Sexual Dysfunction and Paraphilias

Sexual Response Cycle

- First described by Masters and Johnson
- Desire, arousal, climax, resolution
- Disorders of sexual function can be classified by phase of response cycle

Caveats with DSM-5

- Focus on heterosexual relationships
- Focus on cis-gender individuals however notes: "The population of gender-diverse persons, including transgender, nonbinary, and agender, may not identify with or appear to fit into the existing sex- and gender-based diagnostic categories described in this chapter. Despite the names given to male hypoactive sexual desire disorder and female sexual interest arousal disorder, the diagnostic criteria describe symptoms and experiences that are not dependent on the individual's specific sex or gender. As such, either diagnosis can be applied to gender-diverse individuals based on clinical judgment. For diagnoses linked to reproductive anatomy (e.g., erectile dysfunction, premature [early] ejaculation, delayed ejaculation, and genito-pelvic pain/penetration disorder), diagnoses should be based on the individual's current anatomy and not on the individual's sex assigned at birth."
- Implicitly characterizes sexual variances as deviant
- Implicity focused on monoamorous relationships
- Not inherently kink-positive

Sexual Health is Part of Health

- Sexual Dysfunction and dissatisfaction is common
- Patients reluctant to seek help for such problems
- Clinicians uncomfortable with asking
- Many problems are due to misconceptions, lack of education, unrealistic expectations
- Many people receive their sex education from pornography fueling misconceptions
- Sexual problems are prototypical biopsychosociocultural problems
- Asexuality is a sexual orientation that is considered a normal variant of human sexuality

Sexual Dysfunction Diagnoses

Male Hypoactive Sexual Desire Disorder

- Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life.
- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Factors to consider in assessment:
    1. partner factors (e.g., partner's sexual problems, partner's health status)
    2. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)

3. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
4. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
5. medical factors relevant to prognosis, course, or treatment.

- Differential:
    - Medications: TCA, MAOIs, SSRI/SNRIs, antiseizure medicines, antihypertensives (beta-blockers, ACE inhibitors, CCBs, diuretics), antiandrogens, GnRH analogs, opioids, benzodiazepines, antipsychotics, chemotherapy
    - Substances: alcohol, cannabis, opioids, cocaine, amphetamines, benzos
    - Psychiatric diagnoses: depression, anxiety, PTSD, schizophrenia
    - Other medical problems: diabetes, hypogonadism, hyperprolactinemia, hypothyroidism, CNS disorders, HIV, cardiovascular disease, inflammatory bowel disease, renal impairment, liver disease
- Treatment:
    - Individual psychotherapy
    - Couples therapy
    - Testosterone replacement or supplementation
    - If anti-depressant induced, sometimes use bupropion, mirtazapine, buspirone etc to try to reverse

Female Sexual Interest/Arousal Disorder

- Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:

    - Absent/reduced interest in sexual activity.
    - Absent/reduced sexual/erotic thoughts or fantasies.
    - No/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate.
    - Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
    - Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
    - Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Factors to consider in assessment:
    1. partner factors (e.g., partner's sexual problems, partner's health status)
    2. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)

3. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
4. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
5. medical factors relevant to prognosis, course, or treatment.

- Differential:
    - Medications: TCA, MAOIs, SSRI/SNRIs, antiseizure medicines, beta blockers, GnRH analogs, opioids, benzodiazepines, antipsychotics, aromatase inhibitors, tamoxifen, ?contraceptives
    - Substances: alcohol, cannabis, opioids, cocaine, amphetamines, benzos
    - Psychiatric diagnoses: depression, anxiety, PTSD, schizophrenia
    - Other medical problems: diabetes, hyperprolactinemia, hypothyroidism, CNS disorders, HIV, cardiovascular disease, renal impairment, liver disease
- Treatment:
    - Individual psychotherapy
    - Couples therapy
    - If antidepressant induced – PDE-5 inhibitors (e.g. Viagra), bupropion, mirtazapine, trazodone, buspirone
    - Flibanserin/Addyi (5-HT1a agonist/5-HT2A antagonist). About 10% pts report robust response vs placebo. Adverse effects in 60% (50 in placebo group) with somnolence, dizziness, nausea, fatigue most common. Boxed warning for use with alcohol due to severe hypotension.
    - Bremelanotide/Vyleesi (melanocortin receptor agonist, especially MCR1 and MCR4). About 25% patients reported increase of 1.2+ in sexual desire (17% in placebo group). 4% difference between drug and placebo in reduced distress (35% v 31%). 40% patients experienced nausea. Administered by subcutaneous injection 45minutes prior to sexual activity.

Genito-Pelvic Pain Penetration Disorder

- 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.
    - Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.

- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Risk factors: sexual/physical abuse, vaginal infections, early puberty, inflammation, early use of oral contraceptives, vulvar pain receptor proliferation (i.e., increase in the number of receptors) and sensitization (i.e., touch may become perceived as pain), and lower touch and pain thresholds,

abnormalities of the pelvic floor muscles while at rest, including hypertonicity, poor muscle control, hypersensitivity.

- Differential: lichen sclerosis, endometriosis, pelvic inflammatory disease, genitourinary syndrome of menopause (all of which may be comorbid), somatic symptom disorder, inadequate sexual stimuli
- Treatment:
    - CBT
    - Desensitization exercises including dilator/vaginal trainers
    - Pelvic floor exercises/physical therapy
    - TCAs (e.g. amitriptyline, nortriptyline)
    - Botox

Erectile Disorder

- At least one of the three following symptoms must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):

    - Marked difficulty in obtaining an erection during sexual activity.
    - Marked difficulty in maintaining an erection until the completion of sexual activity.
    - Marked decrease in erectile rigidity.

- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Factors to consider in assessment:
    1. partner factors (e.g., partner's sexual problems, partner's health status)
    2. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)
    3. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
    4. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
    5. medical factors relevant to prognosis, course, or treatment.
- Differential:
    - Psychiatric: depression, anxiety, PTSD, stress, performance anxiety, social anxiety disorder
    - Medications: TCAs, MAOIs, SSRI/SNRIs, antipsychotics, antiandrogens, antihypertensives
    - Other medical conditions: cardiovascular disease, hypertension, diabetes, hyperlipidemia, radical prostatectomy, spinal cord injury, obstructive sleep apnea, Parkinson's disease, MS, Peyronie's disease, hypogonadism, hyperprolactinemia, hypothyroidism, adrenal failure, systemic disease (e.g. renal failure)
- Recommended labs: A1c, lipids, 0800 testosterone. Possibly TSH, CBC, BUN/Cr, LFTs, ?PSA
- Treatment:
    - Individual Psychotherapy
    - Couples Therapy/Sex Therapy

- Phosphodiesterase-5 inhibitors (e.g. sildenafil, tadalafil, vardenafil)
- Intraurethral alprostadil injections (prostaglandin E1 analog)
- Vacuum erection device/pump
- Penile prosthetic implant

Female Orgasmic Disorder

- Presence of either of the following symptoms and experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):

    - Marked delay in, marked infrequency of, or absence of orgasm.
    - Markedly reduced intensity of orgasmic sensations.

- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Factors to consider in assessment:
    1. partner factors (e.g., partner's sexual problems, partner's health status)
    2. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)
    3. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
    4. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
    5. medical factors relevant to prognosis, course, or treatment.
- Differential diagnosis:
    - Psychiatric: depression, anxiety, PTSD, schizophrenia
    - Medications: antidepressants, antipsychotics, benzodiazepines, barbiturates, antiseizure medicines, beta-blockers
    - Substances: alcohol, benzos, opioids, stimulants (cocaine and amphetamines)
    - Medical illness (uncommon): spinal cord injury, MS, diabetic neuropathy, hyperprolactinemia, hypothyroidism. Most physical illnesses that affect orgasm may do so through psychological rather than physical effect
- Treatment:
    - Individual psychotherapy
    - Couples therapy
    - If SSRI-induced, can try PDE-5 inhibitors, bupropion

Delayed Ejaculation

- Either of the following symptoms must be experienced on almost all or all occasions (approximately 75%–100%) of partnered sexual activity (in identified situational contexts or, if generalized, in all contexts), and without the individual desiring delay:
    - Marked delay in ejaculation.
    - Marked infrequency or absence of ejaculation.
- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Factors to consider in assessment:
    1. partner factors (e.g., partner's sexual problems, partner's health status)
    2. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)
    3. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
    4. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
    5. medical factors relevant to prognosis, course, or treatment.
- Differential:
    - Medications: SSRI/SNRIs, TCAs, MAOIs, antipsychotics, antihypertensives, tamsulosin, opioids
    - Medical conditions: SCI, stroke, MS, radical prostatectomy, diabetes, sleep apnea, hypothyroidism, hyperprolactinemia, hypogonadism, OSA, ejaculatory duct obstruction
    - Substances: alcohol, benzos, opioids, stimulants
- Treatment is limited. No pharmacological real options sometimes bupropion, buspirone, amantadine, cyproheptadine are used, especially if drug-induced. Individual psychotherapy

Premature Ejaculation

- 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.
    - **Note:** Although the diagnosis of premature (early) ejaculation may be applied to individuals engaged in nonvaginal sexual activities, specific duration criteria have not been established for these activities.
- >6 months duration
- Significant distress
- Not better explained by another mental disorder or medical condition
- Lifelong or acquired
- Situational or generalized
- Of note, American Urological Association guidelines use 2 minutes, rather 1 minute as cut-off for diagnosis
- Factors to consider in assessment:

6. partner factors (e.g., partner's sexual problems, partner's health status)
7. relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)
8. individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement)
9. cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality)
10. medical factors relevant to prognosis, course, or treatment.

- Differential diagnosis: prostatitis, opioid withdrawal, unrealistic expectations/lack of education
- Treatment: behavioral interventions (sensate focus, start-stop-squeeze) daily SSRI, on-demand clomipramine, on-demand tramadol, daily alpha-1 blockers (e.g. tamsulosin, doxazosin)

Paraphilias

- Per DSM-5-TR "The term paraphilia denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners"
- Per DSM-5-TR "A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention."
- Can be classified as:
    - *Anomalous activity preferences*
        - *Courtship disorders* – distorted components of courtship behavior (voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder)
        - *Algolagnic disorders* involving pain and suffering (sexual masochism disorder, and sexual sadism disorder)
    - *Anomalous target preferences*
        - Directed at humans (pedophilic disorder)
        - Directed elsewhere (fetishistic and transvestic disorder)
- Diagnoses cause clinically significant distress or impairment in social, occupational or other important areas of functioning
- Often lead to criminal justice involvement
- Must be at least 18 years old
- *Voyeuristic disorder* - 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.
- *Exhibitionistic disorder* - 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.
- *Frotteuristic disorder* - 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.
- *Sexual masochistic disorder* - 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.

- *Sexual sadism disorder* - 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.
- *Pedophilic disorder* - 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).
- *Fetishistic disorder* - 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.
- *Transvestic disorder* - over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.
- Paraphilic disorders are mainly seen in forensic settings after individuals have been convicted of sex offenses

- Pedophilic disorder
    - Has been most studied
    - Most child molesters do not have pedophilic disorders
    - Differential includes autism spectrum disorder, dementia, frontal lobe pathology, obsessive-compulsive disorder, drug-induced hypersexuality (e.g. stimulants), antisocial personality disorder, alcoholism
    - FBI typology of child molesters distinguishes between *situational* and *preferential* (i.e. pedophilic) child molesters. Situational includes:
        - *Regressed* – low self-esteem, poor coping, children are sexual substitute for preferred partners
        - *Morally indiscriminate* – antisocial individuals with poor impulse control, lack of conscious, opportunity, tendency to exploit vulnerable others
        - *Sexually indiscriminate* – "trysexual" individuals interested in sexual experimentation. Varied sexual interests
        - *Inadequate* – often "eccentric loners" who view minors as nonthreatening objects to explore sexual fantasies.
    - Pedophiles sometimes classified as follows:
        - *Virtuous (non-offending)* – preferential sexual fantasies involving children but never act on these with children.
        - *Amorous* – believe they can have loving/romantic sexual relationships with children
        - *Sadistic* – derive sexual pleasure from harming children
    - Treatments include covert sensitization and behavioral interventions, high dose SSRIs (e.g. paroxetine), GnRH analogs, medroxyprogesterone

Case 1

Ms A is a 52 year old lesbian cis woman with a history of osteoarthritis, epilepsy, PTSD and depression who presents with worsening depression in the context of workplace stress. She has a history of childhood neglect and childhood sexual abuse. She served in the airforce where she experienced military sexual assault and was previously treated for PTSD. She is on lamotrigine for epilepsy and takes ibuprofen PRN for pain. She has 5 prior serious romantic relationship, the first two with men, and the subsequent with female-identified partners. She came out as lesbian when she was 28. She has been married for 8 years, and with her partner for 15 years. They have a monogamous, monoamorous relationship. They have not been sexually active in 6 months. She has little interest or desire in having sex. She asks you if this is abnormal and is concerned her partner may not be interested in her in the same way. They often argue these days. She reports otherwise being unconcerned by their level of sexual activity.

Questions

1. What risk factors does Ms. A have for low libido?
2. How would you respond to her question about whether her level of sexual activity is normal?

You start the patient on escitalopram for treatment of her depression. She later reports even lower libido and inability to achieve orgasm with masturbation. She asks you if this is medication related and what to do about it.

Questions

3. What is the likelihood that escitalopram is causing the patient's symptoms? What other factors might you consider?
4. If it is related to escitalopram, what options could we consider?

Two months later, the patient reports she and her wife have not been sexually active. She worries that this may be causing tension in their relationship. She feels guilty and depressed and feels like she has been "depriving" her partner. She has heard there are some medications that are like "the female Viagra" and interested in hearing more about this.

Questions

5. Would this patient meet diagnostic criteria for a sexual dysfunction?
6. What medications are FDA approved for female hypoactive sexual desire disorder?
7. How would you counsel this patient regarding the use of medications for low sexual desire?

Case 2

Mr B is a 23 year old pansexual cis man with no significant past medical history. He presents to his PCP for his annual physical. He reports being in good health but reports concern about his sexual performance. He is single and sexually active with both male- and female-identified partners. He is a non-smoker but drinks 5-6 alcoholic drinks 2-3 times per week. He smokes cannabis daily. He denies use of other substances. He reports concerns about ejaculating too quickly. He typically ejaculates after 2-3 minutes and is concerned he cannot

satisfy sexual partners. He reports this has always been the case since he became sexually active at 18. He engages in oral, vaginal and anal intercourse. He reports concerns about the firmness of his erection during active anal sex but not vaginal sex. He reports this is the case whether or not he uses condoms. He has no difficulties with achieving or maintaining an erection. He reports having a high sex drive and masturbates daily. He usually does not contact sexual partners after the initial sexual encounter because he feels so embarrassed about his sexual performance he feels he cannot face them again. He feels humiliated and defeated and usually leaves quickly afterwards. Some sexual partners have laughed at him. He also reports that some sexual partners have contacted him afterwards wanting to meet up again but he never responds.

Questions

1. Does Mr. B meet criteria for a sexual dysfunction?
2. What interventions would be helpful for him?

Case 3

Mr. B is a 25 heterosexual cis man who is admitted to the inpatient psychiatric unit following a suicide attempt. He has a history of depression, anxiety, and alcohol use disorder. He drinks a 6 pack of beer nightly. He tells you that he is a terrible person and deserves to be dead. He reports having had “evil” thoughts since the age of 10 or 11 involving sexual contact with young girls. He denies ever molesting any children. He has looked at child pornography before.

Questions

1. What is the differential diagnosis for his unwanted sexual thoughts?
2. What questions would you ask to distinguish pedophilia from sexual OCD?
3. If he did have pedophilic disorder, what interventions might be helpful?