. These views were popularized in 1766 by Tissot in his treatise on the ills of onanism (solitary masturbation). Tissot attributed a whole variety of ills to masturbation and recommended that the state establish controls on sexuality, although just how these controls were to be enacted was not made clear. Popular writers on sex in the nineteenth century took up Tissot's claims with gusto. The Reverend Sylvester Graham and Dr. John Harvey Kellogg published treatises declaring that masturbation caused numerous problems, including lassitude, dullness, defective development, untrustworthiness, and even ill health and rounded shoulders. Parents were warned to watch for these signs and prevent the destructive behaviour at all costs. Excessive sexuality could be counteracted by healthy activities and a diet of bland foods. Graham developed Graham Crackers and Kellogg developed Corn Flakes to meet this need.

Krafft-Ebing (1901) published the first strictly medical textbook on sexual aberrations, called *Psychopathia Sexualis*. Again, masturbation was blamed for numerous illnesses. The range of sexual behaviours considered to be deviant was initially extremely broad, including whatever was thought to differ from prevailing beliefs about acceptable practices. Accordingly, up to the early part of the twentieth century, the list of deviant activities included a variety of sexual practices that are no longer officially listed as abnormal.

Research on sexuality has not progressed at the same rate as has research on other human problems, apparently as a result of notions concerning the privacy of sex. Such notions have encouraged the general public to view sex researchers with suspicion. The publication of Alfred Kinsey's research (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) investigating human sexual practices was greeted with animosity by the general public, the media, and many of his scientific colleagues because his findings upset established beliefs about sexuality. His data revealed that masturbation, oral-genital sex, and homosexuality, for example, were engaged in by far more people and with far greater frequency than was previously believed. Masters and Johnson's (1966) study of human sexual response was greeted with much the same animosity. Starting in the 1990s and continuing today, several sexuality studies in the United States were stopped as a result of political pressure, despite the fact that they had already been carefully screened and approved by scientific communities (Udry, 1993). Perhaps even more illustrative are the funding levels provided by the National Institute of Mental Health (NIMH), the primary source of research funding in the United States. Despite the well-established damage that sexual offenders cause to society, in 1993 NIMH devoted $1.2 million to research on this topic, while spending $125.3 million on studies of depression (Goode, 1994). Although less of an issue in Canada, some studies have come under scrutiny by the government, resulting in loss of research funds and less funding available to researchers. However, in general, the lay public and governmental agencies in Canada demonstrate greater tolerance of sexuality research.

Diagnostic Issues

As in all other areas of human functioning, it is necessary to have at least an approximate idea of what is normal (including some indication of the frequency of behaviours) in order to define abnormal functioning. Simple frequency, however, will not always do. Premature ejaculation, for example, is subject to both parties' perception of the act, and can therefore cause problems based on this perception (Byers & Grenier, 2003). Even if most men ejaculated rapidly upon being sexually aroused, would this be considered normal? It certainly would be from a statistical point of view, but if the man and his partner were dissatisfied and sought help, the diagnosis of a problem would nevertheless be likely from a clinical standpoint.

Satisfaction with present functioning is an important criterion, reflected in DSM-5's definition of sexual dysfunctions. A problem for reliable diagnosis is that DSM-5's criteria require diagnosticians to make somewhat subjective judgments: to decide, for example, whether a client's experiences are "persistent," "recurrent," or "delayed." There are no perfectly objective standards for these qualities, which will vary within the same individual from one time and setting to another.

In the DSM-5, the question of distress of the person suffering from, or being affected by, a paraphilic disorder versus a paraphilia is more straightforward than in the previous DSM. Paraphilias—intense and persistent

atypical sexual interests—cannot be diagnosed as a disorder unless the individual experiences distress or impairment because of the paraphilia, or harms others. For example, a person who engages in sexual sadism with consenting, adult partners as part of a kinky lifestyle and is not distressed by this behaviour would simply have a paraphilia called sexual sadism, but one who engages in this behaviour and harms others would be diagnosed with sexual sadistic disorder. So, a paraphilia is a necessary, but not sufficient, condition for having a paraphilic disorder, and a paraphilia does not justify or require clinical intervention.

Although homosexuality will not be discussed as a topic in this chapter, the history of homosexuality as a disorder is of relevance in terms of the role of the prevailing mindset of society in determining what "problems" are considered mental disorders. Homosexuality (that is, sexual relations between persons of the same sex) is no longer identified in the diagnostic manual as a disorder. Up to and including DSM-II (APA, 1968), homosexuality was listed as a disorder, and people (mostly males) with this sexual orientation were subjected to treatment aimed at changing their attraction from same-sex to opposite-sex partners. Homosexuality was also illegal, and all too often homosexuals were imprisoned. In 1973 the APA's Nomenclature Committee recommended that homosexuality be eliminated from the list of disorders. However, this committee also suggested the addition of "sexual orientation disturbance" to refer to those homosexuals who experienced conflict with their sexual orientation or who wished to change their orientation. Accordingly, DSM-III (APA, 1980) included **egodystonic homosexuality** to refer to conflicted homosexuals and, although this category was dropped from DSM-III-R (APA, 1987) and DSM-IV (APA, 1994), both included, as one possible form of a sexual disorder not otherwise specified, "persistent and marked distress about sexual orientation" (APA, 1994, p. 538). These remarks about sexual orientation are not included in the DSM-IV-TR or DSM-5.

Sexual Response

It is difficult to gain an understanding of what most people "do" sexually and how often people engage in various kinds of sexual activity. There are wide ranges in types and frequency of sexual behaviour, and differences can be seen within an individual depending on age, sexual experience, partner status, length of relationship, and many other factors. Also, sex is a private topic for most people, so simply asking the people we know may not give us accurate information (or any information at all!). Research can sometimes shed light on questions related to sexuality (e.g., how does sexuality differ between men and women?), but we also have to keep in mind that people who participate in sexuality studies likely differ from those who do not. Regardless, research has shown some interesting differences in frequency of fantasies and sexual behaviour patterns between men and women. In an investigation into the sexual activity of Canadians (Fischtein, Herold, & Desmarais, 2007), results indicated that adult men fantasized about sex much more frequently than did women (see Table 13.1). Not surprisingly, in another survey, 61 percent of men compared to only 38 percent of women reported masturbating during a specified one-year period (Das, 2007). Furthermore, of those who do report masturbating, men do so over three times more frequently than women (Laumann, Gagnon, Michael, & Michaels, 1994). In addition, men report an earlier age at first intercourse and a greater number of sexual partners (Smith, 1992). All of this makes intuitive sense; these patterns fall right into the sex stereotypes we all have that men are more sexually permissive and less discriminating and women are more sexually cautious. But if men are consistently reporting a higher number of sexual partners than women, who exactly are these men having sex with?

TABLE 13.1 RESPONSE TO THE QUESTION: "HOW OFTEN DO YOU THINK ABOUT SEX?"

	"Several times per day"	"A few times per week"	"A few times per month"
Men	46.1%	25.0%	4.6%
Women	10.6%	42.3%	18.3%

Source: Adapted from Fischtein, Herold, and Desmarais (2007).

In an ingenious experiment devised to investigate this issue, Alexander and Fisher (2003) used the bogus pipeline to examine sex differences in self-reported sexuality domains. Male and female participants were randomly assigned to one of three conditions: the bogus pipeline condition, in which participants were given a false polygraph test while they answered questionnaires after being told that the polygraph would detect dishonest responding; the anonymous condition, in which participants were asked to fill out the questionnaires privately and leave them in a locked box; and the exposure-threat condition, in which participants were asked to give their names to the experimenter and complete the questionnaires while the experimenter was in the room. Results indicated that the smallest sex differences in behaviour were found in the bogus pipeline condition; the authors suggest that the participants were motivated to answer honestly given the belief that false responding would be detected. Slightly larger sex differences were found in the anonymous condition, and the largest differences were found in the exposure-threat condition. Interestingly, although women underreported sexual behaviours in the anonymous and exposure-threat conditions as compared to the bogus pipeline condition,

Sex therapists Virginia Johnson and William Masters.

men's responses were consistent across conditions. Specifically, women underreported frequency of masturbation and pornography use; in the bogus pipeline condition, however, the results for these behaviours were similar for men and women. It appears as though sex differences in reported sexual behaviours may at least be partly explained by sex differences in reported as opposed to actual sex differences. So it is important to keep a critical eye when drawing conclusions about sex differences in the domain of sexuality.

To emphasize this point, a recently published meta-analytic study demonstrated that sex differences were typically small in such behaviours as petting, intercourse incidence, younger age at first intercourse, and number of sexual partners (Petersen & Hyde, 2010), indicating that men and women are more similar than different for most behaviours reported.

The issue of sex differences aside, research has revealed considerable cultural differences in sexuality. For example, Canadians tend to have more permissive sexual attitudes than do Americans; 29 percent of Americans as compared to 12 percent of Canadians feel that premarital sex is morally wrong (Widmer, Tread, & Newcomb, 1998). Furthermore, certain countries have sexual norms that differ considerably from those of Canadians. On the island of Inis Beag off the coast of Ireland, for example, the citizens have no knowledge of sexual practices; in fact, during sexual intercourse both parties keep their underwear on, and a female orgasm is unheard of (Messenger, 1993). However, there are some common sexual trends across cultures. Kissing is the most common sexual technique in nearly all cultures, whereas incest is considered universally taboo (Firestone, Dixon, Nunes, & Bradford, 2005).

Some norms for sexual behaviour also change with time. Beginning in the mid-1960s, liberalization of attitudes toward sexuality appeared to be accompanied by greater sexual experience (there are few earlier statistics available). A study of Canadian university students reported that, from 1968 to 1978, the percentage of female students who had had intercourse increased from 32 to 58 percent, and of male students from 40 to 62 percent (Barrett, 1980). More current estimates suggest that the trend is continuing for both genders: 10 to 13 percent of 14-year-olds, 20 to 25 percent of 15-year-olds, 40 percent of 16-year-olds, and 50 percent of 17-year-olds have engaged in penile–vaginal intercourse (Maticka-Tyndale, 2001).

Interestingly, people have different views of what constitutes sex. Canadian sex researcher Sandra Byers (University of New Brunswick) and her colleagues surveyed students' definitions of "having sex" (Byers, Henderson, & Hobson, 2009). Not surprisingly, less than 5 percent of students defined behaviours that did not include genital touching as "having sex." Only 12 to 15 percent included manual genital touching in their definition of having sex, and 24 to 25 percent included oral-genital stimulation. Ninety percent of students agreed that vaginal–penile intercourse was having sex, but only 83 percent agreed that anal–penile intercourse was sex.

William Masters and Virginia Johnson (1966) were the first investigators to study and document the physiological stages that take place in human sexual response. They noted the changes that occur in the body during sexual arousal, orgasm, and the return to the unaroused state, and referred to this sequence as the **sexual response cycle**. Masters and Johnson divided the sexual response cycle into four stages: excitement, plateau, orgasm, and resolution.

During the *excitement* stage, the genital tissues of both males and females swell as they fill with blood (vasocongestion). This causes erection of the penis in men and engorgement of the clitoris and vaginal lubrication in women. Furthermore, the testes and nipples become engorged, muscular tension and heart rate increase, and breathing becomes more rapid and shallow. See Focus box 13.1 for the role of thermal imaging in measuring sexual response in current studies in males and females.

The *plateau* stage consolidates this arousal, with additional swelling of the penis and vaginal tissues. In men, the testes become elevated and may reach one and a half times their unaroused size. In women, the clitoris retracts underneath the clitoral hood and the inner part of the vagina expands. During *orgasm*, both sexes experience rhythmic, muscular contractions at about eight-second intervals. In men, orgasm comprises two stages, which quickly follow one another. First, seminal fluid collects in the urethral bulb, at the base of the penis. As this happens, there is a sense of orgasmic inevitability and nothing can prevent ejaculation from following. Within two or three seconds, contractions lead to expulsion of the ejaculate from the penis. Women experience contractions of the uterus and of the muscles surrounding the vagina during orgasm. Blood pressure and heart rate reach a peak during orgasm, and there are involuntary muscular contractions. Following orgasm, the body gradually returns to its pre-aroused state,

FOCUS 13.1

A Hot Topic: Measuring Sexual Arousal in Men and Women

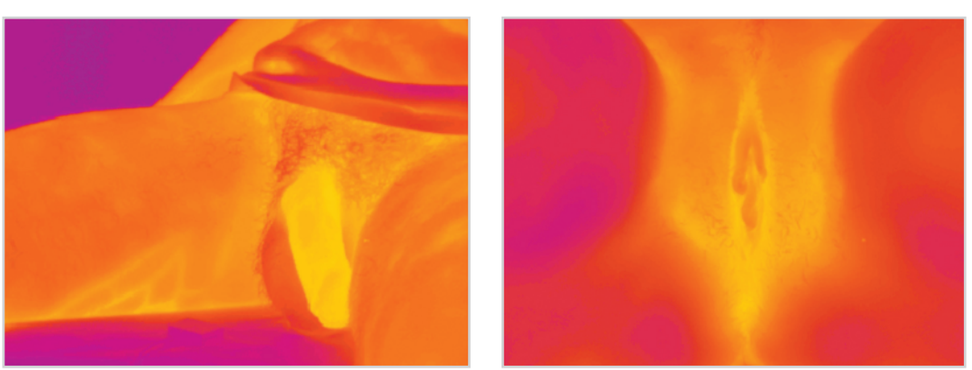
To date, the psychophysiological measurement of sexual arousal, and by extension, our understanding and treatment of sexual arousal problems, has differed between men and women. While the measurement of male erectile functioning in a laboratory setting has led to clinical guidelines and pharmaceutical treatment options for erectile dysfunction (Connoly, Boriakchanyavat, & Lue, 1996; Goldstein et al., 1998), similar studies in women have not been successful (Graham, 2010a, 2010b). Part of the issue is that different instruments have been used to measure physical sexual response in men and women, making it impossible to directly compare male and female sexual arousal. Furthermore, the numerous practical and quantitative limitations with widely used instruments for the measurement of female physiological sexual arousal have limited the use of these devices in clinical settings and have not made it possible to quantify physical parameters for arousal disorders (Prause & Janssen, 2006).

Researchers in Canada, however, may be close to solving these problems through the use of thermographic imaging to assess physiological sexual response. Thermography cameras, similar to night vision goggles, pick up infrared emissions from the human body through remote sensing and provide temperature readings of the target in focus. As temperature is directly related to blood flow, and genital blood flow is a physical marker of sexual response, thermography offers a unique way to examine sexual arousal in men and women through the measurement of genital temperature. Because the camera does not require any physical contact with participants, the same methodology can be used for both sexes, allowing for a direct comparison of sexual arousal between men and women.

During her Ph.D. studies at McGill University, Dr. Tuuli Kukkonen, an assistant professor at the University of Guelph, assessed the validity of thermography to measure and compare sexual arousal in men and women. By recording genital and thigh temperature while participants watched sexually arousing, neutral, anxiety-provoking, or humorous film clips, Kukkonen and colleagues found that temperature increases were specific to the genitals during the sexual arousal condition only (Kukkonen, Binik, Amsel, & Carrier, 2007, 2010a). Of interest is that both men and women had significant correlations between their self-reported sexual arousal and genital temperature, indicating that this physical measure matched how participants were feeling, a finding that goes against most previous research on women. In addition, a comparison of men and women demonstrated that the sexes did not differ in the time it took them to reach a peak sexual response, a finding that might contradict popular culture assumptions regarding sexual response. Finally, research across multiple testing sessions demonstrated that these results are consistent across time, providing support for the use of thermography in longitudinal studies (Kukkonen, Binik, Amsel, & Carrier, 2010b).

Although all this research was conducted on sexually healthy individuals, a significant decrease in physical sexual arousal with age for both men and women was noted, suggesting that the development of age-appropriate parameters for normative sexual response might be worthwhile before examining clinical populations (Kukkonen, Binik, Amsel, & Carrier, 2009).

Clearly, thermography holds great potential as a tool to measure physiological sexual response. These initial studies have laid the groundwork for examining clinical issues of sexual arousal in women by demonstrating the reliability and validity of thermography in sexually healthy individuals. Furthermore, by having an instrument that can be used for both men and women, researchers can address issues of sex differences and similarities in sexual arousal, which might answer the age-old question of whether men and women really are that different.



Source: Contributed by Dr. Tuuli Kukkonen of the University of Guelph.

in the stage that Masters and Johnson called *resolution*. Shortly after ejaculation, men experience what is called a *refractory period* during which they are unresponsive to sexual stimulation. Women, however, may be able to experience multiple orgasms without any refractory period. Although Masters and Johnson did not include same-sex oriented individuals in their sample, it is likely that the physiological responses of same-sex partners follow similar patterns as described above. Or do they? See Focus box 13.2 for research examining sexual arousal in same-sex partners

FOCUS 13.2

Nonspecificity of Sexual Response in Women

Research by Dr. Meredith Chivers at Queen's University in Kingston, Ontario, suggests that the patterns of sexual response in women and men are not opposite sides of the same coin. By studying the relationship between people's sexual attractions (to women, men, or both) and sexual responses in the laboratory to stimuli depicting women or men, Chivers has discovered a compelling gender and sexual-orientation difference: whereas men's physiological and psychological sexual responses are strongly related to their sexual attractions to women or men, a pattern of response described as *category specific*, heterosexual women's are not—they are *nonspecific* (Chivers, Reiger, Latty, & Bailey, 2004). Women who report sexual attractions exclusively to men show physiological sexual responses to stimuli depicting women and men; their self-reported arousal (that is, how sexually aroused they report that they feel) is, however, more strongly related to their sexual attractions. Women who are sexually attracted to women, on the other hand, do show greater arousal to sexual stimuli depicting women than men, suggesting that their arousal patterns are more category specific than those of heterosexual women (Chivers, Seto, & Blanchard, 2007). These results may relate to the greater fluidity and flexibility in women's same- and other-gender attractions; with a capacity to be sexually responsive to both genders, women's sexuality may not be as restricted as men's.

The reasons for these differences in the *specificity* of sexual arousal are not currently known, but other research by Chivers and colleagues suggests that, for women, physiological sexual response may not be strongly related to psychological states, such as sexual attractions, sexual desires, or psychological states of sexual arousal. For example, in a somewhat controversial study, Chivers showed women and men films of bonobos (chimpanzees) mating, along with films of human couples engaged in sex, while measuring physiological and psychological sexual responses. Only women showed significant increases in physiological responses to the bonobo film, though both women and men reported not feeling aroused by this unusual stimulus (Chivers & Bailey, 2005). These results suggest that, despite being an unarousing film psychologically, something about watching bonobos have sex was sufficient to cause women to experience an increase in genital vasocongestion.

Chivers and colleagues have proposed that women's genital responding to a broader range of sexual cues may have very little relationship to a woman's sexual desires or attractions and is, instead, an automatic, protective response. Vaginal lubrication, necessary to reduce the likelihood of genital injury and to make sexual penetration more comfortable, is thought to result from a process called *transudation*—fluid passing into the vaginal canal caused by genital vasocongestion. So even though a woman might not feel sexually aroused, her body is prepared for the possibility of sex, similar to how even vegetarians might find themselves salivating to the smell of a cooking steak: they may not actually want to eat the steak, but the smell is a powerful cue that leads to an automatic reflex that aids in chewing and swallowing food.

The potential for disconnect between physiological and psychological states of sexual responding is not exclusive to women; men can show this too, and, conversely, some women show strong agreement between these two states. On average, however, the concordance between genital and psychological sexual responses in the laboratory is significantly greater for men; Chivers and her colleagues quantified *sexual concordance* in a recent meta-analysis and reported that the average agreement for women is a correlation of about 0.26, whereas the correlation is about 0.66 for men (Chivers, Seto, Lalumière, Laan, & Grimbos, 2010). The reasons for this difference are still under investigation by several laboratories. ●

Source: Contributed by Dr. Meredith Chivers of Queen's University.

and heterosexual men and women. Figure 13.1 depicts the sexual response cycles of men and women derived from Masters and Johnson's research.

Helen Singer Kaplan (1979) proposed an alternative model of sexual stages, consisting of desire, excitement, and orgasm. An important contribution of her work was the distinction of desire as primarily a psychological component to sexual response. She also treated the stages as independent components, and noted that normal sexual experiences do not necessarily follow the full sequence described by Masters and Johnson. Thus, a couple's sexual encounter may sometimes involve excitement followed by diminished arousal without orgasm. This information is valuable in that it suggests that many sequences of sexual response exist and each of them is normal.

Many older individuals engage in sexual intercourse well into their eighties and nineties, although the frequency of sex decreases with age (Kessel, 2001). It is also evident that as women experience menopause, interest in sexual activity and sexual intercourse usually decreases (Palacios, Menendez, Jurado, Castano, & Vargas, 1995), which is associated with a more general reduction in sexual interest (Dennerstein, Smith, Morse, & Burger, 1994). These effects were demonstrated to be attributable to menopause independently of the effects of aging (Dennerstein, Dudley, Lehert, & Burger, 2000). However, Dennerstein and colleagues also showed lowered levels of sexual responsivity with age in women who were not menopausal.

1 BEFORE MOVING ON

It is important to note that people's sexual response cycles vary immensely; for example, men can have multiple orgasms, although this feature was not captured in the Masters and Johnson model. What are some of the advantages and disadvantages of models that combine hundreds of responses into a general representation?

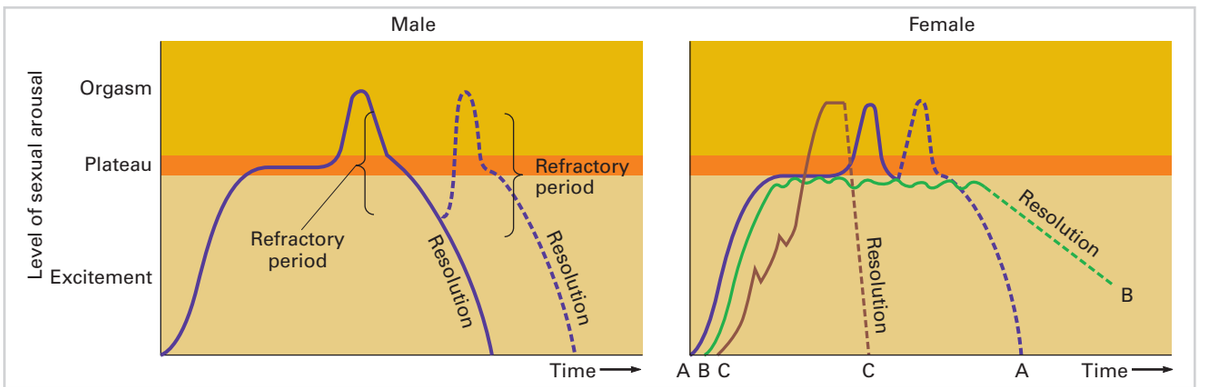


FIGURE 13.1 Levels of Sexual Arousal During the Phases of the Sexual Response Cycle

Masters and Johnson divided the sexual response cycle into four phases: excitement, plateau, orgasm, and resolution. During the resolution phase, the level of sexual arousal returns to the pre-aroused state. For men there is a refractory period following orgasm. As shown by the broken line, however, men can become re-aroused to orgasm once past the refractory period and their levels of sexual arousal have returned to pre-plateau levels. Pattern A for women shows a typical response cycle; the broken line indicates multiple orgasms, should they occur. Pattern B shows the cycle of a woman who reaches the plateau phase but for whom arousal is "resolved" without orgasm. Pattern C shows the sexual response of a highly aroused woman who passes quickly through phases.

Sexual Dysfunctions

As the following case illustrates, multiple factors (for example, shame and ignorance about sex, anxiety about sex, lack of experience with physical affection, and low self-confidence) may contribute to the development of sexual dysfunctions. Joan's problem clearly developed over time, becoming worse the more she worried about it. By the time someone like Joan consults a therapist, the problem has typically become more complex and involves secondary difficulties, such as relationship problems and low self-esteem.

Case Notes

Joan sought help at the insistence of her best friend, in whom she had confided. Recently, Joan had become interested in a man. Ron, she believed, was gentle and caring, and she wanted to return his affection. Joan had never had an orgasm, and she thought that this had contributed to the breakdown of her only previous relationship and was afraid it would mar things with Ron.

Joan had been reared in a strict religious family in which the word *sex* had never been spoken. Anything to do with the body was held to be shameful and disgusting. Joan had never touched her own body except while washing, and felt uncomfortable even seeing herself undressed in a mirror. Her parents never showed open affection, and, although her mother hugged her, her father merely shook her hand when she left home for university.

Joan was sexually inexperienced, and tolerated Ron's advances because she was too embarrassed to protest. She believed that she should stop him from making love to her, but could not find the words to say no. She grew very fond of him and enjoyed the tenderness he showed her, although she found the intensity of his sexuality frightening and completely foreign to her own experience.

Joan felt constricted by Ron's needs, which she felt obliged to satisfy but resented. She was completely unable to express her own wishes, but expected him to know what she wanted. Finally, in frustration, she broke off her relationship with him, refusing to return his phone calls or open his letters.

Joan had read some popular materials about sexuality in the last several years and had begun to think that there was something wrong with her. The books suggested that she should not be afraid or ashamed of her own sexuality, but she could not shake these negative feelings.

The DSM-5 (APA, 2013) uses an amalgamation of Masters and Johnson's (1966) and Kaplan's (1979) components of the sexual response in classifying sexual dysfunctions. It categorizes them according to which of the three stages is affected: desire, arousal, or orgasm. A separate category deals with instances in which pain during intercourse (dyspareunia) and/or difficulty with vaginal penetration is the primary complaint (see Table 13.2).

Each of the sexual dysfunctions can be further classified into several subtypes. For example, if the person

TABLE 13.2 SEXUAL DYSFUNCTIONS: CATEGORIES AND SUBTYPES

Sexual Desire and Arousal Disorders
Subtypes
Female sexual interest/arousal disorder
Male hypoactive sexual desire disorder
Erectile disorder
Orgasmic Disorders
Subtypes
Delayed ejaculation
Female orgasmic disorder
Premature (early) orgasm
Genito-pelvic pain/penetration disorder

Source: American Psychiatric Association (2013).

has always experienced the problem, the disorder is called **lifelong sexual dysfunction**; if it is of fairly recent onset, it is said to be an **acquired sexual dysfunction**. In addition, sexual dysfunctions may be apparent with all partners and even during solitary sexual activity, in which case they would be termed **generalized sexual dysfunctions**; when the problems are apparent in only one situation (for example, with the client's spouse, or only during masturbation), they are known as **situational sexual dysfunctions**.

We know very little about the prevalence of sexual dysfunctions and even less about their incidence (Simons & Carey, 2001; Spector & Carey, 1990). Existing epidemiological studies are few and suffer from methodological shortcomings. More recent data reveal lifetime prevalence rates for sexual dysfunctions of 43 percent for females and 31 percent for males (Laumann, Paik, & Rosen, 1999) and incidence rates (i.e., currently has a disorder) of 23 percent among women (Bancroft, 2000).

In reviewing reports from a wide variety of studies, Bancroft (1989) found that a lack of sexual interest was the most common complaint of women attending sex therapy clinics, whereas Kaplan (1974) reported orgasmic dysfunction to be the most common problem among women.

Altogether, the evidence suggests that some degree of sexual dysfunction is common: "The lifetime prevalence of sexual dysfunctions may be so high that almost every man or woman who lives a long life can be expected to qualify for a diagnosis at some time" (Levine, 1989, pp. 215–216). However, the authors who published one of the most frequently cited surveys suggest caution in interpreting survey findings, as individuals may experience sexual difficulties without necessarily being dissatisfied with their marriages or even with their sexual relations (Laumann et al., 1994).

2 BEFORE MOVING ON

Think about the specifiers of lifelong versus acquired sexual dysfunction, and generalized versus situational. Which combination do you think would be most difficult to treat? Most easy? Which would most likely have a biological or psychological basis?

SEXUAL DESIRE AND AROUSAL DISORDERS

Both Kinsey and Masters and Johnson found that the frequency of masturbation among men varied from less than once per month to several times per day. However, all of these men regarded their own frequency as "normal"; they thought that a man with higher frequencies was "abnormal," and they considered lower frequencies to be indicative of "low sex drive." These two examples illustrate both the differences among individuals in sexual behaviours and associated desire and the subjective nature of people's definition of the "normal" frequency of sexual desires.

In the DSM-5, a diagnosis of **male hypoactive sexual desire disorder** is made when a client describes persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. These symptoms must be distressing and present for a minimum of 6 months. Although the DSM-5 treats desire problems as separate from arousal problems for men, a combination of "lack of sexual interest" and "arousal disorder" has resulted in the diagnosis of "**female sexual interest/arousal disorder**" in women. The rationale for this amalgamation is based on findings from several studies indicating that the processes of desire and arousal overlap for many women (Brotto, 2010a; Graham, 2010b). Unfortunately, similar data do not yet exist for men.

Hypoactive desire is among the most difficult dysfunctions to define, because of the importance of context. Desire may occur in some situations but not in others, and sexual activity may occur without desire, in both males and females. The discrepancy between partners' desire can create a circular problem, affecting the quantity and quality of both the sexual and the personal relationship (Clement, 2002). Furthermore, social pressure for high levels of sexual interest may play a role in elevating performance pressure and creating unrealistic expectations.

In fact, some have criticized the existence of such a diagnosis as a reflection of culturally imposed standards that are typically male-centred and hypersexual. The very term *hypoactive* implies an established standard—but whose? A population average? A clinical consensus? However it is defined, a standard of desire is value-laden and many question its appropriateness.

Nevertheless, a substantial number of people attending sexual dysfunction clinics report a problematic lack of sexual desire and meet diagnostic criteria for this disorder (Donahey & Carroll, 1993). The majority of these clients (85 percent of the males and 75 percent of the females) also reported other sexual dysfunctions (Donahey & Carroll, 1993).

Sexual arousal disorders involve difficulty becoming physically aroused when the person desires such arousal. In males, sexual arousal or lack of arousal is usually gauged by penile erection, not the only physiological response but certainly the most obvious. Female sexual arousal, however, is less directly evident, and women can have intercourse without arousal. Approximately 20 percent of women

report difficulty with arousal and lubrication during sexual activities (Laumann et al., 1999). As mentioned, arousal disorder as a separate entity in women is not distinct diagnosis in the DSM-5 (APA, 2013).

Erectile disorder characterizes difficulties with obtaining an erection during sexual activity, maintaining an erection until the completion of sexual activity, and/or a marked decrease in erectile rigidity in about 75–100 percent of sexual occasions. These symptoms must be distressing and present for a minimum of 6 months. Erectile disorder is the second most commonly reported male sexual dysfunction (after premature ejaculation). In their large-scale empirical review, Simons and Carey (2001) found a community prevalence rate, based on 10 studies, ranging from 0 to 10 percent. In general mental health settings, the rates ranged from 0.4 to 37 percent, whereas in sexuality clinics, the proportion was as high as 53 percent. Several factors can influence the rates of erectile disorder, including smoking, heart disease, and age, the last factor being particularly salient.

Erectile problems, while certainly not new, have gained increased public attention, partly because of current expectations for lifelong sexuality, women's increased expectations of sexual satisfaction, and media attention (Wincze & Carey, 2001). Erectile problems can be psychologically devastating for men and can contribute to significant relationship problems. Difficulty attaining or maintaining an erection often leads to embarrassment, depression, and even suicidal inclinations. Not surprisingly, erectile disorder has a high comorbidity with depression (Seidman & Roose, 2000). Because the problem carries such connotations about masculinity, men with erectile difficulty are likely to delay seeking help and to avoid confronting the problem, and may try home remedies before approaching a professional. The relationship with a sexual partner is likely to be affected, not just by the erectile problem, but also by the avoidance, depression, and other secondary problems that follow. As a result, by the time a man and his partner seek help, the problem is likely to seem overwhelming and to be much more complex and intractable than it might have been had he sought help earlier.

ORGASMIC DISORDERS

Orgasmic disorders are some of the most commonly reported sexual dysfunctions. Both males and females may experience difficulty in reaching orgasm.

The DSM-5 diagnostic criteria for **female orgasmic disorder** require the presence of either a marked delay in, marked infrequency of, or absence of orgasm; or markedly reduced intensity of orgasmic sensations in about 75–100 percent of sexual occasions. The symptoms must cause distress and be present for a minimum of 6 months.

Kinsey was the first researcher to pay attention to female orgasms, counting them for women as he did for men (Kinsey et al., 1953). In his work, Kinsey noted that women were more likely to experience orgasm through masturbation than with a partner, a finding that has since been replicated (Spector & Carey, 1990). These observations led to marked changes in the way women's sexual functioning was viewed, and today, female orgasmic disorder is typically cited as the most common sexual problem presented at sex clinics. The rates among clinical samples range from 18 to 76 percent (Spector & Carey, 1990).

Delayed ejaculation is diagnosed when there is a marked delay in ejaculation or a marked infrequency or absence of ejaculation, which is present in about 75–100 percent of sexual occasions and for a minimum duration of 6 months. These symptoms must be distressing to warrant the diagnosis. In men with this condition, orgasm may be possible only with oral or manual stimulation or only during erotic dreams, but not during intercourse.

Community estimates for delayed ejaculation have reportedly been as high as 3 percent, whereas in sexuality clinics estimates have been as high as 38 percent. However, the dysfunction appears to be much more frequent (up to 39 percent) among gay males and men with HIV (up to 38 percent; Simons & Carey, 2001).

Premature (early) ejaculation is defined as a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it. Although the diagnosis can be applied to individuals engaging in nonvaginal sexual activities, specific duration criteria have not been established yet for these activities. The symptoms must be distressing and present for 6 months minimum, and they must occur in all, or almost all (75–100 percent), sexual occasions. It is a highly prevalent male sexual dysfunction and affects approximately 20 to 40 percent of sexually active men (Althof, 2007) and 75 percent of men during at least one point in their lifetime (Wang, Kumar, Minhas, & Ralph, 2005).

The 1-minute criterion is based on studies conducted by several investigators who objectively measured the average duration of sexual intercourse. Specifically, duration was measured using the time interval between penetration and ejaculation, known as intravaginal ejaculatory latency time (IELT; Waldinger, 2005). Normative IELT data have been obtained and results generally indicate that the average duration is between five and six minutes (Waldinger, 2005; Waldinger, Hengeveld, Zwinderman, & Olivier, 1998). In an attempt to operationally define this criterion, Waldinger and colleagues (1998) interviewed 110 individuals diagnosed with premature ejaculation and found that 90 percent of men ejaculated within 1 minute of penetration, and 60 percent ejaculated within 15 seconds; therefore, it was suggested that premature ejaculation should be defined as ejaculating in less than 1 minute in greater than 90 percent of episodes of sexual intercourse (Wang et al., 2005).

Undoubtedly, IELT provides a simple and objective method to assist in the diagnosis of premature ejaculation (Jannini, Lombardo, & Lenzi, 2005). However, some suggest that solely focusing on latency is one-dimensional and

ignores several essential features of this disorder (Wang et al., 2005). Indeed, an adequate assessment should be multi-dimensional and, as such, include objective data (i.e., IELT) in addition to other features, such as voluntary control over ejaculation, sexual satisfaction in both partners, and the presence of distress.

GENITO-PELVIC PAIN/PENETRATION DISORDER

The DSM-5 replaced the formerly termed category of "sexual pain disorders" that contained two disorders—**dyspareunia** and **vaginismus**—with the overarching category of "**genito-pelvic pain/penetration disorder**." This diagnosis involves persistent or recurrent difficulties with one or more of the following: vaginal penetration during intercourse; marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts; marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration; and marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration. These symptoms must be present for at least 6 months and cause distress to the individual. The main rationale for including one category combining the previously separate conditions of dyspareunia and vaginismus was that it was difficult to reliably differentiate the two on measures of pain and pelvic muscle tension (Binik, Bergeron, & Khalifé, 2007; Reissing, Binik, Khalifé, Cohen, & Amsel, 2004). Although women with vaginismus tend to display more distress related to penetration and avoidance-based behaviours than women with dyspareunia (Reissing et al., 2004), these characteristics are not sufficient to justify separate diagnoses. Studies reporting the prevalence of vaginismus alone are few, and none have reported on the prevalence of the newly termed genito-pelvic pain/penetration disorder. John Lamont (1978) reported that, at the Human Sexuality Clinic at McMaster University in Hamilton, 47 percent of all patients seen between 1972 and 1976 received a diagnosis of vaginismus. Other epidemiological reports obtained from various clinics have varied between 12 and 55 percent (Spector & Carey, 1990). Dr. Irv Binik, at McGill University's Department of Psychology, has been one of the leading researchers on dyspareunia and vaginismus for many years, and he played a key role in the revised DSM-5 definition.

The true incidence and prevalence of genito-pelvic pain/penetration disorder is difficult to determine, given significant methodological problems, and the recent definition change. Studies have indicated prevalence of dyspareunia rates ranging from 3 to 18 percent in the general population and up to 46 percent in primary care settings (Simons & Carey, 2001). It has been claimed that dyspareunia is the second most common female dysfunction and that it is increasingly reported in clinics. One study in New York (Glatt, Zinner, & McCormack, 1990) surveyed 324 women in their early thirties. Thirty-three percent of these women had persistent dyspareunia at the time of the study; in addition, almost 30 percent had previously experienced dyspareunia. In 34 percent of the cases of dyspareunia, the women reported an important adverse effect on their relationships, and 48 percent reported a decrease in frequency of intercourse as a result. Fewer than half of those still experiencing dyspareunia had ever consulted a health care professional about the problem.

Interestingly, different subtypes of dyspareunia exist, based on pain location and pattern (Meana, Binik, Khalifé, & Cohen, 1997). Provoked vestibulodynia is likely the most common form of dyspareunia in young women. It is characterized by a severe, sharp/burning pain at the entrance of the vagina in response to vaginal penetration. It affects many aspects of women's lives other than sexuality (e.g., relationship adjustment, mood) (Pukall & Binik, 2009; Pukall, Smith, & Chamberlain, 2007).

HYPERSEXUALITY

The concept of **hypersexuality**, or sexual addiction, is not new. In his eighteenth-century *Mémoires écrits par lui-même*, Giovanni Jacopo Casanova De Seingalt (known simply as Casanova) provided clear illustrations of an intense preoccupation with pursuing sex with women. Later, Richard von Krafft-Ebing, in *Psychopathia Sexualis* (1901), described what he called "hyperaesthesia" (i.e., abnormally increased sexual desire). Krafft-Ebing labelled this disorder as either "nymphomania" (excessive desire in women) or "satyriasis" (excessive desire in men). However, the modern conceptualization of hypersexuality is most often credited to Patrick Carnes, an American psychologist, who described a series of patients suffering from an addiction to sex (Carnes, 1983, 1989).

The notion of hypersexuality has been widely criticized (for summaries of these criticisms, see Orford, 2001, and Walters, 1999). While there is disagreement regarding terminology (e.g., sexual addiction, sexual compulsivity), there is some consistency with regard to the essential features of the disorder. In other words, sexual addicts typically experience a loss of control over sexual urges, fantasies, and behaviours, and they often engage in sexual activity to regulate negative emotional states (e.g., anxiety, depression).

The behavioural component of sexual addiction has received increasing attention and has been suggested as an essential feature of this disorder. To quantify sexual frequency, researchers rely on an index, termed *total sexual outlet* (TSO), initially described by Kinsey and colleagues (1948). TSO was based on the number of orgasms achieved through any combination of methods (e.g., intercourse, masturbation) during a specific week. Research has suggested that few males (approximately 5 to 10 percent) report a sexual outlet of seven or more times per week and that this level of sexual activity is rarely maintained over time (e.g., Janus & Janus, 1993; Kinsey

et al., 1948). Based on such evidence, Kafka (1997) proposed that hypersexuality should incorporate TSOs of at least seven times per week, over a period of at least six months. While this definition is useful, it is clearly not sufficient. For example, the applicability of this criterion to women is problematic, given research suggesting that a significant proportion of women have difficulty reaching orgasm (Laumann et al., 1994). Additionally, there is some dissension as to whether excessive levels of sexual behaviour are, in fact, pathological.

Although hypersexuality has never been included as an official diagnostic category in any of the DSM versions, it is included as a diagnosis (excessive sexual drive) in the International Classification of Diseases (ICD-10) of the World Health Organization (1992).

Hypersexuality has been identified in approximately 3 to 6 percent of the general population (Black, 2000) and is associated with a variety of emotional and physical problems, including depression, relationship instability, and sexually transmitted infections (Kafka, 2007).

ETIOLOGY OF SEXUAL DYSFUNCTIONS

Most of the research conducted on the causes of sexual dysfunctions has focused on specific disorders, although all of these disorders possess common factors to some degree. Early reports in the literature expressed the belief that most female sexual dysfunctions were the result of some interference with psychological functioning (Berman, Berman, Chhabra, & Goldstein, 2001). However, Berman and colleagues' review of recent findings indicates that, in many instances, these dysfunctions are secondary to medical problems and appear to have an organic basis. Consistent with this, Guay (2000) found that both premenopausal and postmenopausal women suffering some form of sexual dysfunction had unusually low androgen levels. Guay also found that treatment with androgens alleviated the problems of these women. In addition, Korenman (1998) reported that men with erectile disorder say they experience sexual arousal despite the fact that their penis does not respond, suggesting problems with the vascular reflex mechanism that normally generates an erection. Finally, people who rate their physical health as excellent report markedly fewer sexual problems than those who rate their health as poor (Laumann et al., 1994). Clearly, both physical and psychological factors are involved in the development of most, if not all, sexual dysfunctions, although one factor or another may be more important in a given case.

Almost everyone experiences some sort of sexual performance difficulty at some point. Excessive alcohol, for example, may cause a temporary lessening of desire or interfere with erection or orgasm. After a long period without sex, or during the first time with a new partner, a man may ejaculate prematurely. Usually the problem disappears with the situation that caused it. However, a person who is very upset by such an experience may carefully monitor his or her responses during the next sexual encounter. This second perceived failure, of course, only leads to greater anxiety, and a chronic dysfunction may emerge.

Research findings are consistent with the idea that the person's perspective plays a part in the development or maintenance of sexual dysfunction. For example, men with erectile disorder typically do not pay attention to the arousing properties of sex but rather focus on the threatening consequences of their likely failure to produce an erection (Bach, Brown, & Barlow, 1999). Whether these psychological factors in erectile disorder or vaginismus precede or follow the development of clients' problems is irrelevant for treatment purposes, since it is the maintenance factors that are important for change. Let us now consider etiological factors associated with some of the specific sexual dysfunctions.

SEXUAL DESIRE AND AROUSAL DISORDERS

People with sexual desire disorders are generally not interested in sexual activity, a pattern sometimes evident in depressed patients. This similarity has led to speculation that hypoactive sexual desire may result from depression. Cyranowski and colleagues (2004), for example, found a correlation between high levels of depressive symptoms and reduced levels of sexual desire. In another investigation, Hartmann, Heiser, Ruffer-Hesse, and Kloth (2002) found that a significant number of women with sexual difficulties also satisfied the diagnostic criteria for a mood disorder. With the widespread use of SSRI antidepressants, there is evidence that hypoactive sexual desire may result from depression or from the medication used to treat it (Renshaw, 1998).

Kaplan (1979) emphasized other psychological factors in sexual desire disorders, such as dysfunctional attitudes about sex, relationship problems, and a strict upbringing that associated sexual pleasure with guilt. Indeed, these appear to be factors in all sexual dysfunctions (also see Wincze, Bach, & Barlow, 2008).

In addition to psychological difficulties that may precipitate sexual dysfunctions, abnormal hormonal functioning may cause problems. Certainly, hormones such as **estrogen** (the so-called female sex hormone), **testosterone** (the so-called male sex hormone), and **prolactin** are involved in sexual activity and desire, and variations in the levels of these hormones can lower or increase sex drive (Rosen & Leiblum, 1995). However, the evidence suggests that abnormal hormonal levels contribute to only a few cases of sexual desire disorder (Kresin, 1993).

Perhaps the most commonly reported factor associated with arousal disorders, and to some extent all sexual dysfunctions, is what Masters and Johnson (1970) originally called performance anxiety. **Performance anxiety** is the response of individuals who feel that they are expected to perform sexually. Worried that their performance will not be up to the expectations of their partner, they become *spectators* of their own behaviour, monitoring their own sexual performance and the perceived responses of their

partner. When this happens, the person's focus is on the performance rather than on enjoyment of the sexual experience. Like the watched pot that never boils, the spontaneous sensory response of sexual arousal is blocked. However, anxiety can affect sexual functioning simply as a result of increased activity in the sympathetic branch of the autonomic nervous system. When sympathetic activity occurs, as happens when someone is anxious, its activity inhibits the parasympathetic branch. Since sexual arousal is associated with activation of the parasympathetic branch, inhibition of this branch by sympathetic activity will interfere with sexual arousal and may, as a result, cause sexual dysfunction.

Weisberg and his colleagues (Weisberg, Brown, Wincze, & Barlow, 2001) examined this idea in a laboratory study. Fifty-two sexually functioning men were instructed to watch two erotic films. Following the viewing of these films, the men were given bogus feedback indicating that they had a low erectile response. The men were divided into two groups. Group I was given an external fluctuating attribution (i.e., the films were poorly made), while Group II was given an internal, stable attribution (i.e., problematic thoughts about sex). The participants were then instructed to watch a third erotic film. Individuals in Group II, who were given the problematic sexual thoughts feedback, experienced lower erectile responses than Group I, who attributed their reported sexual malfunctioning during the first films to external factors (i.e., poor videos). This study suggested that the attributions we make regarding our sexual performance may affect our future ability to perform.

Erectile disorder involves a complex interplay between physiological and psychological factors. Physiological factors include cardiovascular disease, neurological diseases, or various medications, whereas psychological factors include performance anxiety (described above), depression, problems in the relationship, and psychological traumas. Other risk factors for **male erectile disorder** include age, diabetes, hypertension, cigarette smoking, and alcoholism (Russell & Nehra, 2003). Hormonal factors have been proposed, where a loss of androgens may ultimately lead to erectile dysfunction. In fact, Gilna (2004) demonstrated that testosterone replacement therapy improved erectile rigidity in men experiencing erectile dysfunction. Masters and Johnson (1970) estimated that psychological factors were primary in 95 percent of the cases of erectile dysfunction, although more recent estimates suggest something closer to a 50/50 split between biogenic and psychogenic origins (Everaerd, 1993). However, methodological problems within these studies make such estimates unreliable. Nevertheless, both psychological and organic causes are important and should be considered in a comprehensive assessment.

ORGASMIC DISORDERS Orgasmic disorders are generally thought to involve primarily psychological factors, but certain medical conditions (for example, heart or circulatory problems) and some medications can cause anorgasmia in women. Again, relationship difficulties are common, although it is often hard to know whether these difficulties preceded or were caused by the sexual dysfunction. Limited sexual techniques, a lack of understanding of their own response, and partners who do not understand their needs may all play a role, as does an inability to let go and allow the natural response to sexual stimulation to occur. As shown in the case of Joan, these barriers are more difficult to overcome if a woman feels constrained in discussing sex with her partner or in exploring techniques.

Premature (Early) Ejaculation Two types of premature (early) ejaculation have been identified: primary and secondary. Secondary premature ejaculation occurs in men who previously had ejaculatory control. In such cases, Metz, Pryor, and Nesvacil (1997) found that premature (early) ejaculation could be caused by trauma to the sympathetic nervous system, abdominal or pelvic injuries, prostatitis, urethritis, or, as Althof (1995) found, withdrawal from narcotics. Grenier and Byers (1995) determined that hormones do not play a role in premature (early) ejaculation. Primary premature (early) ejaculation could be caused by various problems. It may be a conditioned response to rapid ejaculation from the age when boys masturbated and ejaculated rapidly out of convenience (as cited in Carver, 1998), or when young men attempt sexual intercourse under pressure or once again in situations where they had to ejaculate fairly rapidly. With repeated experiences, the conditioning effect becomes stronger. Men may also avoid sex due to feelings of guilt and shame, and thus in clinical situations may be more likely to be diagnosed with low sexual desire when they are simply trying to avoid premature ejaculation. Thus, it is evident that premature (early) ejaculation is largely thought to be psychological in nature, based around men's sensations and perceptions (Byer, Shainberg, & Galliano, 2002). However, it is evident that some men have a low threshold for physical stimulation and therefore are thought to be physiologically predisposed to premature (early) ejaculation (Crooks & Baur, 1996).

GENITO-PELVIC PAIN/PENETRATION DISORDER There is a paucity of research investigating etiological markers of both vaginismus and dyspareunia (Beck, 1993; Binik et al., 2007). Most studies have investigated psychogenic mechanisms and have reported several potential causal factors such as negative sexual attitudes, lack of sexual education, unpleasant or traumatic sexual experiences such as rape or childhood sexual abuse, and various cognitive styles associated with anxiety (Binik et al., 2007; Reissing et al., 2004). Studies have indicated that women diagnosed with either vaginismus or dyspareunia present with significantly more distress and avoidance behaviours pertaining to expected pain than do women without these disorders (Reissing et al., 2004). While this highlights the importance of conditioned responses, further research on causal mechanisms is necessary.

TREATMENT OF SEXUAL DYSFUNCTIONS

PSYCHOLOGICAL INTERVENTIONS Until the publication of Masters and Johnson's (1970) book describing their treatment approach, there was very little literature on therapy for sexual dysfunctions. Masters and Johnson described a comprehensive and intensive approach that required couples to live in their clinic for two weeks. Many aspects of Masters and Johnson's approach have been retained or modified at other clinics, so that most programs now share a number of common elements. Most programs see sexual dysfunctions as involving two people and, as a consequence, they typically insist that both partners attend treatment.

Communication and Exploration. The majority of programs begin with an extensive assessment of the couple, including a detailed sexual history (see Wincze et al., 2008). This is typically followed by sex education, where information is provided and maladaptive ideas about sex are challenged. Procedures are provided for enhancing communication between the partners, not only about sexual matters, but about all issues that may cause disharmony. Effective sexual communication first requires each partner to develop an understanding of his or her own sensations and bodily response. Acceptance of their own bodies may be limited because of embarrassment or guilt. Accordingly, sex therapists often suggest exercises in which clients privately explore their own bodies and use masturbation to become aware of their own arousal response. Clients also learn to communicate their specific sexual preferences to one another so that they can give each other sexual pleasure.

Sensate Focus. An important component in sex therapy programs is what Masters and Johnson (1970) called **sensate focus**, essentially a form of desensitization applied to sexual fears. It is assumed that once the sexual dysfunction has emerged, the person develops performance anxiety or fear, which serves to worsen and entrench the problem.

Given that many sexual dysfunctions are associated with anxiety or fear and performance anxiety, sensate focus is often employed to redirect attention away from the specific sexual response and toward the sexual interaction (Wincze et al., 2008). Sensate focus involves a series of exercises where partners engage in predetermined stages of sexual interaction. In the first step, they undress together with the light on to desensitize any embarrassment they may have about being naked together. They next take turns at massaging or touching one another all over, except for the genital or breast areas. They are learning to enjoy touching and being touched without any fear of imminent demands for sex. After several sessions of this, each person begins to tell the partner during the touching exercises what he or she enjoys. All of these sessions are interspersed with discussions with their therapist, which is meant to enhance communication skills and to identify and deal with any problems that arise during the touching sessions. As the couple becomes comfortable and they begin to expand their enjoyment of the associated physical pleasures, they progress to the next stage: genital and breast touching. There is still, however, a moratorium on sexual intercourse to allow the couple to enjoy sexual sensations and arousal without the fear of having to perform. The aim is to eliminate "spectatoring," allowing each partner to relax and focus on his or her own pleasure. Once the couple can maintain their pleasure without fear, they are advised to enter the last stage of sensate focus, which is designed specifically for the problem that brought them to the clinic. In this final stage, the ban on sexual intercourse is lifted. However, the couple is instructed to progress slowly and they follow a particular gradual program aimed at overcoming the specific dysfunction.

In addition to sensate focus, there are several behavioural exercises aimed at particular sexual dysfunctions. The stop-start and squeeze techniques, for example, are behavioural approaches used to treat premature ejaculation, and can be used either with or without a partner. With the stop-start technique, the partner manually stimulates the man until he feels the earliest signs of approaching orgasm, at which point the partner ceases the stimulation. After a period of time (approximately 40 seconds to 1 minute), the partner begins masturbating him again. This procedure is repeated so that the entire process lasts approximately 15 minutes (employing as many stops as is necessary). Sometimes, just stopping is not enough to prevent the man from ejaculating. In those cases, the squeeze technique is employed by squeezing around the coronal ridge of the penis. Although it is not painful, the squeeze technique diminishes arousal and prevents ejaculation. When the individual can last approximately 15 minutes with only 1 or 2 "stops," the couple can proceed to more arousing stimulation methods (e.g., oral sex). One advantage of the stop-start method is that it can be practised with or without a partner and used with manual, oral, or vaginal sex.

EVALUATION OF PSYCHOLOGICAL TREATMENT Masters and Johnson (1970) claimed that more than 80 percent of their clients were successfully treated for their various dysfunctions. However, they used a rather loose criterion of success and did not follow up with their clients for long enough to properly evaluate the maintenance of their gains.

More recent and careful evaluations have shown that premature (early) ejaculation and vaginismus are most successfully treated with the type of therapy outlined above (Beck, 1993). Success rates as high as 80 percent for vaginismus and 90 percent for premature (early) ejaculation have been reported. Treatment for erectile dysfunction has not fared as well, although as many as 70 percent of men with this disorder reported that they recovered sufficient erectile capacity to have intercourse (Hawton, Catalan, & Fagg, 1992). For problems such as low desire or orgasmic dysfunction in women, directions to engage in self-masturbation appear to enhance the effects of comprehensive therapy (LoPiccolo, 1990).

Overall, psychological sex therapy has been quite successful in treating sexual dysfunctions. Some cases in which

it is not successful may be attributable to undetected physical problems.

PHYSICAL TREATMENTS Physical treatments are best used in conjunction with psychological approaches, even in cases where there is a clear organic cause. In erectile disorder that has a physical basis, for example, there are nevertheless psychological features once the disorder is established. In these cases, the man will very likely become afraid of failing and develop performance anxiety, which may remain a problem even after the physical cause has been corrected.

Medications of one kind or another have been shown to be helpful in some cases of sexual dysfunction. With regard to erectile dysfunction, several muscle relaxants, including Phentolamine, Papaverine, and Alprostadil, can be self-injected into the corpus cavernosum of the penis, which facilitates an erection by relaxing isolated human penile erectile tissue and cavernous arteries (El-Sakka, 2006). Alprostadil, in particular, represents the most common form of **intracavernous treatment** for erectile dysfunction and, upon administration, erections may last for an hour or longer, irrespective of whether there is direct sexual stimulation. Intracavernous treatment using Alprostadil is extremely efficacious, particularly for men who experience problems with the transmission of nerve signals that regulate their erections.

Efficacy rates for intracavernous therapy are extremely high, such that up to 94 percent of individuals undergoing this treatment have reported subsequent sexual activity (Hatzimouratidis & Hatzichristou, 2005; Mohr & Beutler, 1990). However, complications include penile pain, the development of scar tissue, prolonged erections (i.e., priapism), and fibrosis. Despite the positive results of this treatment, the fact that many men find this procedure painful, or at least unpleasant, has led to high discontinuation rates and limited treatment compliance (Althof & Turner, 1992).

Antidepressants have also been used, typically in the treatment of premature (early) ejaculation, as they have demonstrated the ability to delay the ejaculatory response and have led to improved sexual satisfaction in some men (Althof & Seftel, 1995). Aphrodisiacs have also been historically implicated in sexual arousal. The first kind of aphrodisiac is psychophysiological, affecting one's five senses—the idea being that one's senses can be stimulated to heighten sexual awareness. The second kind of aphrodisiac is internal and based on the old belief that certain products have sexually stimulating qualities. Examples include various foods, herbal remedies (e.g., Ginkgo biloba), alcohol, and "love potions" (Slovenko, 2001). However, the positive effects of these aphrodisiacs have not been supported by research.

Considerable publicity has accompanied the announcement of the phosphodiesterase inhibitors (PDE5 inhibitors) designed to treat erectile disorders. The three agents within this class are Sildenafil (marketed under the trade name Viagra), Tadalafil (marketed under the trade name Cialis), and Vardenafil (marketed under the trade name Levitra), and all restrict the breakdown of cyclic guanine monophosphate, which leads to increased blood flow and stronger erections. Each medication has been approved by Health Canada, although some adverse side effects have been noted (e.g., problems with vision). Some patients prefer one type over another, given differences with regard to duration of action (Viagra has the shortest duration at 4 to 6 hours and Cialis has the longest duration at up to 36 hours) and interactions with fatty foods (Ashton, 2007).

Among these agents, Viagra, in particular, has been subjected to well-controlled and systematic research. In one of the early investigations, Goldstein and colleagues (1998) evaluated its effects on more than 850 men who could not generate and maintain an erection of sufficient quality to have intercourse. Their careful examination of these men revealed that some had an organic basis to their problem, others had psychogenic causes, and some had both organic and psychogenic problems. Sixty-nine percent of all attempts at intercourse were successful for the men taking Viagra, while only 22 percent of the attempts were successful on the placebo. Furthermore, increased doses were associated with improved erectile functioning. These findings were essentially confirmed by Mitka (1998), who found that Viagra generated erections in two-thirds of men with severe erectile problems.

PDE5 inhibitors are generally safe, and side effects are typically mild (e.g., headache, flushing, visual disturbances); however, these medications are contraindicated in men who use nitrates to manage cardiovascular disease. Additionally, given the paucity of research, it is still too early to rule out the possibility of more problematic effects with long-term use. Nevertheless, given the encouraging results and typically mild side effects, the administration of these drugs for erectile disorder has become common.

Interestingly, use of PDE5 inhibitors in women with the previously termed sexual arousal disorders has been described in several case reports (Ashton, 2007). In a double-blind crossover design, Caruso, Intelisano, Lupo, and Agnello (2001) investigated the utility of Viagra in 51 women experiencing arousal disorders. Compared to placebo treatment, women treated with Viagra showed significant increases in sexual arousal and in the frequency of orgasm, as well as increases in the frequency of sexual fantasies and intercourse; they also reported marked improvements in their enjoyment of sex. Unfortunately, other studies have not demonstrated such positive changes, and research on the use of PDE5 inhibitors in women has essentially been abandoned at present. Not surprisingly, other treatments (e.g., testosterone gel) have been touted to treat low desire/arousal in women; however, none of these has been approved by the appropriate regulatory boards to date.

Pelvic floor physiotherapy has emerged as a potential treatment for men with erectile dysfunction (primarily in the UK; Dorey et al., 2004)—although the use of vacuum erection devices is more common—and for women with a common form of dyspareunia, provoked vestibulodynia. Both retrospective (Bergeron et al., 2002) and prospective

studies (Goldfinger, Pukall, Gentilcore-Saulnier, McLean, & Chamberlain, 2009) have documented positive outcomes in terms of pain reduction and improvements in sexual function after treatment.

Surgical interventions are also recommended for some individuals with sexual dysfunctions. For example, vestibulectomy (surgical removal of the superficial vestibule) for women with provoked vestibulodynia is the most commonly reported treatment and has positive outcomes (Bergeron, Pukall, & Mailloux, 2008). Surgery can be helpful for males with erectile dysfunction when the cause has been identified as a vascular blockage preventing adequate blood flow to the penis (Mohr & Beutler, 1990).

The most common physical treatment for sexual dysfunctions is penile implants for men with erectile disorder. While a number of different implants were used in the past, currently the most popular approach is to implant inflatable silicone cylinders in the penis (see Figure 13.2). These cylinders are joined to a reservoir of fluid that has been inserted into the man's abdomen along with a tiny pump in the scrotum. To produce an erection, the man presses the pump, which pushes fluid from the reservoir into the cylinders. As the cylinders fill, they cause the penis to become erect. These implants have been very popular, and the early evidence indicated that the patients and their partners were quite satisfied (Anderson & Wold, 1986). However, follow-up studies have shown that 40 percent of such men and their partners are not satisfied, in the long term, with the results. Fears associated with silicone implants and concerns about the invasiveness and irreversibility of the procedure appear to have reduced the popularity of this approach in recent years (Thomas & LoPiccolo, 1994).

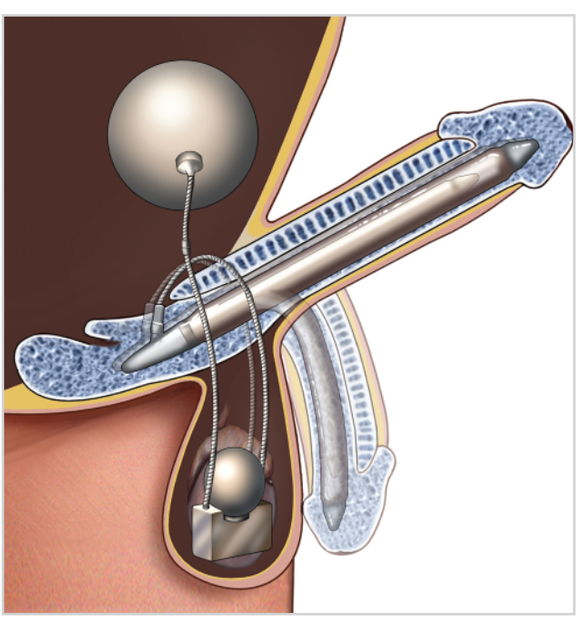


FIGURE 13.2 Penile Implant

Source: Courtesy of Dr. Jan Looman, Regional Treatment Centre, Kingston, Ontario.

3 BEFORE MOVING ON

Imagine a heterosexual couple presenting to a sex therapy clinic in which the male has severe erectile dysfunction. Intercourse is impossible and their main goal is to be able to have intercourse again. Their therapist assigns them the first two steps of sensate focus. The couple is baffled. Why is their therapist asking them to not have sex when their goal is exactly that? How would you explain this apparent paradox to this couple?

Gender Identity

Boys are expected to act like boys, and they are allowed little latitude before they are labelled "sissies." Girls who play hockey and prefer trucks to dolls are tolerated much better. Indeed, Western society presents a very rigid view of what is considered "male" or "female" and offers very little room for expressions outside of these two extremes, especially for males. In many non-Western cultures, however, the existence of individuals who are neither traditionally masculine nor traditionally feminine has long been recognized and accepted; in fact, such gender-variant individuals may be given a specific name and accorded a distinct role in society. In several Native cultures, rituals conducted at or before puberty give a boy the option to choose between the status of a conventional male or that of a transgendered male—a "two-spirit" (male–female) person, or *berdache*. Berdaches wear special clothing fashioned from male and female attire, practise mostly female occupations, and engage in sexual relationships with conventional men. They are often shamans (healers who derived their curative powers from their knowledge of the spirit world), chanters, dancers, or mediators. Such latitude in creating room for a third sex is lacking in Western society; although some individuals resist categorization by "gender-bending" (i.e., actively transgressing expected gender roles), some transpeople may feel forced to "fit" into either the male or female category, and others may simply choose to "switch" their sex through the lengthy, painful, and difficult process of sex reassignment.

Despite the greater latitude offered to women in expressing male behaviours, when Leslie Feinberg was growing up, she was such a tomboy that she was rejected on all sides (Gilbert, 1996). As she matured, the female role chafed so much that eventually Feinberg moved to New York and began to pass as a man. She dressed like a man, acted like a man, and expected others to treat her like a man.

In making this transition, Feinberg identified herself as "transgendered," or simply "trans." She rejected her categorization as female and insisted on having the right to live as she pleased without harassment. Her transformation dealt with more than gender: Feinberg became a spokesperson for a new movement of those in society who have been marginalized. These are the women and men who feel that they are the victims of cruel accidents of biology—that they were born the wrong sex.

Despite many people's assumption that gender is a clear-cut concept, there are many different dimensions of gender, including the following: chromosomal gender (XY in males and XX in females), gonadal gender (testes in the male and ovaries in the female), prenatal hormonal gender (testosterone and anti-Mullerian hormone in the male but not in the female), internal accessory organs (e.g., prostate in the male and Fallopian tubes in the female), external genital appearance (e.g., penis in the male and vulva in the female), assigned gender (based on the external genital appearance at birth, resulting in the "it's a boy" or "it's a girl" announcement that then affects society's labelling of that child and the gender in which the child is raised), and **gender identity** (a person's basic sense of self as male or female, the first signs of which appear between 18 and 36 months of age) (Money, 1987). **Gender role** is the collection of those characteristics that a society defines as masculine or feminine. Because roles relate to social standards, ideas about gender role change over time and from culture to culture. In some instances, these "variables of gender" do not all coincide. In rare cases where the actual biological variables are discordant, **hermaphroditism** occurs, with the reproductive structures being partly female and partly male. When the biological variables are consistent, but are discordant with the person's sense of self, **gender dysphoria** (previously labeled as gender identity disorder, or GID) occurs.

GENDER DYSPHORIA

A "trans" activist, such as Leslie Feinberg, might appear to fulfill the DSM-5 criteria for gender dysphoria (see Table 13.3). She has experienced a strong desire to be, and to be treated as, the other gender. The incongruence between her experienced/expressed gender and assigned gender is key to this diagnosis; however, also necessary for the diagnosis is clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2013, p. 453). Feinberg argues that

TABLE 13.3 DSM-5 DIAGNOSTIC CRITERIA FOR GENDER DYSPHORIA

Gender Dysphoria in Children

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
   3. A strong preference for cross-gender roles in make-believe play or fantasy play.
   4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
   5. A strong preference for playmates of the other gender.
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
   7. A strong dislike of one's sexual anatomy.
   8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically-significant distress or impairment in social, school, or other important areas of functioning.

Gender Dysphoria in Adolescents and Adults

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.

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she is perfectly well adjusted to her transgendered life, although society may have difficulty with it. Such individuals may fulfill some of the cross-gender requirements for the diagnosis, but they do not completely fit the criteria because their gender dysphoria appears not to result in severe distress.

In the DSM-5, two separate diagnoses of gender dysphoria exist, based on the age of the individual presenting with the complaint: gender dysphoria in children and gender dysphoria in adolescents and adults. Both have two possible subtypes (with or without a disorder of sex development, e.g., Turner syndrome), and the diagnosis pertaining to older individuals has an additional specifier of whether the individual is post-transition (i.e., has undergone at least one form of cross-sex treatment and is living full time as the desired gender).

Because they feel as if they are physically the wrong sex, people with gender dysphoria may cross-dress or attempt to rid themselves of secondary sex characteristics in other ways. They may request hormonal treatment or other physical alterations, such as electrolysis to remove facial hair, in attempts to assume the role of the other sex. In some instances, they undertake surgery to change their anatomy and are then known as transsexuals.

Green and Blanchard (1995) reported that GID (the former label of gender dysphoria) occurs more commonly in children than in adults, with 3 percent of boys and 1 percent of girls identified as having the disorder. In fact, the gender dysphoria associated with GID most commonly begins in childhood; most adults having this disorder report gender-role conflicts and transsexual feelings occurring at a very early age (Tsoi, 1990). However, in adults the prevalence of GID is quite low: for males, prevalence ranges from 0.005 percent to 0.014 percent, and for natal females, from 0.002 percent to 0.003 percent (APA, 2013).

ETIOLOGY OF GENDER DYSPHORIA

Very little is known about the origins of gender dysphoria. Unfortunately, what data are available present a rather confusing picture, although most authorities in the field consider the problem to result from some as yet unspecified combination of biological and psychological factors.

A tragic Canadian "test case" that offers some insight into the nature/nurture debate emerged accidentally when one of a pair of male monozygotic twins had his penis cut off during a botched circumcision (Colapinto, 2000). Instead of undertaking the repeated, difficult, and possibly unsatisfactory surgeries necessary to reconstruct a penis, sexologist John Money persuaded the parents to have the boy surgically "reassigned" as a girl. Thus, nature (that is, the hereditary component) was held constant between the twins because of their identical genetic makeup. Only the nurture component varied for the two: one twin was subsequently reared as a girl, the other as a boy. The reports indicated that the reassigned twin became feminine in behaviour and interests. At puberty, she was given hormonal replacement therapy in order to develop breasts and other female secondary sex characteristics. This case is still cited by many writers as evidence that "gender identity is something one *learns* at a very young age" (Barlow & Durand, 1995, p. 419). Such conclusions overlook follow-up information on the reassigned twin (Colapinto, 2000). The professionals who studied this case maintained that, as a young adolescent, the child was extremely masculine (Diamond, 1982). It was clear that this child had not adjusted well to being a female. When the child was told at age 14 of the botched circumcision, it devastated him. He adopted the male role, changed his name to David, and later married. Tragically, he committed suicide in 2004, just two years after his twin brother overdosed on antidepressant medication and as his own marriage was dissolving. The many years he suffered attempting to adapt to the role of a female apparently had no effect on his gender identity, and although this is only a single case, it supports the idea that gender identity is minimally influenced by environmental experiences.

Some theorists have suggested that disturbances in gender identity may be caused by either genetically influenced hormonal disturbances or exposure during fetal development to inappropriate hormones. It has been proposed that an excess or absence of testosterone during a critical point in fetal development may affect the individual's gender identity. Thus, males who were not prenatally exposed to testosterone will act in a feminine manner, whereas females who were exposed prenatally to excess testosterone will be "tomboyish" (Cohen-Kettenis & Gooren, 1999).

One of the most predominant neurobiological theories for the development of gender dysphoria has focused on the role of prenatal hormones. In particular, prenatal exposure to male-typical levels of androgens masculinizes postnatal behaviour, whereas underexposure to male-typical levels of androgens has the opposite effect (Zucker, 1990). Although theoretically complex and not frequently studied, some investigators have pointed to the overrepresentation of left-handed individuals presenting with GID (as it was called then) compared to non-disordered individuals as evidence for instability in neurodevelopment and a general biological marker (see Zucker, Bealieu, Bradley, Grimshaw, & Wilcox, 2001). Other evidence has come from heritability studies. Several studies have reported evidence indicating a significant heritable pattern for children with GID (Zucker, 2005; Zucker & Bradley, 1995). In one study, Coolidge, Thede, and Young (2002) examined the heritability and prevalence of GID in a non-retrospective study of 314 child and adolescent twins. Results indicated that GID within this sample was highly heritable.

A problem with this type of research concerns the issue of what constitutes masculine or feminine behaviour. Certainly, it is common for children to show some supposedly gender-atypical behaviours and interests, and in today's more tolerant climate more parents are comfortable with boys playing with dolls or girls engaging in rough-and-tumble play. In any event, some reviews have cautioned against the hormonal hypothesis (Bancroft, 1989; Bradley & Zucker, 1997; Carroll, 2007).

Psychodynamic and social learning theories of human behaviour emphasize the importance of early childhood experiences and the family environment. For psychoanalytic theory, the basic conflict resulting from a boy's failure to separate from the mother and develop an independent identity creates a gender identity problem (Meyers & Keith, 1991). Behavioural theory (Bernstein, Steiner, Glaiser, & Muir, 1981) suggests that the basis of GID lies in encouragement by parents of gender-inappropriate behaviours, combined with the lack of a same-sex adult model and overprotection by the opposite-sex parent. Some believe that parental characteristics might give children insufficient means to identify with the same-sex parent or to interact in cross-gender reinforcement situations. However, it is important to consider that child-related factors may be evoking certain parental responses—for example, femininity encouraged in a son by an unstable, vulnerable parent (Cohen-Kettenis & Gooren, 1999). Cohen-Kettinis and Arrindell (1990) conducted retrospective studies on the child-rearing practices of the parents of adult gender dysphorics and non-gender dysphorics. Those males who became females reported their fathers as less emotionally warm, more rejecting, and more overly controlling. Females who became males reported that both parents were less emotionally warm, but stated that only their mothers were more overprotective, as compared to the controls. Studies of the importance of the influence of parental behaviours during this developmental period have so far been somewhat supportive of a relationship between parental child-rearing behaviour and adulthood gender dysphoria.

TREATMENT OF GENDER DYSPHORIA

Dr. Kenneth Zucker has worked extensively with children with gender dysphoria at the Centre for Addiction and Mental Health in Toronto. When parents present cross-gender–identified children for treatment, the clinician faces a difficult issue. Some feel it is inappropriate to try to change gender identity, but increasing evidence has indicated that these individuals experience significant distress (Zucker, 1990; Zucker, 2005). The most systematic information on associated problems in these children has come from parent-report data using the Child Behaviour Checklist (Achenbach & Edelbrock, 1983). Several studies have shown that boys and girls diagnosed with gender dysphoria display more behavioural problems and experience more social ostracism than do same-sex siblings and age-matched controls (Cohen-Kettenis, Owen, Kaijser,

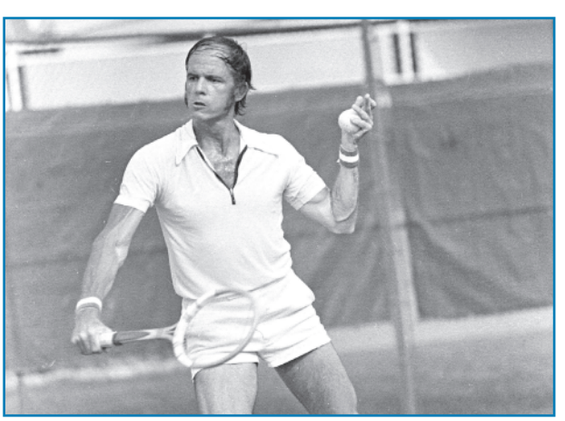
APPLIED CLINICAL CASE

Dr. Richard Raskin

Dr. Richard Raskin was born in New York City in 1934. He was the captain of Yale University's tennis team and went on to become an ophthalmologist and professional tennis player. Richard had been dressing as a woman since he was a child. He married in the early 1970s and had one child. After 10 years of psychoanalysis and a marriage that ended in divorce, Richard underwent sex-reassignment surgery and became Dr. Renée Richards.

Renée is noted for her impact on the "courts." When a number of female professional tennis players complained that her participation in the U.S. Open would result in unfair competition, the U.S. Tennis Association denied her entry. When they told her that she could not play, she suddenly became "the world's activist for the sexually disenfranchised" (Giltz, 2007). In 1977 the New York Supreme Court overturned this policy and ruled in favour of transsexual rights. Renée went on to reach the women's double finals, continued to play tennis until 1981, and ranked twentieth overall. She has published two autobiographies, one in 1986 (*Second Serve*) and another in 2007 (*No Way Renée: The Second Half of My Notorious Life*).

Portrayals of transpeople in the media can be seen in movies such as *The Crying Game*, *Breakfast on Pluto*, *Boys Don't Cry*, *Normal*, *Transamerica*, and *Hedwig and the Angry Inch*, and in television shows such as *Bones*, *Dirty Sexy Money*, *The L Word*, *Nip/Tuck*, and *Ugly Betty*.



Dr. Richard Raskin/Dr. Renée Richards before (left) and after (right) sex-reassignment surgery.

Bradley, & Zucker, 2003; Zucker, 2005). Consequently, attempts have been made to encourage gender-appropriate behaviour and to discourage cross-gender behaviour among these children through various psychotherapeutic techniques. In the short term, these interventions may affect cross-gender behaviour, but little is known about their long-term impact on gender disorders of children.

Some heterosexual but more same-sex oriented people with gender dysphoria eventually request hormonal treatment or surgery to "reassign" them to the opposite sex (Lawrence, 2003). Jeremy Baumbach, a psychologist at the Yukon Family Services Association in Whitehorse, and Louisa Turner, at Case Western Reserve University School of Medicine (Baumbach & Turner, 1992), noted that not all people with gender dysphoria request hormonal or surgical reassignment. Those with the highest desire for surgical sex reassignment appear to be those who are the most sexually aroused by imagining themselves as having the sexual organs of the opposite sex (Blanchard, 1993). The most recent edition of the HBIGDA Standards of Care, Version 6 (Meyer et al., 2001), includes the following minimum eligibility criteria for sex-reassignment surgery: (1) "12 months of successful continuous full time real-life experience," (2) "usually 12 months of continuous hormonal therapy for those without a medical contraindication," and (3) "if required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional" (p. 28; as cited in Lawrence, 2003). This "real-life test" helps to ensure that patients are able to function fully in the desired gender role before potentially irreversible measures are undertaken.

Toronto researchers have found that hormonal therapy assists in developing the desired secondary sex characteristics (Dickey & Steiner, 1990). Males treated with feminizing hormones show breast enlargement, increased fat deposits, and decreased muscle mass, as well as decreased facial and body hair. Their capacity to have erections and to ejaculate diminishes. Treatment of women with testosterone leads to an increase in muscle bulk and facial hair, deepening of the voice, enlargement of the clitoris, and suppression of ovarian function.

Currently, there are more than 80 empirical studies and reviews reporting outcome data on gender reassignment surgery and, while methodological concerns are evident, these procedures have resulted in satisfactory outcomes in approximately 90 percent of patients (Carroll, 2007). More specifically, patients usually experience satisfaction with interpersonal functioning and general psychological health but have reported negative effects on cosmetic results and sexual functioning. One study conducted by Lawrence (2003) examined factors associated with satisfaction and regret following sex-reassignment surgery in 232 male-to-female patients where the surgeon and his surgical technique are the same across all participants. One year after the operation, patients were asked to complete a questionnaire evaluating their attitudes and experiences. Most patients were very satisfied, claiming that it improved their quality of life. Only a few patients experienced regret, and that was only on an occasional basis. Dissatisfaction was usually associated with unsatisfactory physical or functional results of the surgery. Yet, psychological issues can still occur and, as such, most clinics now offer psychotherapy and counselling both before and after surgery for their transsexual clients. Clients who receive such counselling appear to do better than clients who do not receive assistance with the transition from one gender to another (Green & Fleming, 1990).

4 BEFORE MOVING ON

Consider just one of the unique challenges that a person with gender dysphoria may experience. Although this individual's experience of maleness or femaleness is in his or her head and part of a constant inner reality, society sees only the physical body of this person and treats him or her accordingly. The larger society is only acting on what is observable without any regard for that person's inner experience. Understandably, the person with gender dysphoria considers this treatment unwanted, ignorant, and offensive as it is not part of his or her reality. What do you think would be best for all involved—to change the inner experience of the person with gender dysphoria, to change the physical appearance of the person with gender dysphoria, or to change society's perception?

The Paraphilias

Case Notes

Shortly after his fiftieth birthday, Joseph Fredericks was sent to prison for life for the murder of an 11-year-old boy. Fredericks had kidnapped the boy from a shopping mall in Brampton, Ontario, and then repeatedly raped him before stabbing him to death.

Fredericks's history revealed that in his second year at school, he had been assessed by a school psychologist who concluded that his intelligence was extremely low. Fredericks was taken from his poverty-stricken parents and placed in an institution for the retarded (as they were then called), where he knew no one and lost all contact with the parents he loved. Many years later, it was discovered that Fredericks's intelligence was normal.

Fredericks was introduced to sexual activities by older residents of the institution. Frightened at first, he soon sought out other boys for sex. There was little else to do in the institution and sex became his only pleasure.

At age 17, Fredericks was considered too old for the institution and sent out into the world with some money in his pocket but no idea what to do with it. He did not know how to find a room or a job. Because he was assumed to be incapable of learning, he had not been

taught any job skills. He went on welfare until he found casual work. Since he had no friends or relatives that he knew of, Fredericks soon began to seek out the company of young boys, the only people he had ever learned to relate to. He was arrested for sexual molestation soon after leaving the institution and repeated this behaviour over the next 30 years. In 1985, he was sent to Kingston Penitentiary for five years, but was released after serving two-thirds of his sentence because he was considered to pose no great risk to the community.

Evidently, this conclusion was disastrously mistaken, for within a few weeks he had murdered the young boy.

DSM-5 describes unusual sexual interests as **paraphilias**, which means "beyond the usual" (*para*) form of love (*philia*). According to the diagnostic manual, paraphilias are characterized by "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (APA, 2013, p. 685; see Tables 13.4–13.11 in this chapter). The DSM-5 defines a paraphilic disorder as a paraphilia that is currently causing distress or impairment to the individual, or a paraphilia that causes personal harm, or risk of harm, to others when acted upon. According to this perspective, if a clinician ascertained the presence of a paraphilia, it would not necessarily require psychiatric diagnosis or intervention. Only in the case that this paraphilia caused distress to the individual experiencing it or harm to others would it then be diagnosed as a paraphilic disorder. Second, the criterion for the paraphilic disorders that involves nonconsenting persons is more specific in terms of the number of nonconsenting persons involved, and this number varies depending on the **paraphilic disorder**. This information is detailed below. Note that all disorders specify a period of at least six months' duration and need to be manifested by fantasies, urges, or behaviours in order for the diagnosis to be made.

PARAPHILIC DISORDERS

FETISHISTIC DISORDER The DSM-5 describes **fetishistic disorder** as recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on a nongenital body part, or parts.

Since it is mostly men who appear at clinics for treatment of fetishisms, it is often presumed that these fixations are primarily found in males, although there is no clear evidence that this is so. Of the fetishistic objects that have been reported in the literature, women's underwear or women's shoes appear to be among the most common, but there are reports of fetishisms for leather, rubber, plastic, babies' diapers, furs, and purses. Indeed, almost any object, or even behaviour, can become a fetish. For example, apotemnophilia is the disturbing fetish for amputation and genital mutilation. One case was even documented where a man cut off his own penis due to a genital mutilation fetish (Lowenstein, 2002).

TABLE 13.4 DSM-5 DIAGNOSTIC CRITERIA FOR FETISHISTIC DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body part(s), as manifested by fantasies, urges, or behaviors.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

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The fetishist typically likes to smell or rub the object against his or her body or, in some cases, wear the article or have his partner wear it. When the articles worn by the fetishist are clothes of the opposite sex and this behaviour is considered distressing, it should be called *transvestic disorder*, which we will describe in more detail in a moment. Some fetishists are driven to steal their desired objects. It is often this theft rather than their actual sexual behaviour that gets them into trouble with the law.

Very little is known about the psychological adjustment of fetishists, but many of those who enter treatment appear in all other aspects to be quite normal. A fetishist who accepts his own feelings, odd though they may seem to others, and who has found ways of meeting his desires in ways that do not harm others and do not interfere with his social functioning, does not seem to pose a problem. And indeed, since he would not meet the criterion of distress, he would not be diagnosed by DSM-5 standards as having a disorder.

We know very little about the origin of fetishes, although many fetishists report that their unusual sexual attraction began in childhood. Massie and Szajnberg (1997), for example, reported a case study of a man who recalled having sexual fetishes at age 5 or 6, and Gosselin and Wilson (1980) reported that, in their sample, sexual fetishes developed between ages 4 and 10.

In considering possible etiological mechanisms, early hypotheses were based on the psychoanalytic perspective but, unfortunately, it is not clear how such theories can be empirically tested (Lowenstein, 2002). More recently, classical conditioning and social learning perspectives were advanced, highlighting the importance of early childhood events and social interaction. However, as Baron and Byrne (1977) pointed out, if it was simply fortuitous associations between sexual arousal and some object, then there should be many fetishists who are attracted to pillows or ceilings

Transvestites like this man are sexually aroused by cross-dressing.

since sexual arousal occurs very frequently at bedtime or upon waking. There are, however, no reports in the literature of such fetishisms. Finally, a number of authors have considered biological factors and their association with fetishism, with most focusing on temporal lobe abnormalities. El-Badri and Robertshaw (1998), for example, conducted a study in which they found that temporal lobe epilepsy or a disturbance in the temporal area was associated with fetishism.

TRANSVESTIC DISORDER A person who cross-dresses—wears the clothing associated with the opposite sex—to produce or enhance sexual excitement is said to be a **transvestite** (or to have transvestism) in the DSM-5. The diagnosis of transvestic disorder applies to individuals whose cross-dressing or thoughts of cross-dressing are always or often accompanied by sexual excitement, and who are emotionally distressed by this pattern, or who feel that it impairs social or interpersonal functioning. Transvestic disorder is rare in males and is extremely rare in females (APA, 2013). Evidence from the first population-based study (Långström & Zucker, 2005) of 2450 randomly selected men and women indicated that 2.8 percent of men and only 0.4 percent of women reported episodes of transvestic fetishism, suggesting that this is primarily a male disorder.

People cross-dress for various reasons. Performers who earn their living impersonating people of the opposite sex are not transvestites unless they are sexually excited by their work, which few seem to be. Men who wear women's clothing to attract other men are better understood as homosexuals who adopt a particular style to make themselves appealing (called "drag queens" in the argot of the street). Most transvestites, on the other hand, are clearly heterosexual. Docter and Prince (1997) conducted a study of 1032 male transvestites and found that 87 percent identified themselves as heterosexual, 83 percent were married or had married at some point during the survey, and 69 percent had fathered children. Similarly, Långström & Zucker (2005), in their large sample, indicated that no man reported a primary same-sex sexual orientation.

In general, most transvestites state that cross-dressing allows them to express themselves, although significant proportions of these men seek therapy or counselling to help them with the effects of cross-dressing—for example, anxiety and depression (Docter & Prince, 1997), which, it should be noted, may not result from transvestism directly but from being social outcasts.

TABLE 13.5 DSM-5 DIAGNOSTIC CRITERIA FOR TRANSVESTIC DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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SEXUAL SADISM AND MASOCHISM AND THEIR ASSOCIATED DISORDERS **Sexual sadism** describes a sexual preference toward inflicting pain or psychological suffering on others and can be considered either a sexual variant (if it involves co-operative, willing partners) or a sexual offence (if it involves unwilling partners). **Sexual masochism**, on the other hand, describes individuals who enjoy experiencing pain or humiliation from another individual. Sexual sadism disorder and sexual masochism disorder are diagnosed when the individual has acted upon 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 (APA, 2013). Sexual masochism can range from harmless behaviour, such as being restrained, to potentially dangerous activity, such as **hypoxyphilia** (also known as **autoerotic asphyxia** or **asphyxiophilia**). This particular behaviour involves the deliberate induction of unconsciousness by oxygen deprivation, chest compression, strangulation, enclosing the head in a plastic bag, or various other techniques. Oxygen deprivation is usually self-induced and follows a ritualistic pattern, terminating just prior to losing consciousness. Unfortunately, when miscalculations occur, they sometimes result in death.

TABLE 13.6 DSM-5 DIAGNOSTIC CRITERIA FOR SEXUAL SADISM DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another 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.

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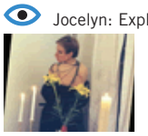
Jocelyn: Exploring Sadism and Masochism



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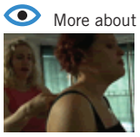

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In North American nosology, sexual sadism and masochism are separate diagnostic entities (Berner, Berger, & Hill, 2003; Kingston & Yates, 2008), whereas the nomenclature used in the rest of the world (i.e., ICD-10; WHO, 1992) advocates a dimensional approach to classification, combining both submissive (masochism) and dominant (sadism) elements within the same classification. As evidenced by these two nosological systems, there is some dissension as to whether these disorders are, in fact, mutually exclusive. In other words, some researchers suggest that sadistic and masochistic partners routinely switch roles (Reinisch & Beasley, 1990), whereas others (e.g., Kingston & Yates, 2008) report that individuals typically adopt one specific role.

In addition to the characteristics of pain and humiliation, several other features have been associated with sadism and masochism, such as fantasy and ritualization (Santtila, Sandnabba, Alison, & Nordling, 2002). Sadistic and masochistic fantasies are common and, in a study conducted at the University of New Brunswick, Renaud and Byers (1999) indicated that 65 percent of students reported fantasies of being tied up, while 62 percent had fantasies of tying up someone else. Participants in sadomasochistic behaviour also often engage in elaborate rituals and use a variety of equipment (e.g., handcuffs, masks). Ritualistic patterns of sexual behaviour involve the assignment of roles to partners and require them to engage in specific sequences of behaviours. Among the variety of role plays enacted, the "master and slave" game, wherein the sadist leads the masochist around by a leash and requires him or her to perform degrading activities, seems to be the most commonly performed (Sandnabba, Santtila, Alison, & Nordling, 2002). For most, sadistic elements are ritualized and symbolic rather than actual painful experiences, and extreme forms of pain and torture are rare. However, some sadists find ritualized sadism with a willing partner to be unsatisfying and seek out nonconsenting partners, thus satisfying the definition of a sexual offence. These sadists will be considered in more detail in the later section dealing with rape.

TABLE 13.7 DSM-5 DIAGNOSTIC CRITERIA FOR SEXUAL MASOCHISM DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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The causes of sadism and masochism are unclear, although several theories have been advanced, including psychodynamic, behavioural, social learning, and physiological perspectives. While some have highlighted the importance of early negative childhood experiences (Blum, 1991), others have suggested that this conclusion is premature (Sandnabba et al., 2002) and needs further investigation. Other evidence has pointed to biological mechanisms and highlights the release of endorphins (which produce feelings of euphoria) in the brain in response to pain. While this area undoubtedly requires further research, it is important to note that many sadists and masochists are generally well-adjusted individuals with otherwise conventional lifestyles.

The DSM-IV-TR lists four specific paraphilic disorders involving sexual desires that, if enacted, constitute a criminal offence. **Exhibitionistic disorder** in the DSM-5 involves exposure of the genitals to an unsuspecting person, **voyeuristic disorder** entails secretly looking at naked people, and **frotteuristic disorder** is touching or rubbing against a nonconsenting person for the purpose of sexual pleasure. **Pedophilic disorder** describes recurrent fantasies or behaviours involving sexual activity with prepubescent children.

EXHIBITIONISTIC DISORDER Exhibitionism is the most frequently occurring sexual offence in Western countries. According to one survey, 33 percent of university women have been the victims of an exhibitionist (Cox, 1988). Yet Byers and colleagues (1997) found that only 6 percent of arrested sex offenders in New Brunswick were exhibitionists. Abel and colleagues (1987) found that exhibitionists committed in excess of 70 000 acts of exposure, for an

TABLE 13.8 DSM-5 DIAGNOSTIC CRITERIA FOR 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.

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TABLE 13.9 DSM-5 DIAGNOSTIC CRITERIA FOR VOYEURISTIC DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, 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.

C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

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average of 514 acts per offender. Furthermore, exhibitionists have the highest rate of reoffending, with up to 57 percent being reported again within four years of being originally convicted (Marshall, Eccles, & Barbaree, 1991). Freund (1990) found that many exhibitionists also peep into windows to watch women undressing or having sex (voyeurism), and as many as 12 percent had also committed rape. Dr. Philip Firestone and his research group at the University of Ottawa (Firestone, Kingston, Wexler, & Bradford, 2006; Rabinowitz Greenberg, Firestone, Bradford, & Greenberg, 2002) have investigated the characteristics of various types of sexual offenders, including exhibitionists. They found that a substantial number of exhibitionists go on to commit more serious "hands-on" sexual offences and that such individuals are at greater risk for committing another offence when compared to other types of sexual offenders. In addition, standardized psychological tests have indicated that these men score in the lowest fifth percentile of general sexual functioning and demonstrate significant levels of deviant sexual arousal, as indicated by phallometric assessments. The DSM-5 specifies exhibitionistic disorder according to preferred developmental stage of the victim: prepubertal children, physically mature individuals, or both (APA, 2013).

5 BEFORE MOVING ON

How many people do you know who have been the victim of exhibitionism, for example? How common do you think this is? For females? For males? What reaction is expected from the victims when the exhibitionist "flashes" that person? What is the best way to respond to this kind of situation?

VOYEURISTIC DISORDER Voyeurs or "Peeping Toms" are individuals who experience recurrent and intense sexually arousing urges/fantasies or behaviours involving the observation of unsuspecting individuals who are naked, disrobing, or engaged in sexual activity (APA, 2013). An essential feature of this disorder is that the person of interest must be unaware that he or she is being watched. Usually, voyeurs do not seek sexual relations with the person being watched and will often masturbate while engaged in the voyeuristic activity or later in response to the memory of what the person has witnessed. The DSM-5 specifies that voyeuristic disorder cannot be diagnosed in individuals under the age of 18, in order to avoid pathologizing normative sexual interest and behaviour during puberty.

The available research on voyeurs is quite limited. Most research has identified that voyeuristic activity occurs prior to age 15 (Abel & Rouleau, 1990; APA, 2000). Moreover, while most voyeurs are not dangerous, some do commit "hands-on" sexual offences and many present with comorbid paraphilic disorders. As examples, Abel and Rouleau (1990) found that 37 percent of their sample of voyeurs (*n* 62) had been involved in sexual assault and more than half in child molestation, whereas Freund (1990; *n* 94) found that 19 percent had engaged in sexual assault.

FROTTEURISTIC DISORDER Almost all detected frotteurs are male. Frotteurism (or *frottage*—from the French *frotter*, "to rub"), according to the DSM-5, refers to touching or rubbing up against a noncompliant person so that the frotteur can become sexually aroused and, in many cases, reach orgasm. These offences typically occur in crowded

TABLE 13.10 DSM-5 DIAGNOSTIC CRITERIA FOR FROTTEURISTIC DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from touching or rubbing against a nonconsenting 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.

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places such as busy sidewalks, stores, or shopping malls, or on packed public transport. The impersonal nature of this type of sexual contact is considered by some authorities (Money, 1987) as essential to the pleasure of the frotteur. Abel and colleagues (1987) found that while some frotteurs keep the contact brief and furtive to make it appear accidental, others seem unconcerned about being detected and are more intrusive and aggressive, fondling the victim's genitals, buttocks, or breasts, or rubbing the penis vigorously against the victim until orgasm occurs. Observations like these encouraged Langevin (1983) to view frotteurism as a form of sexual aggression belonging to the same category as rape. He pointed out that both are aggressive forms of direct sexual touching without the consent of the victim.

PEDOPHILIC DISORDER Pedophilic disorder is evident most often in males and describes individuals who exhibit a predominant sexual interest in, or preference toward, prepubescent children (Freund, 1981; Marshall, 1997). Specifically, this paraphilia is characteristic of recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child (generally aged 13 years or younger). Additionally, either the individual must have acted on these sexual urges or the sexual urges/fantasies have caused marked distress or interpersonal difficulty. Lastly, the individual being assessed is at least 16 years old and at least 5 years older than the victim (APA, 2013).

TABLE 13.11 DSM-5 DIAGNOSTIC CRITERIA FOR PEDOPHILIC DISORDER

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify whether:

Exclusive type (attracted only to children)

Nonexclusive type

Specify if:

Sexually attracted to males

Sexually attracted to females

Sexually attracted to both

Specify if:

Limited to incest

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It is important to note that the terms *pedophile* and *child molester* are often used interchangeably, which creates confusion among professionals who work with these individuals (Barbaree & Seto, 1997; Kingston, Firestone, Moulden, & Bradford, 2007). In the literature on sexual offending, a **child molester** is described as an individual who has engaged in a sexually motivated act against a prepubescent child, without an indication of preference, whereas a **pedophile** is described as an individual who has displayed a preference for sexual behaviour with a child (O'Donohue, Regev, & Hagstrom, 2000). This distinction is important, as not all child molesters are pedophiles, and some pedophiles may not have committed a sexual offence against a child (Konopasky & Konopasky, 2000).

The purpose of diagnosis is to categorize individuals into homogeneous subgroups, which is intended to promote accurate prognosis and effective treatment. However, several problems associated with the diagnosis of pedophilic disorder have been identified, and researchers have questioned the value added by the use of such a label (Marshall, 1997; O'Donohue et al., 2000). For example, specific concerns have included the ambiguous nature of the terms *recurrent* and *intense* within the diagnostic criteria, which possibly contributes to reduced reliability. In fact, one study (Levenson, 2004) evaluated the reliability of various diagnoses in a sample of 295 adult incarcerated sexual offenders, and results indicated that the diagnosis of pedophilia was clearly below acceptable standards (kappa = 0.65). In addition to problems with reliability, the diagnosis of pedophilia, as it was formerly termed, has shown poor criterion-related validity and predictive validity. Kingston and colleagues (2007), for example, found that the construct of pedophilia, according to the DSM, was unrelated to other measures purported to assess the same paraphilia. Finally, in two studies (see Moulden, Firestone, Kingston, & Bradford, 2007, and Wilson, Abracen, Picheca, Malcolm, & Prinzo, 2003), a DSM diagnosis of pedophilia was unrelated to long-term recidivism.

Based on the problems indicated above, some (e.g., Marshall, 2007; Marshall, Marshall, Serran, & Fernandez, 2006) have questioned the value of providing a diagnosis of pedophilic disorder. In fact, research conducted with child molesters irrespective of diagnosis has contributed more to our understanding of these individuals. While the diagnosis of pedophilic disorder is limited, this is not to say that there are not individuals who demonstrate a preference toward children. Clearly, such information is important when implementing effective treatment and case management strategies.

RAPE The term *rape*, in its traditional sense, refers to forced penetration of an unwilling female's vagina by a male assailant's penis. Not only did this definition exclude the rape of males, it placed quite unnecessary emphasis on penile–vaginal intercourse. In terms of legal processes, this requirement of demonstrated forced vaginal intercourse in order to obtain a conviction of rape caused so many

problems that Canadian legislators decided to change the law. Rape, as a criminal offence, and various other sexual crimes were replaced in 1983 in Canadian law by three crimes of *sexual assault*. These three types of sexual assault are defined by varying levels of forcefulness by the offender and incur, upon conviction, increasing lengths of possible sentences. These improvements in the law served to make clear the intrusiveness of these crimes, and to diminish the legal relevance of whether penetration had occurred. This is quite reasonable, since the severity of psychological damage caused by an incident of sexual assault does not depend only on whether the vagina was penetrated, but on many other factors as well. Over and above sexual objectification, many offenders also make a point of degrading and humiliating their victims and may physically hurt them. The current Canadian laws better reflect the reality of sexual assault than did the earlier rape laws.

Because sexual assault laws have not been similarly modified in most jurisdictions of the United States, nor in other countries, most researchers continue to use the terms *rape* and *rapist*. For convenience, we will use these terms, but this should not be taken to imply support for the old laws. The current Canadian laws, we believe, are superior to any in the world in terms of encouraging victims to report and in having the courts focus on the appropriate issues.

Because of these changes, and because there are now restrictions on questioning the victim in court about previous sexual experiences, more victims are coming forward. Nevertheless, sexual assault remains a markedly underreported crime. Koss (1992), from a thorough analysis of survey data, concluded that the real rate of rape was 6 to 10 times as high as the officially recorded statistics. Relying on estimates such as these, Marshall and Barrett (1990) took the official Canadian figures for 1988 and multiplied them by four (a conservative strategy) to estimate the true frequency of rape in Canada. This calculation suggested that more than 75 000 women are raped in Canada every year, at the frightening rate of one every seven minutes. As Figure 13.3 reveals, strangers actually constitute a very small percentage of rapists.

Until quite recently, forcible sex by a spouse was not covered by the sexual assault laws of most countries, and it is still excluded from these laws in many places. In addition to rape being an underreported crime, several studies have investigated the rate at which sexual offenders with adult victims reoffend after serving a period of incarceration (i.e., recidivism). Several studies have demonstrated that after 5 to 10 years in the community, more than 25 percent of rapists will commit another sexual assault, and that this rate is typically higher than what is found among child molesters (Firestone et al., 1998; Harris et al., 2003).

In contrast to pedophilia, there is no formal paraphilic diagnosis to identify men who prefer sexual activity with a nonconsenting partner in the DSM-5. As such, clinicians required to diagnose these individuals often used the diagnosis of other specified paraphilic disorder and listed the descriptor of rape to explicate the type of mental disorder

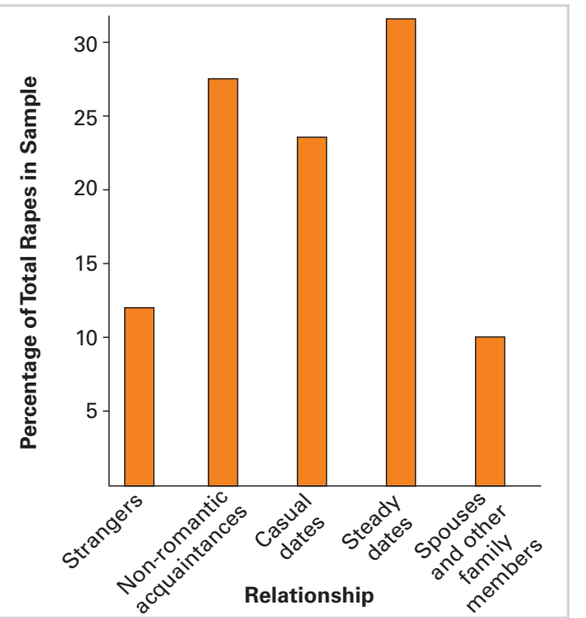

FIGURE 13.3 Relationships of Rapists to Their Victims

Source: Adapted from Koss (1988).

Note: These data are drawn from a large-scale survey of women attending colleges in the United States.

(Doren, 2002). Obviously, this omission was unfortunate, as it was not very useful in defining relevant treatment needs (Marshall, 2007).

In addition to other specified paraphilic disorder, some evaluators have diagnosed rapists as sexual sadists. In an interesting analysis of a 27-year-old man serving a 7-year sentence for rape in a Canadian penitentiary, Barbaree (1990) found that the man showed greater sexual arousal to both rape and non-sexual assault on a woman than he did to consenting sex. This pattern is just what we would expect of a sadistic rapist, and the details of this man's offence revealed that it was particularly vicious. Furthermore, he described himself as having enjoyed hurting his victim.

Although cases like the one described by Barbaree (1990) are clear-cut examples of sexual sadism, the number of rapists who meet the criteria for a diagnosis of sadism, as it was previously called, is likely to be small (Kingston & Yates, 2008) and several problems with the diagnosis have been noted (Marshall, 2007).

For example, in a review of the literature, Marshall and Kennedy (2001) found substantial differences across studies in how they defined the diagnosis, such that some research centres defined sadists in terms of their desire to exercise control over their victims, while others considered violence to be the crucial feature, and yet others considered humiliation of the victim to be the primary factor. Unfortunately, these criteria did not exhaust the various definitions that Marshall and Kennedy identified. Even more problematic is the fact that all rapists display these features to some degree. Rape is, by definition, an exercise in control and

involves some degree of violence. Also, Darke (1990) found that more than 60 percent of rapists reported deliberately humiliating their victims. In fact, in one study, Marshall, Kennedy, and Yates (2002) found that they could not distinguish rapists diagnosed as sadists from those who were said not to be sadists on any of the above features nor on any other feature. Furthermore, internationally renowned experts could not agree on the diagnosis of sexual sadism applied to 12 quite violent and brutal rapists (Marshall, Kennedy, Yates, & Serran, 2002).

The primary problem facing diagnosticians in deciding whether a rapist meets the criteria for sexual sadism is that the diagnosis must be based on the offender being sexually aroused by the idea of physically or psychologically hurting another person. Unless the offender tells the diagnostician that he is aroused by these characteristics (or any other feature), there is little alternative for the clinician except to guess what arouses the offender. Phallometric assessment could answer this question, but to date no one has demonstrated that phallometric testing can identify sadists, although some researchers have tried (Seto & Kuban, 1996). These problems with the diagnosis of sexual sadism are also true for other paraphilias (Marshall, 1997). This, in part, has led many clinicians and researchers working with sexual offenders to eschew diagnoses and to simply describe their clients in terms of their offending behaviours—for example, calling them child molesters rather than pedophiles, and dangerous or violent rapists rather than sadists.

While most rapists do not exhibit a sexual preference toward nonconsenting sexual activity, clearly some do. An interesting hypothesis has been proposed, which differentiates among three distinct sexual arousal patterns seen in rapists (Lalumière, Quinsey, Harris, Rice, & Trautrimas, 2003). The three profiles include **biastophilia**, a sexual preference toward nonconsenting and resisting but not necessarily physically suffering victims; *sadism*, a preference toward the suffering or humiliation of others; and *antisociality*, a marked sexual indifference to the interests and desires of others. Studies reporting on sexual preferences have indicated some support for the above categories (Lalumière et al., 2003).

6 BEFORE MOVING ON

Consider the following legal definition of rape in Canada that was in effect prior to 1983: forced heterosexual intercourse of a woman by a man outside of marriage. In addition, a victim's prior sexual experience could be considered as evidence of her consent. What implications did this definition have for married versus single women, for female versus male victims, and for women with prior sexual experience?

UNUSUAL SEXUAL VARIANTS New Zealand–born psychologist John Money (1984) claims that there are many more paraphilias than are listed in the diagnostic manual. He suggests that there are at least 30 or more different types, although DSM-5 has a category that would accommodate these, if they cause distress or harm to others, called Other Specified Paraphilic Disorder. Sexual satisfaction derived from receiving enemas (klismaphilia), as well as urination (urophilia) or defecation (coprophilia), occurs frequently enough that pornographers cater to such interests. Some less frequent paraphilias, however, involve activities that break the law, such as sex with corpses (necrophilia) or with animals (zoophilia or bestiality), or that take the form of obscene telephone calls (scatologia). All of these unusual sexual variants, although occasionally described in the literature, are far too infrequently seen at clinics to permit adequate descriptive research.

ETIOLOGY OF SEXUAL OFFENDING Over the years, many theorists have speculated about the origins of sexual offending. Behaviourists have tended to view such offending as being sexually motivated, and consequently they have offered explanations that focus on the misdirection of sexual desires. As we saw with fetishes, the most frequently cited of these explanations is the claim that accidental sexual experiences result in classical conditioning processes making deviant sexual practices attractive.

Conditioning Theories. McGuire, Carlisle, and Young (1965) were the first to propose that conditioning was the basis of acquired preferences motivating men to engage in unusual or offensive sexual behaviours. A young male, for example, might be caught in the act of masturbating by an attractive woman, and this association between high sexual arousal and a woman seeing his exposed penis might, according to this conditioning account, serve to entrench an attraction to (or preference for) exposing his penis to women. Similar accidental associations between sexual arousal and seeing younger children were said to be the conditioning bases of future child molestation, while masturbating to pornographic images of, or to thoughts of, sexually assaulting a woman were said to instill a preference for rape.

A similar theory, which assumes that sexual offenders are aroused by their deviant acts, was advanced by Kurt Freund, who began his outstanding career in his native Czechoslovakia but lived and worked in Toronto from the 1960s until he died in 1996. Freund outlined what he called a **courtship disorder theory** of sexual offending. Freund (1990) suggests, by analogy with animal courtship behaviour, that there are four phases in human sexual interactions: (1) looking for and appraising a potential partner, (2) posturing and displaying oneself to the partner, (3) tactile interaction with the partner, and (4) sexual intercourse. Freund's notion of courtship disorder suggests that fixation at any one of these stages produces sexual offending. Fixation at stage 1 would result in voyeurism; at stage 2 in exhibitionism; at stage 3 in frotteurism; and at stage 4 in rape.

These theories have some intuitive appeal as long as we accept that these offensive behaviours are sexually

motivated. However, not everybody accepts that sexual crimes are driven exclusively by sexual desires. Indeed, Marshall and Eccles (1993), in their review of the relevant literature on animal and human sexual behaviour, found little supporting evidence for conditioning theories.

Feminist Theories. Feminist theories of sexual offending are quite diverse, but they do have common threads. Most feminists vigorously hold men to be personally, as well as collectively, responsible for sexual assault. Feminist theorists typically see sexual abuse as arising naturally out of the socio-cultural environment of our societies, which they see as essentially patriarchal (Brownmiller, 1975; Clark & Lewis, 1977). In this context, these theorists point to the differential ways in which parents and other influential people (e.g., peers, teachers) respond to boys and girls. According to this analysis, girls are encouraged to be submissive, co-operative, nurturing, and emotional, whereas boys are encouraged to be dominant and competitive and are discouraged from displaying any emotions (other than perhaps anger). Feminists see this difference as setting up women and children to be dominated by, and to be subservient to, adult males. Such a power differential provides few constraints on men's behaviour toward women and children, which may facilitate sexual abuse.

Feminist theorists typically see rape as a non-sexual, or pseudo-sexual, offence. They emphasize instead offenders' apparent anger toward women, as seen in their efforts to humiliate the victims and to exercise power and control. Canadian psychologist Juliet Darke (1990) examined both what rapists said about their own motives and victims' perceptions. Both sources revealed that more than 60 percent of rapes involved some form of intentional humiliation of the victims. Consistent with feminist analyses, Seidman and colleagues (1994) found that rapists attending community clinics were angrier toward women than were matched, non-offending males.

Consistent with the idea that patriarchal structures encourage rape, Sanday (1981), in her examination of data from 156 tribal societies, found higher rates of rape in societies characterized by patriarchal systems. In these rape-prone societies, women were seen as the property of men and were excluded from all positions of power and influence. These societies, where violence was endemic, had far higher rates of sexual assault than did societies where both sexes were treated more equally. Rape was less common in societies in which women were respected and had an equal say in religious, political, and economic matters.

In terms of men's likelihood to rape, there is a fairly extensive body of literature indicating that approximately 30 percent (and even higher in some studies) of non-offending males acknowledge that they would rape a woman if they knew they could get away with it (Malamuth, 1986; Malamuth, Heavey, & Linz, 1993). These figures, taken at face value, are quite startling and appear to strongly support feminist claims. However, it is difficult to determine how to rate a response that amounts to a guess about what the respondent might do in a purely hypothetical situation.

Despite some problems with the evidence taken to support feminist views of sexual assault, the analyses offered by feminists have radically changed and expanded our understanding of these crimes. They have made it clear that these are primarily crimes committed by men (which needs explaining in any theory of sexual assault) and that there are clear socio-cultural bases to sexual offending. Most importantly, lobbying by feminists has changed the way we deal with sexual abuse as a society. The investigation and prosecution processes have been made far easier on victims than they were just a few years ago, and the offenders who are identified are more likely to be convicted and jailed than excused and let go, as so many were in the past.

Comprehensive Theories. Marshall and his colleagues (Marshall & Barbaree, 1990; Marshall, Hudson, & Hodkinson, 1993; Marshall & Marshall, 2000) have integrated a broad range of evidence to suggest that the childhoods of sexual offenders create a predisposition for aggression and a social inadequacy that makes them readily attracted to deviant sexual behaviours. These deviant acts, unlike prosocial sexual behaviours, require little social skill, have no built-in obligations to others, and do not require the offender to be concerned about the other person's needs or rights. Deviant sexual acts, then, might appeal to males who are lacking in social skills and who are self-centred. Also, sexual offences provide the opportunity to exercise power and control over others, and this is particularly satisfying to powerless males who lack self-confidence.

As we have seen, sexual offenders do typically have disrupted childhoods, and there is clear evidence that such experiences leave a child feeling unlovable, lacking in self-confidence, with poor social skills, and with a propensity for antisocial behaviour (Loeber, 1990). In this theory, however, it is not just poor parenting that produces sexual offending.

Socio-cultural factors, accidental opportunities, and transitory states all contribute to the complex array of influences that set the stage for sexual offending. Sanday's (1981) research revealed that those societies with high rates of sexual assaults were characterized by an acceptance of violence and by male dominance over women and children. Violence is all too frequently presented by the media in our society as an acceptable way to solve problems (Cantor, 2000), and men are still portrayed in many popular sitcoms as the dominant figures. A vulnerable young male would be expected to find these images of males (as dominant and violent) attractive, and he might subsequently look for ways to act as powerfully as the men in the stories. Sexually assaulting a woman or a child certainly puts the offender in a position of power over the victim and allows the offender to control what happens—and, of course, it produces the added satisfaction of sexual gratification.

Transitory states such as anger, depression, intoxication, and boredom have been found to immediately precede sexual offending (Pithers, Beal, Armstrong, &

Petty, 1989), but Marshall's theory suggests that it is only vulnerable males who will respond in abusive ways to such circumstances. Even under these conditions, a vulnerable male cannot offend unless he has an opportunity, or creates one.

The implications of Marshall's account that have been examined have generally been confirmed. In addition, the general theory has led to more precise sub-theories, including the role of self-esteem (Marshall, Anderson, & Champagne, 1997), empathy (Marshall, Hudson, Jones, & Fernandez, 1995), and relationship functioning (Ward, Hudson, Marshall, & Siegert, 1995).

There are other comprehensive accounts of sexual offending (e.g., Finkelhor, 1984; Hall & Hirschman, 1991; see Ward, Polaschek, & Beech, 2006, for summaries) that have the same advantages as Marshall's theory—that is, they integrated a breadth of currently available knowledge, have generated clearly testable implications, and have contributed to the development of effective treatment programs. Most recently, Ward and Beech (2006) have developed an integrated theory of sexual offending, which possesses many of the strengths of other sexual offending theories (e.g., Marshall's theory) and accounts for some of their weaknesses. The theory is extremely broad and complex and accounts for the dynamic interaction among neuropsychological systems as well as ecological factors to explain both the onset and the maintenance of sexual offending. Further investigation is necessary to determine the utility of this theory to the understanding of sexual offenders and the development of effective treatment programs.

TREATMENT OF SEXUAL OFFENDERS Prior to the 1970s, most treatment programs for sexual offenders were derived from some form of psychoanalytic theory. However, the programs were not very effective (Furby, Weinrott, & Blackshaw, 1989), so clinicians turned to other models for direction.

Medical Interventions. The early medical treatment of sexual offenders involved surgical castration, whereas more recent methods consisted of either pharmacological treatments designed to reduce levels of testosterone or various antidepressant medications, particularly selective serotonin reuptake inhibitors (SSRIs). The aim of most of these treatment approaches was either to eliminate or to reduce sexual drive so that the person will be uninterested in sex or will easily be able to control the expression of his or her deviant interests.

The first, and most extensively employed, procedure used to achieve this goal of reduced sexual drive was physical castration. Physical castration refers to the surgical removal of the testicles, thereby essentially eliminating the body's production of testosterone, the sex steroid that primarily activates sexual drive. Some 3600 male sexual offenders were castrated in Germany during the period 1934–1977 (Heim & Hursch, 1979), and similar numbers were castrated in various other European countries as well as in North America. Efficacy studies, despite some methodological problems, have demonstrated that castration was associated with lower recidivism rates in offenders (Bradford, 2001). However, given the irreversible nature of this approach and the significant side effects, there is considerable controversy surrounding this procedure (it is not permitted in Canada except to save a person's life when it is endangered by disease).

Chemical castration (i.e., the reduction in testosterone resulting from the action of pharmacological treatment) has not drawn the same ethical criticisms, presumably because the changes it produces are reversible when the drug is withdrawn. The principal androgen related to sexual development and activity is testosterone, and its relationship to sexual aggression is well established (Bradford, 2000). The primary anti-androgens are Cyproterone Acetate (CPA) and Medroxyprogesterone Acetate (MPA). CPA can be used as a chemical castration agent or, at lower doses, to reduce deviant sexual fantasies (Rösler & Witztum, 2000). CPA and MPA have been shown to reduce sexual interest, fantasies, and behaviours in sexual offenders (Rösler & Witztum, 2000). Of note, the side effects of both medications are considerable and include diabetes mellitus, dyskinetic and feminization effects, and increased blood pressure. In terms of outcome, given that anti-androgens are typically administered in conjunction with psychological treatment, it is difficult to determine whether the drug, psychotherapy, or the synergistic effects of both have contributed positively to the decreased recidivism rates among treated offenders.

Alternatives to anti-androgens have been proposed, including SSRIs and luteinizing hormone-releasing hormone agonists (LHRH agonists). SSRIs, originally used to treat depression and obsessive-compulsive disorders, appear to give sexual offenders a sense of control over their deviant urges that they did not previously have, although most data have come from clinical case reports (e.g., Fedoroff, 1993). LHRH agonists have also demonstrated an ability to reduce or alleviate sexual fantasy, urges, and behaviours (Briken, Nika, & Berner, 2001; Rösler & Witztum, 1998) without causing significant side effects.

The evidence appears to demonstrate a valuable role for medications in the treatment of sexual offenders. However, as noted, these have typically been administered while the offender was involved in psychological treatment and, as we will see, psychological interventions have been effective with sexual offenders. It is therefore somewhat difficult at present to identify the contribution of medications to the effectiveness of treatment with these offenders.

Behaviour Therapy. In the late 1960s, behaviour therapists were just beginning to extend their treatment theories to sexual offenders. Bond and Evans (1967), for example, developed a simple approach to treatment based on the assumption that these offensive behaviours were driven by deviant sexual preferences. They thought that all that was necessary in treatment was to eliminate these deviant

preferences (e.g., a sexual attraction to children, or to forced sex, or to exposing oneself) and the offending behaviour would disappear. Typically, sexual preferences in these early studies were modified by associating the deviant thoughts with a strongly aversive event, such as an electric shock to the calf muscles. Rice, Quinsey, and Harris (1991) examined this treatment program, offered at the Oak Ridge Mental Health Centre in Ontario during the 1970s and early 1980s, and found that it was ineffective.

Comprehensive Programs. As a result of the lack of benefits from these early behavioural interventions, more comprehensive approaches began to emerge based primarily on a cognitive-behavioural perspective. American psychiatrist Gene Abel and his colleagues (Abel, Blanchard, & Becker, 1978) were among the first to develop such programs, and similar programs have been developed in Canada (Lang, Pugh, & Langevin, 1988; Marshall, Earls, Segal, & Darke, 1983; Yates et al., 2000).

These comprehensive programs typically address sexual offenders' tendency to deny or minimize their offending. They work to improve self-esteem and social and relationship skills, to enhance empathy, and to alter offence-supportive attitudes and deviant sexual preferences. Various other offence-related problems are also addressed, such as substance abuse, anger, and an inability to handle stress. Sexual offenders are trained to identify factors that might increase their risk of reoffending, and they are taught ways to deal with these problems should they arise. In addition to the above, current programs (e.g., Marshall, Marshall, Serran, & Fernandez, 2006; Yates et al., 2000) emphasize the role of positive psychology in the treatment of sexual offenders, which takes into account the offenders' strengths and helps them to construct a meaningful and prosocial life.

Benefits of Treatment. To evaluate the effects of treatment, it is necessary to follow treated offenders for several years after their discharge from treatment or release from prison, and to compare their reoffence rates with a matched group of untreated offenders. The ideal treatment outcome design would require the random allocation of those who volunteered for treatment—to either treatment or no treatment (Quinsey, Harris, Rice, & Lalumière, 1993)—but unfortunately this ideal study cannot easily be implemented for a variety of ethical reasons. As such, treatment evaluators have adopted alternative strategies, such as incidental matching procedures, where treated participants are matched with untreated sexual offenders on demographic features and offence characteristics.

Two large-scale meta-analyses have evaluated the extent to which sexual offender treatment is associated with lowered recidivism rates. First, Hanson and colleagues (2002) reviewed the sexual offender treatment outcome literature and found 42 studies, with a total of 9316 participants. Results indicated that treatment was associated with reductions in both sexual and general recidivism (i.e., the percentage who reoffended). These beneficial effects were found to be greatest among those programs that employed the broad cognitive-behavioural approach described in the previous subsection. Furthermore, these benefits were evident whether the program was based in the community or in an institutional setting. Second, Lösel and Schmucker (2005) have provided the largest and most recent meta-analyses of sexual offender treatment outcome. Specifically, this review included published and unpublished studies that were reported in a variety of languages. The final review consisted of 80 comparisons derived from 69 studies (*n* 22 181). With regard to sexual, violent, and criminal recidivism, the treatment group displayed reductions of 37, 44, and 31 percent, respectively, compared to the base rates of the control groups. As such, the results indicated a positive treatment effect for all types of recidivism.

TABLE 13.12 REOFFENCE RATES FROM CURRENT COGNITIVE-BEHAVIOURAL TREATMENT PROGRAMS

	Treated	Untreated
Sexual recidivism	9.9%	17.3%
General recidivism	32.3%	51.3%

Source: Adapted from Hanson, R. K., Gordon, A., Harris, A. J., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. (2002). "First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders," *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169–194. Reprinted by permission of Kluwer Academic/Plenum Publishers.

Table 13.12 summarizes the data generated by Hanson's analyses. Clearly, treatment can be effective, but this is not to say that all treatment programs reduce sexual offender recidivism. In Hanson and colleagues' study, those programs based on approaches other than cognitive-behavioural ones were ineffective, although Hanson did not evaluate any medically based treatments.

Two other ways to look at the benefits of treatment for sexual offenders is to consider the reduction in the number of innocent victims harmed by these offenders and the financial savings associated with treatment benefits. In a study of the effects of their community-based program, Marshall and Barbaree (1988) found that each recidivist sexually abused at least two further victims. Marshall and Barbaree's results indicated that 13 percent of the treated offenders reoffended, compared to 34 percent of the untreated offenders. This is a difference of 21 percent, which, given that the recidivists abused at least two victims each, means that for every 100 treated offenders more than 42 innocent people were saved from suffering. In addition, Marshall (1992) calculated the costs incurred by police investigations, the prosecution of an offender, and his imprisonment. He found that it costs taxpayers $200 000 to convict and imprison each sexual reoffender. Table 13.13 presents a calculation of the estimated financial benefits of treating sexual offenders by subtracting the costs of treating 100 offenders from the savings resulting from the reductions in recidivism produced by treatment. Obviously, treating sexual offenders can be effective and, when it is, fewer victims suffer and taxpayers are saved considerable money.

TABLE 13.13 COST-BENEFIT ANALYSIS OF TREATING SEXUAL OFFENDERS

		Rate of Reoffence		
		Treated	**Untreated**	**Reduction in Reoffenders**
Prison program		24%	52%	28%
Reduction in number of victims per 100 offenders treated (i.e., 28 x 2 victims per reoffender)	=	56		
Cost per reoffender (to convict and imprison)	=	$ 200 000		
Cost to prison service to treat and supervise 100 offenders	=	$1 000 000		
Savings per 100 offenders treated:				
Savings (28 x $200 000)	=	$5 600 000		
Less costs	=	$1 000 000		
TOTAL SAVINGS	**=**	**$ 4 600 000**		

Source: Reoffence data are from Hanson and colleagues (2002) and cost-benefit analysis is derived from Marshall (1992). Adapted from Kluwer Academic Publishers, *Sexual Abuse: A Journal of Research and Treatment*, *14*(2), 2002, 169–194, "The 2000 ATSA report on the effectiveness of treatment for sex offenders" by Hanson et al.

CANADIAN RESEARCH CENTRE

Dr. Elke Reissing, Human Sexuality Research Laboratory

Dr. Elke Reissing is an associate professor at the University of Ottawa and the assistant director of the School of Psychology. She is the director of the Human Sexuality Research Laboratory (HSRL) and supervisor for sex therapy at the Centre for Psychological Services and Research (CPSR).

Originally, Dr. Reissing came to Canada from Germany to complete one year of undergraduate studies at Concordia University in Montreal, but she stayed for her Ph.D. studies at McGill University and accepted a faculty position at the University of Ottawa. At McGill, she worked with Irv Binik and a close cohort of graduate students, which included Marta Meana, Sophie Bergeron, and Caroline Pukall—all groundbreakers in the study of sexuality who inspired her work with sexual pain disorders in general and vaginismus in particular.

Dr. Reissing joined the University of Ottawa for a pre-doctoral, clinical internship at the Centre for Psychological Services in 2001 and as faculty the following year. She developed the HSRL, which is home to clinical and experimental graduate students in sexuality and various research collaborators. Current research programs in the lab include two applied areas—vaginismus, and sexuality and aging—and two experimental/sexological research areas—uncommitted sexual relationships and bisexuality. Dr. Reissing also treats sexual pain disorders and other sexual dysfunctions. She has a small private practice but works with more clients through her supervision of sex therapy training at the CPSR. Services there are provided by senior Ph.D. students in clinical psychology who are supervised session-by-session by Dr. Reissing. Sex therapy is based on the scientist-practitioner model and, because the clinic is a training site, it is one of the few places that offer sex therapy at greatly reduced fees. Dr. Reissing has also served on the executive committee of the Canadian Sex Research Forum and on the editorial boards of journals covering first-rate research topics related to sexuality and psychology.

Dr. Reissing's main research interest lies in the examination of women who have such severe difficulties with vaginal penetration that they cannot experience intercourse, use tampons, or have a gynecological examination. This may be due to pain with attempted penetration or fear of possible pain. Difficulties may also be due to fear and/or disgust related to vaginal penetration. All women seem to share one aspect: a very tense pelvic floor that makes penetration attempts painful and ultimately impossible. In the past, the diagnosis of vaginismus focused solely on pelvic floor pathology, but increasingly, psychological factors are being taken into account. This is not to pathologize women but rather to understand the scope of the problem and the severity of their suffering, and to come up with more effective treatment solutions. Dr. Reissing's current projects focus on examining the necessary and sufficient elements of psychological interventions (e.g., components of sex therapy and cognitive-behavioural treatment) for problem-focused and successful—yet short-term—treatment of women with vaginismus. The goal is to combine these with physiological treatment approaches, in particular pelvic floor physiotherapy, in order to provide a multidisciplinary, multimodal treatment package for women with vaginismus.

SUMMARY

- Masters and Johnson developed the sexual response cycle based on their research examining the physiological correlates of human sexual response.
- During the excitement stage, the genital tissues of both males and females swell as they fill with blood, causing penile erection and vaginal lubrication, among other changes.
- The plateau stage involves additional swelling of the penis, vaginal tissues, and other areas as the body gets ready for orgasm.
- During orgasm, both sexes experience rhythmic, muscular contractions of the pelvic and genital areas, and males ejaculate.
- Following orgasm, the body returns to its pre-aroused state during the resolution stage. Males experience a refractory period, although women have the capacity to be multiply orgasmic.
- Several sexual dysfunctions are listed in the DSM that can affect men and women in the following areas: desire, arousal, orgasm, and pain.
- Lifelong sexual dysfunctions have always been experienced by the individual, and acquired sexual dysfunctions are those that are of recent onset.
- If sexual dysfunctions are apparent in all sexual situations, they are categorized as generalized, whereas when the problems are apparent in only one situation, they are known as situational.
- Sensate focus is a form of desensitization applied to sexual fears and anxiety.
- Gender can differ on many dimensions, including the following: chromosomal gender, gonadal gender, prenatal hormonal gender, internal accessory organs, external genital appearance, assigned gender, gender identity, and gender role.
- There are several paraphilic disorders that involve nonconsenting persons. Exhibitionistic disorder involves exposure of the genitals to an unsuspecting stranger, voyeuristic disorder entails secretly looking at naked people, and frotteuristic disorder is touching or rubbing against a nonconsenting person for the purpose of sexual pleasure.
- The DSM-5 does not include a formal paraphilic diagnosis to identify men who prefer sexual activity with a nonconsenting partner.
- To diagnose these individuals, clinicians often used the diagnosis of other specified paraphilic disorder and listed the descriptor of rape to explicate the type of mental disorder.

KEY TERMS

egodystonic homosexuality (p. 327)
sexual response cycle (p. 328)
lifelong sexual dysfunction (p. 332)
acquired sexual dysfunction (p. 332)
generalized sexual dysfunctions (p. 332)
situational sexual dysfunctions (p. 332)
male hypoactive sexual desire disorder (p. 332)
female sexual interest/arousal disorder (p. 332)
female orgasmic disorder (p. 333)
delayed ejaculation (p. 333)
premature (early) ejaculation (p. 333)
dyspareunia (p. 334)
vaginismus (p. 334)
genito-pelvic pain/penetration disorder (p. 334)
hypersexuality (p. 334)
estrogen (p. 335)
testosterone (p. 335)
prolactin (p. 335)
performance anxiety (p. 335)
male erectile disorder (p. 336)
sensate focus (p. 337)
intracavernous treatment (p. 338)
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pedophilic disorder (p. 346)
child molester (p. 348)
pedophile (p. 348)
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courtship disorder theory (p. 350)