LO 8.1

Sexual problems: sexual dysfunctions

There are two broad categories of sexual problems: sexual dysfunctions and the paraphilias. Sexual dysfunctions, which will be considered first, generally involve problems in the desire, arousal or orgasm phases of sexual functioning. The paraphilias refer to deviant types of sexual behaviours that lead to sexual gratification through sexual activity with inanimate objects or behaviours that do not involve consent. The paraphilias include exhibitionistic disorder, fetishistic disorder, frotteuristic disorder, paedophilic disorder, sexual masochistic disorder, sexual sadism disorder, transvestic disorder and voyeuristic disorder.

sexual dysfunctions Disorders characterised by some type of disturbance in the phases of sexual functioning including desire, arousal and orgasm.

desire phase Stage of sexual functioning characterised by the urge or inclination to engage in sexual activity.

arousal phase Stage of sexual functioning characterised by the subjective experience of pleasure and excitement as well as physiological changes (such as the tensing of muscles and enlargement of blood vessels).

orgasm Stage of sexual functioning characterised by the discharge of neuromuscular tension built up during sexual activity; in men, entails rhythmic contractions of the prostate, seminal vesicles, vas deferens and penis, and seminal discharge; in women, entails contractions of the orgasmic platform and uterus.

THE DEFINITION OF SEXUAL DYSFUNCTION

Sexual dysfunction generally consists of an impairment or disturbance in one or more of the three stages of sexual functioning identified by Kaplan (1979): desire, arousal and orgasm. **The desire phase** refers to the individual's experience of thoughts and feelings to engage in sexual activity. The aim of the **arousal phase** is to produce physiological changes that allow intercourse to take place (such as erection of the penis and lubrication of the vagina). The orgasmic phase refers to the experience of **orgasm**, which entails rhythmic contractions of the penile urethra and muscles at the base of the penis for men and of the muscles around the base of the vagina and pelvic floor for women.

This three-stage model of the sexual response cycle is compatible with the current diagnostic scheme for men of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association [APA], 2013). However, for the first time, in this current edition of the DSM, the desire and arousal phases have been combined into a single disorder for women. Thus, the *DSM-5* includes four male and two female sexual dysfunctions that fit within this three-stage model of sexual functioning and also includes an additional genito-pelvic pain/penetration disorder for women. These disorders are outlined in Table 8.1.

TABLE 8.1 The *DSM-5* (APA, 2013) classification of sexual dysfunction

STAGE OF SEXUAL RESPONSE	MEN	WOMEN
Desire	Male hypoactive sexual desire disorder	Female sexual interest/arousal disorder
Arousal	Erectile disorder	
Orgasm	Delayed ejaculation Premature ejaculation	Female orgasmic disorder
Pain		Genito-pelvic pain/penetration disorder

Three dimensions are used by the *DSM-5* to specify subtypes of these disorders. The first dimension is used to indicate the nature of the onset of sexual dysfunction as either lifelong or acquired. Lifelong dysfunctions are those that have been present since the individual became sexually active, whereas acquired sexual dysfunctions are those that develop after a period of normal functioning. The second dimension is used to indicate the context in which the sexual dysfunction occurs. This can be either generalised (where the dysfunction is not limited to a certain context) or situational (where the dysfunction is limited to certain types of stimulation, situations or partners). Third, the *DSM-5* specifies subtypes of sexual dysfunction on the basis of the severity of the dysfunction, which may be mild, moderate or severe. This classification of mild, moderate or severe generally relates to the level of distress experienced by the man or woman, except for premature ejaculation where the severity is specified by time to ejaculation.

METHODOLOGICAL ISSUES

Before discussing each of the disorders listed in Table 8.1, it is important to highlight some of the methodological flaws of research in this area. First, one of the greatest problems in the literature on sexual dysfunction is the wide range of different sub-populations from which samples are drawn. While large-scale epidemiological studies utilising participants from the general population have been carried out, studies often assess and compare groups that vary considerably in their dysfunctional nature. For instance, studies have variously included sexually dysfunctional participants who have sought treatment for their sexual problem, sexually dysfunctional participants from the community who have not sought treatment, participants from the general population who do not have a sexual problem, dysfunctional and functional participants from various medical settings, or students. Second, studies vary greatly in the age groups that they examine. Some studies look only at men and women aged over 40, others at respondents aged over 18, and others look at people only up to age 70. Finally, the existing literature is plagued by inconsistency in the manner in which the various dysfunctions are defined and measured. Where samples are composed of clinically (i.e., treatment-seeking) dysfunctional participants, the measures used to assess the presence of sexual dysfunction (such as clinical diagnosis) are much more reliable than those used to measure and assess dysfunction in non-clinical populations (generally one-item self-report measures) and where the severity and duration of the dysfunction may not be assessed.

One result of these methodological shortcomings is that the prevalence rates of sexual dysfunctions across studies are often substantially different, depending on the type of participants included and the different criteria used to diagnose sexual dysfunction. For example, McCabe and Goldhammer (2013) found that among Australian women, the prevalence of sexual desire disorders varied from 3 per cent to 31 per cent, depending on whether strict *DSM* criteria, responses to questionnaire measures of sexual desire or self-classification measures were used to define desire problems. A recent Danish study reported prevalence rates for each of the separate dysfunctions in a sample of 4415 sexually active men and women aged 16–95 years (Christensen et al., 2011). This study found that 11 per cent of both men and women reported at least one sexual dysfunction. In terms of specific problems the prevalence rates were: premature ejaculation, 7 per cent; erectile dysfunction, 5 per cent; arousal disorder, 7 per cent; and anorgasmia, 6 per cent. No data were reported on sexual desire disorders or sexual pain disorders.

SEXUAL DESIRE DISORDERS

Sexual desire is the interest one has in being sexual and engaging in sexual activity alone or with a partner (Goldhammer & McCabe, 2011; Wincze & Carey, 2001). Individuals who are persistently and recurrently uninterested in sexual expression, who report the absence of sexual fantasies altogether, and who are distressed by their lack of interest, are said to be experiencing low sexual desire. In the *DSM-5*, **hypoactive sexual desire disorder** is a distinct classification for males but is combined with sexual arousal disorder for females, due to the high levels of overlap in the prevalence and aetiology of these two disorders for women. Estimates of the one-year prevalence rate (i.e., the number of individuals with the disorder in any one year period) of hypoactive sexual desire disorder in community samples have been up to 7 per cent (Schiavi, Stimmel, Mandeli, & White, 1995). The disorder's prevalence has been found to increase with age. For example, Panser et al. (1995) found that for men in a community sample aged 40–49 years, the prevalence of hypoactive sexual desire disorder was 0.6 per cent, while for men aged over 70 years, the prevalence increased to 26 per cent. More recently, McCabe and Connaughton (2014) found that 8 per cent of Australian men experienced sexual desire problems, whereas 55 per cent of women were reported by Giles and McCabe (2009) to experience desire problems. Laumann, Paik, and Rosen (1999) found that lack of sexual desire was the most common sexual dysfunction for women, with 33 per cent of women experiencing this sexual dysfunction.

hypoactive sexual desire disorder Sexual dysfunction in which an individual's desire for sex is diminished to the point that it causes him/her significant distress or interpersonal difficulties and is not due to transient life circumstances or another sexual dysfunction.

SEXUAL AROUSAL DISORDERS

erectile disorder Sexual dysfunction in men entailing recurrent inability to attain or maintain an erection until the completion of sexual activity.

female sexual arousal disorder Sexual dysfunction in women characterised by recurrent inability to attain or maintain the swelling-lubrication response of sexual excitement.

hypertension Condition in which the blood supply through the blood vessels is excessive and is a major risk factor for heart disease and stroke (also known as high blood pressure).

delayed ejaculation When an individual experiences a marked difficulty or inability to ejaculate.

premature ejaculation Sexual dysfunction characterised by a man's inability to delay ejaculation after minimal sexual stimulation or until he wishes to ejaculate, causing significant distress or interpersonal problems.

female orgasmic disorder Sexual dysfunction in women characterised by recurrent delay or absence of orgasm following a normal excitement period (also termed 'anorgasmia').

According to Wincze and Carey (2001), sexual arousal refers to 'the physiological, cognitive and affective [emotional] changes that serve to prepare men and women for sexual activity' (p. 23). Inadequate sexual arousal in men is generally experienced as the inability (which may be further classified as either partial or complete) to attain or maintain an erection that is sufficient for sexual intercourse (APA, 2013). This dysfunction is labelled **erectile disorder** by the *DSM-5*. **Female sexual arousal disorder** is experienced as difficulty in attaining or maintaining adequate lubrication until the completion of the sexual act (APA, 2013). As noted earlier, in the *DSM-5* arousal disorder and sexual desire disorder have been combined for women.

Early prevalence estimates for erectile disorder suggested that as many as 50 per cent of men will experience erectile difficulties at some stage in their life (Frank, Anderson, & Rubenstein, 1978; Kaplan, 1974). Australian prevalence estimates indicate that erectile disorder increases substantially with age, ranging from 3 per cent of men aged 40–49 years to 64 per cent of men aged 70–79 years in a community sample (Pinnock, Stapleton, & Marshall, 1999). In a more recent study of Australian men, the prevalence rate was found to be 40 per cent (McCabe & Connaughton, 2014). The prevalence of erectile disorder is also higher among men who smoke and who have a range of medical conditions such as heart disease, diabetes and **hypertension** (high blood pressure) (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994; Mannino, Klevens, & Flanders, 1994; Panser et al., 1995; Ventegodt, 1998).

Compared to erectile disorder, less is known about the prevalence of female sexual arousal disorder and it is difficult to accurately estimate the prevalence of this disorder given its overlap with other sexual dysfunctions among women. However, it has been estimated that between 30 and 50 per cent of women experience dysfunction in the desire, arousal or orgasm phases of the sexual response cycle (Laumann, Paik, & Rosen, 1999; Spector & Carey, 1990). An Australian study found that 52 per cent of women experienced arousal problems (Giles & McCabe, 2009).

ORGASMIC DISORDERS

The *DSM-5* identifies two types of orgasmic disorders in men: delayed ejaculation and premature ejaculation. **Delayed ejaculation** is diagnosed when the individual experiences a marked difficulty or inability to ejaculate, despite the apparent presence of adequate stimulation and desire to ejaculate (APA, 2013). It is a disorder that most commonly refers to men who are not able to ejaculate with their partner, but are able to ejaculate during sleep or masturbation (Wincze & Carey, 2001). This disorder is relatively rare, with estimates of its prevalence ranging between 0 per cent (Schiavi, Stimmel, Mendeli, & White, 1995) and 3 per cent (Ventegodt, 1998) in community samples. An Australian study found that delayed ejaculation was experienced by 4 per cent of a community sample of men (McCabe & Connaughton, 2014).

Premature ejaculation is identified in the *DSM-5* as a sexual dysfunction characterised by a persistent or recurrent pattern of ejaculation within approximately one minute following vaginal penetration and happening before the man wishes it. Community estimates of the one-year prevalence of premature ejaculation have generally been about 5 per cent (Schiavi, Stimmel, Mendeli, & White, 1995; Ventegodt, 1998). McCabe and Connaughton (2014) found the prevalence to be 8 per cent.

Female orgasmic disorder is defined by the *DSM-5* as a marked delay or absence of orgasm or reduced intensity of orgasmic sensations. The woman must experience clinically significant distress about her symptoms. A woman may experience lifelong anorgasmia (when she has never experienced an orgasm) or acquired anorgasmia (the existence of orgasmic problems in a woman who was previously able to experience orgasm). Female orgasmic disorder may occur in some situations but not in others (e.g., problems with one sexual partner but not with a different partner). Laumann, Paik, and Rosen (1999) estimate that the prevalence of anorgasmia in women is 24 per cent, although an Australian study found the prevalence to be 51 per cent (Giles & McCabe, 2009).

THE DIAGNOSIS OF PARAPHILIC DISORDERS

Paraphilic disorders involve sexual activities or interest in engaging in behaviours other than genitally focused sexual activities with mature consenting partners. However, it should be noted that Ahlers et al. (2011) found that 62.4 per cent of men in their study reported sexual arousal to either a fantasy or experience of paraphilic situations, indicating that such experiences are common and not necessarily a disorder. Details on these patterns are summarised in Table 8.5. The paraphilias included in the *DSM-5* (APA, 2013) are exhibitionistic disorder, fetishistic disorder, frotteuristic disorders, paedophilic disorder, sexual masochistic disorder, sexual sadism disorder, transvestic disorder and voyeuristic disorder. The characteristics of each of these disorders are outlined below.

TABLE 8.5 Frequency of paraphilia-associated sexual arousal patterns in a community sample of men (n=367)

PARAPHILIC SITUATION	FANTASY n (%)	MASTURBATION FANTASY n (%)	REALITY n (%)
Fetishistic	110 (30.0)	97 (26.4)	90 (24.5)
Transvestic fetishistic	18 (4.9)	21 (5.7)	10 (2.7)
Masochistic	58 (15.8)	50 (13.6)	45 (2.3)
Sadistic	80 (21.8)	73 (19.9)	57 (15.5)
Voyeuristic	128 (34.9)	90 (24.5)	66 (18.0)
Exhibitionistic	13 (3.5)	12 (3.3)	8 (2.2)
Frotteuristic	49 (13.4)	26 (7.1)	24 (6.5)
Paedophilic	35 (9.5)	22 (6.0)	14 (3.8)
Other*	23 (6.3)	23 (6.3)	12 (4.6)
Presence of at least one of the above categories	215 (58.6)	175 (47.7)	163 (44.4)

*Other includes wearing diapers, sex with babies, sex with elderly, sex with amputees, asphyxia, necrophilic, urophilic, koprophilic or zoophilic.

Source: From Ahlers, C. J., Schaefer, G. A., Mundt, I. A., Roll, S., Englert, H., Willich, S. N., & Beier, K. M. (2011). How unusual are the contents of paraphilias? Paraphilia-associated sexual arousal patterns in a community-based sample of men. *Journal of Sexual Medicine, 8,* 1362–1370.

EXHIBITIONISTIC DISORDER

Exhibitionistic disorder is a paraphilic disorder that involves a person obtaining intense sexual arousal from exposing his/her genitals to an involuntary observer, generally a complete stranger. In order to be classified as a paraphilic disorder, the person needs to have engaged in these behaviours for a period of at least six months and it is also necessary that the person has experienced marked distress or interpersonal problems as a result of the exhibitionistic fantasies or behaviours. Most exhibitionists are males and a large percentage of females have observed exhibitionistic behaviours on at least one occasion.

exhibitionistic disorder A paraphilic disorder that involves a person obtaining intense sexual arousal from exposing his/her genitals to an involuntary observer, generally a complete stranger.

The exhibitionist obtains sexual gratification from the shock, fear or disgust that the victim displays. If the victim does not react, there is no sexual gratification. There is rarely sexual contact with the victim. The offender often repeats the exhibitionistic act, which is in a public place, a number of times. It is not at all uncommon for these offenders to be arrested for repeat offences as the acts are generally repeated in the same location.

FETISHISTIC DISORDER

Fetishistic disorder involves the use of non-living objects or a highly specific non-genital body part (e.g., feet, toes, hair) to obtain sexual arousal. For heterosexual men, these are commonly women's clothing (e.g., bras, underpants, shoes or stockings). The differences between a fetish and being aroused by a woman wearing these items of clothing is that for a person with a fetish the sexual arousal is focused on the clothing, whereas for other heterosexual men the clothing simply enhances the sexual appeal of the woman wearing the apparel.

fetishistic disorder The use of non-living objects or a highly specific non-genital body part (e.g., feet, toes, hair) to obtain sexual arousal.