CHAPTER 12: Sexual Variants, Abuse, and Dysfunctions

Chapter Overview/Summary

Defining boundaries between normality and psychopathology in the area of variant sexuality is very difficult, in part because sociocultural influences on what have been viewed as normal or aberrant sexual practices abound. Degeneracy theory and abstinence theory were very influential for long periods of time in the United States and many other Western cultures, and led to very conservative views on heterosexual sexuality. In contrast to Western culture, in the Sambia tribe in Melanesia, homosexuality is practiced by all adolescent males in the context of male sexual initiation rites; they later transition to heterosexuality in young adulthood. Until rather recently, in many Western cultures homosexuality was viewed as either criminal behavior or as a form of mental illness. However, since 1974, homosexuality has been considered by mental health professionals to be a normal sexual variant.

Sexual deviations in the form of **paraphilias** involve persistent and recurrent patterns of sexual behavior and arousal, lasting at least six months, in which unusual objects, rituals, or situations are required for full sexual satisfaction. They almost always occur in males. The paraphilia disorders include (1) fetishistic disorder, (2) transvestic **disorder**, (3) voyeuristic disorder, (4) exhibitionistic disorder, (5) sexual sadism disorder, (6) sexual masochism disorder, (7) pedophilic disorder, and (8) frotteuristic disorder.

Gender dysphoria occurs in children and adults.. Most boys who have this disorder grow up to have a homosexual orientation; a few become transsexuals. Prospective studies of girls who have this disorder suggest that perhaps half of women develop a homosexual orientation and the other half may desire sex reassignment surgery.

Transsexualism is a very rare disorder in which the person believes that he or she is trapped in the body of the wrong sex. It is now recognized that there are two distinct types of transsexuals: homosexual transsexuals and autogynephilic transsexuals, each with different characteristics and developmental antecedents. The only known effective treatment for transsexuals is a sex-change operation. Although its use remains highly controversial, it does appear to have fairly high success rates when the people are carefully diagnosed and participate in a lengthy readjustment program

There are three overlapping categories of sexual abuse: pedophilia, **incest**, and **rape**. All three kinds of abuse occur at alarming rates today. Controversies about the accuracy of children's testimony, and about the accuracy of recovered memories of sexual abuse that may often occur in psychotherapy, have recently arisen.

Traditionally, sexual abuse has been seen as leading to both serious short-term and long-term consequences for its victims. Recent reassessments of the literature have revealed that the results of sexual abuse vary from person to person with some individuals showing little to no negative long-term consequences. What leads people to engage in sexual abuse is poorly understood at this time. Treatment of sex offenders has not as yet proved highly effective in most cases, although promising research in this area is being conducted.

Sexual dysfunction involves impairment in the desire for sexual gratification or in the ability to achieve it, and can occur in the first three of the four phases of the human sexual response, which are the **desire phase**, the **excitement phase**, the **orgasm** phase, and the **resolution** phase.

Sexual dysfunctions in men include **delayed ejaculation**, **erectile disorder**, **premature (early) ejaculation**, and **male hypoactive sexual desire disorder**. Sexual dysfunctions in women include **female orgasmic disorder, female sexual interest/arousal disorder**, and **genito-pelvic pain/penetration disorder**. In the past 35 years, remarkable progress has been made in the treatment of sexual dysfunctions.

Detailed Outline

I. Sociocultural Influences on Sexual Practices and Standards

1. Males place a great emphasis on a partner's attractiveness.
2. Less than 100 years ago sexual modesty where women's arms and legs were covered.
3. Jeffrey Dahmer was sexually aroused by killing men, having sex with them, storing their corpses, and sometimes eating them.
4. Degeneracy theory, which led to being conservative about sexual practices.

A. Case 1: Degeneracy and Abstinence Theory

1. Early formation of degeneracy theory by Simon Tissot, a Swiss physician (1750s).
   a. Central belief was that semen is necessary for physical and sexual vigor in men and for masculine characteristics such as beard growth.

b. Based on observations of eunuchs and castrated animals.
c. Asserted that masturbation and patronizing prostitutes was harmful as they wasted the vital fluid (semen).

2. Sylvester Graham and abstinence theory (1830s)
   a. Three cornerstones were healthy food, physical fitness, and sexual abstinence.
   b. Kellogg—described 39 signs of the "secret vice" (masturbation) and provided treatments including sewing the foreskin with a silver wire, circumcision, burning the clitoris with carbolic acid, etc.
   c. Kellogg believed meat increased sexual desire and invented Kellogg's cornflakes as an anti-masturbation food.
3. *Onania, or the Heinous Sin of Self-Pollution*—asserted that masturbation was the cause of insanity.
4. In 1972, the American Medical Association declared that masturbation was normal for adolescents and required no medical care.

B. Case 2: Ritualized Homosexuality in Melanesia

1. Semen conservation.
2. A group of islands in the South Pacific that has been studied have discovered that sexual practices for 10%–20% of Melanesian societies practice homosexuality within the context of rituals.
3. Female pollution—female body is unhealthy to males, primarily because of menstrual fluids.
4. To obtain or maintain adequate amounts of semen, young males practice semen exchange through fellatio in order to ingest sperm or by inseminating younger boys.
5. Then a gradual change occurs in adulthood, when most interactions are with women; upon the birth of the first child, with females exclusively.

C. Case 3: Homosexuality and American Psychiatry

1. Homosexuality as a sickness.
   a. 2003 U.S. Supreme Court struck down Texas state law banning sexual behavior between two people of the same sex.
   b. In 1973 homosexuality was officially removed as a psychiatric disorder from the DSM (e.g., articles such as: "Effeminate homosexuality: A disease of childhood.")
   c. During the sixteenth century King Henry VIII of England declared anal sex as a felony punishable by death.
   d. Ellis and Hirschfield—homosexuality is natural and consistent with psychological normality.
   e. Rado—homosexuality develops in those whose heterosexual desires were too psychologically threatening; blamed domineering, emotionally smothering mothers and detached, hostile fathers.
2. Homosexuality as a nonpathological variation.
   a. Kinsey—homosexuality more common than previously thought.
   b. Around 1950 the view of homosexuality as a sickness began to be challenged by scientists and homosexual individuals.
   c. 1960s—gay liberation movement.
   d. Openly gay psychiatrists and psychologists worked within field to have homosexuality removed from the DSM.
   e. Removed from the DSM by a vote of 5854 to 3810; decision seen as embarrassing as it reflects that mental health is simply a reflection of the values of mental health professionals.

II. Gender Dysphoria

A. The Paraphilias

1. Fetishistic disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving the use of an inanimate object for sexual gratification.
b. Female cases are rare.
c. These patterns must last at least 6 months.

d. *DSM-5* recognizes the following paraphilia disorders: fetishistic disorder, transvestic disorder, voyeuristic disorder, exhibitionistic disorder, sexual sadism disorder, sexual masochism disorder, pedophilic disorder, and frotteuristic disorder.
e. Men have an erotic preoccupation with nonsexual body parts like feet, hair, ears, and hands.
f. Masturbation often accompanies the fetishistic behavior.
g. Obtaining the inanimate object may lead to criminal acts.
h. Classical conditioning and social learning can be involved in its development

2. Transvestic disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving cross-dressing for sexual gratification.
b. Onset occurs in adolescence and includes masturbation while wearing female clothing.
c. **Autogynephilia**—paraphilic sexual arousal by the thought or fantasy of being a woman. Predicts **gender dysphoria** and desire for sex reassignment surgery.
d. Hirschfeld—identified cross-dressing men who are sexually aroused by seeing themselves as a woman.
e. Most common in men.

3. Voyeuristic disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving observation of unsuspecting persons who are undressing, or of couples engaged in sexual activity.
b. Known as "Peeping Toms."
c. Primarily seen in young men.
d. Curiosity is satisfied in shy and inhibited youngsters through this behavior.
e. Voyeurism meets individual's needs while avoiding possible rejection
f. A sense of power maintains the behavior.
g. Permissive pornography laws may provide alternatives for the voyeur.

4. Exhibitionistic disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving exposure of genitals for sexual gratification.
b. The exposure may occur in a secluded place like a park, church, department store, or bus.
c. Typically begins in adolescence or young adulthood.
d. The most common sexual offense reported by the police in the U.S., Canada, and Europe.
e. Exposure is consistent in type of situation and victim.
f. Usually begins in adolescence or young adulthood.
g. A subtype with antisocial characteristics may be present.
h. Considered a criminal offense.

5. Frotteuristic disorder

a. A Sexual excitement at rubbing one's genitals against, or touching, the body of a non-consenting person.
b. Reflects inappropriate and persistent interest in something that many people enjoy consensually.
c. Co-occurs with voyeurism and exhibitionism.
d. Being the victim is common on crowded buses or subway trains.
e. Willingness to touch others sexually without consent means that they are at risk for more serious offending.

6. Sexual sadism disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving inflicting psychological or physical pain on another individual for sexual gratification.
b. "Bondage and discipline" is a closely related pattern.

c. Named after Marquis de Sade (1740–1814) who liked to inflict pain on his victims for sexual purposes.
d. Themes of dominance, control, and humiliation.
e. Sexual gratification can come from the sadistic practice alone.
f. Occurs mainly in heterosexual men.
g. Serial killers tend to be sexual sadists such as Ted Bundy, Jeffrey Dahmer, and Dennis Rader, the BTK Killer.
h. May mentally replay the torture scenes later while masturbating.

7. Sexual masochism disorder

a. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving the act of being humiliated, beaten, or bound for sexual gratification.
b. Complementary relationships are formed.
c. Named after the Austrian novelist Leopold V. Sacher-Masoch (1836–1895) whose fictional characters dwelt lovingly on the sexual pleasure of pain.
d. Involves at least two people, one superior "disciplinarian" and one obedient "slave."
e. Appears to be more common than sadism and occurs in both males and females
f. Dominatrixes.
g. Many females who enter into these relationships were sexually or physically abused in childhood.
h. More common than sadism, occurring in both men and women.
i. Autoerotic asphyxia—500 to 1000 deaths per year in the United Sates.

B. Causal Factors and Treatments for Paraphilias

1. Usually found in males.
2. Typically begin around puberty or early adolescence.
3. When found in women, the most likely ones found are pedophilia, sadomasochistic activities, and exhibitionism.
4. Individuals, usually men, have a very strong sex drive and often masturbate numerous times a day.
5. Typically more than one found in a person.
6. Money—suggested that male vulnerability to paraphilias is due to their greater dependence on visual sexual imagery.
7. Many believe paraphilias arise as a result of classical and operant conditioning and social learning.
8. Developments in Research Hypersexual Disorder—the idea of sex addiction or hypersexual disorder is proposed for the DSM-5.
9. Treatments for paraphilias
    a. Most studies conducted with sex offenders.
    b. Non-sex offenders rarely seek treatment.

C. Gender Dysphoria

1. Gender dysphoria in childhood
    a. Boys outnumber girls 5:1 to 3:1 for clinic-referred GID.
    b. Characterized by strong and persistent cross-gender identification and gender dysphoria.
    c. **DSM-5** change from GID to gender dysphoria.
    d. Gender identity refers to one's sense of maleness or femaleness.
    e. Most common adult outcome of boys is homosexuality, rather than transsexualism.
    f. Argument as to whether this should be seen as a disorder.
    g. Generally treated psychodynamically but there is a lack of outcome studies.
2. Treatment
    a. Brought in by their parents for psychotherapy.
    b. Treatment focuses on the child's unhappiness and strained relationship with parents.

3. Transsexualism

a. Defined as adults with gender dysphoria who desire to change their sex.
b. European studies show 1 in 30,000 adult males and 1 in 100,000 adult females seek sex reassignment surgery.
c. More recent data suggest 1 in 12,000 men in Western countries have actually undergone the surgery.
d. Homosexual male-to-female transsexual.
e. Autogynephilic transsexual—a paraphilia in which the originally male individual is attracted to thoughts, images, or fantasies of himself as a woman.
f. Treatment
(1) Psychotherapy is usually ineffective.
(2) Surgery and hormone treatment are used.
(3) Trial periods are needed before surgery.
(4) Outcome studies show a success rate of 87% of 220 male-to-female transsexuals and 97 % of 130 female-male transsexuals.

III. Sexual Abuse

A. Childhood Sexual Abuse

1. Increase in relevant research
a. Childhood sexual abuse is more common than once thought.
b. **Sexual abuse**—sexual contact that involves physical or psychological coercion
or at least one individual who cannot reasonably consent to the contact.
c. Possible links between childhood sexual abuse and some disorders.
d. Dramatic and well publicized cases have created controversy about the validity of childhood memories and the accuracy of recovered memories.
2. Prevalence of childhood sexual abuse
a. Depends on the definition of abuse and childhood.
b. Data from 22 countries found that 7.9% of men and 19.7% of women had
suffered sexual abuse before age 18.
3. Consequences of childhood sexual abuse
a. Short-term consequences include: fears, PTSD, sexual inappropriateness, poor self-esteem; one-third of children show no symptoms.
b. Long-term consequences include: adult psychopathology, sexual symptoms.
4. Controversies concerning childhood sexual abuse
a. Children's testimony
(1) McMartin Preschool case.
(2) Accuracy of testimony is a crucial issue because leading or coercive questioning methods were used.
(3) Concocting stories increases when interviewers ask leading questions, repeat questioning, and reinforce some kinds of answers more than others.
(4) Failure to proceed with care can result in false accusations.
(5) Legal case: U.S. v. Desmond Rouse (2004).
b. Recovered memories of sexual abuse
(1) The cases of Eileen Franklin against her father and Patricia Burgus against two Chicago psychiatrists.
(2) 0Patricia Burgus was awarded $10.6 million in 1997.
(3) Bass and Davis—*Courage to Heal.*
(4) Induction of false memories.
(5) Negative consequences of recovered memories.

B. Pedophilic Disorder

1. Recurrent, intense sexually arousing fantasies, urges, and behaviors involving sexual activity with a prepubertal child generally age 13 or younger.
2. The manipulation of the child's genitals is usually involved.
3. Rejected *DSM-5* proposal of encompassing both pedophilia and hebephilia.

4. Nearly all pedophiles are male; two-thirds of victims are girls.
5. Studies using the penile phlethysmograph.
6. Pedophiles are more likely to believe that children benefit from sexual contact and that children initiate sexual contact.
7. Pedohebephilia usually begins in adolescence and persists throughout a person's life.
8. Cases of pedophilia among the Catholic clergy—at least 400 priests were charged with sexual abuse during the 1980s; $400 million was paid out in damages between 1985 and the early 1990s.
9. B4UAct (Before You Act).
10. John Geoghan was found guilty of sexually molesting two boys and accused of sexually molesting dozens more in the Boston area.

C. Incest

1. Historical and biological considerations about incest are presented; this is universally considered taboo in almost all human societies.
2. Incidence may be underreported in our society.
3. Brother–sister incest most common; father–daughter incest is second.
4. Multiple patterns of incest may exist within the same family.
5. Associated with pedophilia.

D. Rape

1. Prevalence
   a. Studies show wildly different estimates.
   b. Definitions are not consistent.
   c. Statutory rape is sexual activity with a person is under the age of consent (see Figure 12.1).
   d. Variability in the way information is gathered.
2. Is rape motivated by sex or aggression?
   a. Traditionally classified as a sex crime.
   b. 1970s—rape seen as motivated by the need to dominate, exert power, and humiliate rather than by sexual desire.
   c. Sexual motivation is often an important factor
      (1) Victims tend to be in their teens and early 20s.
      (2) Rapists cite sexual motivations.
      (3) Some rapists exhibit features associated with paraphilias and have multiple paraphilias.
   d. Several prominent researchers argue that all rapists have both aggressive and sexual motives.
   e. Classification systems for rapists; not clear which is best.
3. Rape and its aftermath
   a. Repetitive, planned activity rather than a single event.
   b. 80% of rapists commit the act in the neighborhoods in which they live.
   c. Most rapes occur in urban settings, at night, in places ranging from dark, lonely streets to elevators, hallways, apartments, and homes.
   d. Acquaintance rapes account for two-thirds of reported rapes (See Figure 12.2).
   e. Physical trauma combines with psychological factors (rape trauma syndrome).
   f. Possibility of pregnancy or sexually transmitted disease.
   g. Negative impact on victim's intimate relationships.
   h. Myth of victim-precipitated rape; rape shield laws began to appear in the 1970s.
4. Rapists and causal considerations
   a. FBI statistics indicate that rape is a young man's crime; 60% of all rapists are under age 25, 30%–50% are married and living with their wives at the time of the crime.
   b. Low end of socioeconomic ladder and commonly have a prior criminal record.
   c. Date rapists have a different profile: often middle- to upper-class young men who rarely have criminal records.

d. Both types of rapists may be characterized by promiscuity, hostile masculinity, and emotionally detached, predatory personalities.
e. Some are afflicted by a paraphilia.
f. Deficits in cognitive appraisal of women, social and communication skills, insensitivity to social cues or pressures, a lack of personally intimate relationships, quick loss of temper, and impulsivity.
g. Only 20%–28% of rapes are reported.
h. Conviction rates are low (50%); only two-thirds of rapists serve any jail time, 50% are convicted.

C. Treatment and Recidivism of Sex Offenders

1. Psychotherapies and their effectiveness
2. The world around us: Megan's Law
   a. Therapies typically have one of four goals:
      (1) Modify patterns of sexual arousal typically with aversion therapy or covert sensitization; must replace deviant arousal patterns with arousal to acceptable stimuli.
      (2) Modify cognitions and social skills through cognitive restructuring and social skills training.
      (3) Change habits or behavior.
      (4) Reduce sexual drive.
   b. Sexual offenders are difficult to treat successfully; many studies show no differences between treated and untreated groups; recent meta-analysis showed that treated offenders were less likely to offend but effects were modest.
   c. Cognitive behavioral techniques appeared to be most effective.
   d. Non-pedophile child molesters and exhibitionists also found to respond better to treatment than pedophiles and rapists.
3. Biological and surgical treatments
   a. SSRIs have been found useful in reducing paraphilic desire and behavior but not with sex offenders.
   b. Controversial treatment of surgical and chemical castration.
4. Combining psychological and biological treatments.
5. Summary.

IV. Sexual Dysfunctions: Refers to impairment either in the desire for sexual gratification or in the ability to achieve it.

A. Human Sexual Response

1. Desire phase
2. Excitement(or arousal) phase
3. Orgasm
4. Resolution

B. Sexual Dysfunctions in Men

1. Male hypoactive sexual desire disorder
   a. Little or no sexual drive is present; most common female sexual dysfunction.
   b. What is "not enough" sexual interest is debatable.
   c. For many women, sexual desire is experienced only after sexual stimuli have led to subjective sexual arousal; linear sequence not accurate for women.
   d. Sustained use of bupropion improved sexual arousability and orgasm frequency in women.
   e. Treatment
      (1) Lower levels of testosterone may be involved; however, replacing testosterone does not typically help.
2. Male **erectile disorder** (or erectile insufficiency)
   a. Barlow—cognitive distractions frequently associated with anxiety in dysfunctional people that seem to interfere with sexual arousal; preoccupation with negative thoughts.
   b. Formerly called impotence.
   c. Occur in as many as 90% of men using antidepressants.

d. 18% of men ages 50–59 have some degree of erectile dysfunction.
e. 37% between ages 57–85 report significant erectile difficulties.
f. Vascular disease is the most common cause of erectile problems in older men.
g. Untreated cases of priapism result in erectile dysfunction 50% of the time.
h. Treatment
(1) Cognitive-behavioral.
(2) Medications such as Viagra.
(3) Injections of smooth-muscle-relaxing drugs into the penile erection chambers.
(4) Vacuum pump.
(5) Penile implants.
(6) Viagra
(a) Works by making nitric oxide more available.
(b) Promotes erection only if some sexual excitement is present.
(c) More than 70% of men report improvement.
(d) Two similar drugs introduced: Cialis and Levitra.
(e) Improvements enhanced by cognitive-behavioral therapy.

3. Early ejaculation (premature ejaculation)
a. Persistent and recurrent onset of orgasm and ejaculation with minimal sexual stimulation that may occur before, on, or shortly after penetration and before the man wants it to.
b. Most common male sexual dysfunction at least up to age 59
c. Treatment:
(1) Behavioral therapy such as the pause-and-squeeze technique.
(2) Antidepressants such as Paxil and Zoloft can significantly prolong ejaculatory latency.

4. Delayed ejaculation disorder
a. Persistent inability to ejaculate during intercourse.
b. Psychological treatments emphasize the reduction of performance anxiety in addition to increasing genital stimulation.
c. Specific physical problems such as multiple sclerosis and certain medications (especially the SSRIs) may be involved.
d. Treatment
(1) Focus on reducing anxiety over orgasm and focus on enjoying intimacy.

C. Female Sexual Interest/Arousal Disorder

1. Involves an absence of arousal and unresponsiveness to stimulation.

2. Possible causes include: early sexual traumatization, excessive and distorted socialization about the "evils" of sex, dislike or disgust with sexual partner, lowered tactile sensitivity.
a. Treatment:
(1) Few controlled studies have been conducted.
(2) Vaginal lubricants are effective.
(3) Viagra, Cialis, and Levitra not useful for women unless sexual arousal problems are due to antidepressants.

3. Genito-pelvic pain/penetration disorder
a. Vaginismus and Dyspareunia combined in *DSM-5*
b. Vaginismus defined as involuntary spasm of the muscles at the entrance to and outer third of the vagina. Difficult to diagnose and often occurs with pain during intercourse which overlapped with dyspareunia.

c. Genito-pelvic pain/penetration disorder combines the genital pain of dyspareunia with muscle tension (not muscle spasms) and fear and anxiety related to genital pain or penetrative sexual activity.
d. Some argue that sexual pain disorders should be classified as pain disorders rather than sexual disorders because it appears to have more organic than psychological causes.
e. Treatment
(1) Cognitive behavioral treatment includes education, graduation vaginal dilation exercises, and progressive muscle relaxation.
(2) Medical treatment includes surgical removal of the vulvar vestibule

4. Female orgasmic disorder
a. "Extra" stimulation is required for orgasm.
a. No amount of stimulation can produce orgasm in lifelong orgasmic dysfunction; affects are highest in 21–24 year olds.
b. Causal factors not well understood
(1) Anxiety and tension.
(2) Feelings of inadequacy.
c. Treatment requires distinction between lifelong and situational dysfunction
(1) Instruction and guidance for lifelong with high rates of success.
(2) Situational more difficult to treat than lifelong.

V. Unresolved Issues: How Harmful Is Childhood Sexual Abuse (CSA)?

A. Rind, Tromovitch, & Bauserman (1998)
1. Correlations between childhood sexual abuse and later problems of small magnitude.
1. Family pathology, not abuse, may be involved.
2. Incest and forced sex associated with more problems.
3. Age at which CSA was experienced unrelated to adult outcome.

B. Controversy over study ignited by Dr. Laura Schlessinger
1. Claims were socially dangerous: giving comfort to child molesters and being insensitive to victims of CSA.
2. U.S. House of Representatives condemned the study.
3. Study not scientifically strong enough to justify conclusions
a. Relied on college students; however, results confirmed with community samples.
b. Statistical decisions and analyses were criticized; however, results did not change when analyzed differently.

C. Rind has extended this discussion to adult–adolescent sexual relationships.
1. Reviews evidence that current views are driven by ideology and moral panic rather than by empirical research.
2. Evidence suggests that many teenage boys see perceived benefits from such relationships in regards to their sexual confidence and self-acceptance.

Key Terms

autogynephilia
delayed ejaculation disorder
desire phase
erectile disorder
excitement (or arousal) phase
exhibitionistic
female orgasmic disorder
female sexual interest/arousal disorder
fetishism
frotteurism
gender dysphoria
genito-pelvic pain/penetration disorder
incest
male erectile disorder
male hypoactive sexual desire disorder
masochism
orgasm
paraphilias
pedophilic disorder
rape
resolution
sadism
sexual abuse
sexual aversion disorder
sexual dysfunction
sexual sadism disorder
transsexualism
transvestic fetishism
voyeuristic disorder