

Topics in Human Sexuality: Sexuality Across the Lifespan

Childhood and Adolescence

Introduction

Take a moment to think about your first sexual experience. Perhaps it was “playing doctor” or “show me yours and I’ll show you mine.” Many of us do not think of childhood as a time of emerging sexuality, although we likely think of adolescence in just that way. Human sexual development is a process that occurs throughout the lifespan. There are important biological and psychological aspects of sexuality that differ in children and adolescents, and later in adults and the elderly.

This course will review the development of sexuality using a lifespan perspective. It will focus on sexuality in infancy, childhood and adolescence. It will discuss biological and psychological milestones as well as theories of attachment and psychosexual development.

Educational Objectives

1. Describe Freud’s theory of psychosexual development
2. Discuss sexuality in children from birth to age two
3. Describe the development of attachment bonds and its relationship to sexuality
4. Describe early childhood experiences of sexual behavior and how the child’s natural sense of curiosity leads to sexual development
5. Discuss common types of sexual play in early childhood, including what is normative
6. Discuss why it is now thought that the idea of a latency period of sexual development is inaccurate
7. Discuss differences in masturbation during adolescence for males and females
8. List and define the stages of Troiden’s model for development of gay identity
9. Discuss issues related to the first sexual experience
10. Discuss teen pregnancy

Freud’s Contributions to Our Understanding of Sexual Development

Prior to 1890, it was widely thought that sexuality began at puberty. This changed with the advent of Sigmund Freud. His theory, aptly known as the psychosexual theory of development, involves the idea that personality development is centered on the effects of the sexual pleasure drive on an individual’s psyche. The term *libido* refers to a person's drive or desire for sex. At each stage of development a particular body part is sensitive to erotic stimulation. These erogenous zones are the mouth,

the anus, and the genital region. According to Freud, the child must resolve a conflict during each psychosexual stage in order to advance to the next stage. If that conflict is not resolved, the child will fixate in this stage, and this will affect the child's adult personality.

This training material will discuss each of Freud's stages in the appropriate age categories.

Sexuality In Childhood (Birth To Age 2)

The capacity for a sexual response is present from birth. Male infants, for example, get erections, and in fact, boy babies are sometimes born with erections. Vaginal lubrication has been found in female infants in the 24 hours after birth (Masters, Johnson, & Kolodny, 1982). Infants and young children have many other sensual experiences, including sucking on their fingers and toes,

The first intimate relationship that children experience is with the mother or the primary caretaker. This relationship involves many of the tactile senses and includes being rocked and cuddled, being bathed, cleaned and diapered. These experiences may establish preferences for certain kinds of stimulation that persist throughout life.

Masturbation

Infants have been observed fondling their genitals, and the rhythmic type of manipulation associated with adult masturbation appears at age 2 1/2 to 3 (Martinson, 1994). There is some question as to the infant's goal with self-stimulation, but it is thought to be pleasurable. In fact, there are cultures in which parents fondle infant's genitals in order to keep them quiet (Hyde & DeLamater 2003.)

Orgasms from masturbation are possible even at a young age although boys cannot actually ejaculate until puberty. Masturbation, even at this age, is both normative and may even be optimal. This was discovered as early as the 1940s through the work of Rene Spitz, an attachment theorist who studied the effects of inappropriate experiences of early care. Spitz (1949) compared infants with optimal and dysfunctional relationships with their mothers. He found that those infants with more optimal relationships were more likely to engage in masturbation, reinforcing the idea that masturbation is normative and healthy.

Infant masturbation tends to be a singular experience, but it is not uncommon for infants to masturbate alongside one another, reminiscent of the idea of parallel play. In later infancy there may be some infant to infant sexual encounters, in which children may pat, stroke or gaze at one another (Hyde & DeLamater, 2003; Lidster & Horsburgh, 1994.)

Freud's Oral Stage of Development

The experiences noted in this section form the basis of the first stage of Freud's psychosexual stages: the oral stage of development. This stage begins at birth. During the oral stage, the mouth is the primary focus of libidinal energy. Nursing infants derive pleasure from sucking and accepting things into the mouth. Should difficulties occur at this stage, such as problems with nursing, the adult may develop an oral character. The oral stage culminates in the primary conflict of weaning, which concludes the sensory pleasure of nursing. This stage lasts approximately one and one-half years (Freud, 2010; Gabbard, 2010).

Freud's Anal Stage of Development

At one and one-half years, the child enters the anal stage. This stage generally coincides with the beginning of toilet training. According to Freud, the child becomes preoccupied with the erogenous zone of the anus and with the retention or expulsion of the feces. There is a conflict between the id-driven compulsion and pleasure connected with the expulsion of bodily wastes, and the ego and superego, which represent parental and societal pressures to control bodily functions. Struggles around toileting may result in an anal fixation, leading to anal character traits. This stage lasts from one and one-half to two years (Freud, 2010; Gabbard, 2010).

Attachment

Freud's theory discusses the idea of attachment in only a peripheral way. Attachment theorists such as Bowlby (1988) and Ainsworth felt that psychoanalytic theory failed to see attachment as a psychological bond in its own right rather than an instinct derived from feeding or sexuality. These theorists look at the bonds between infant and caregiver as a pivotal organizing factor in the child's later capacity for relationships. Attachment theorists look not only at an individual's later emotional adjustment but also his or her ability to relate sexually. Early nongenital sensual experiences, such as rocking and cuddling, promote attachment bonds. These begin shortly after birth. The quality of these attachments, whether stable or secure or insecure and frustrating, seems to affect a person's capacity for adult attachment as well as adult sexuality (Bowlby, 2004).

Recognition of Male-Female Differences

As early as about age 2 ½, children begin to recognize gender differences and can identify themselves as male or female. They can generally identify which parent they are most like physically. Although initially their ability to differentiate genders is related to clothing style or hair, by age 3 there is awareness that genitals play a role in gender differentiation. There may be an interest in exploring these differences with other children (Martinson, 1994).

Sexuality In Early Childhood (Ages 3 to 7)

The early childhood years are marked by an increased interest in the environment as well as an increase in sexual exploration. As children become more social beings, their sexual interactions expand from self-focused activities, such as genital stimulation and masturbation, to other-focused activities. By interacting socially, children begin to learn what is socially acceptable and to learn privacy boundaries. For example, although the incidence of masturbation continues in frequency, children begin to learn that that masturbation is something that is done in private. This stage also marks the beginnings of both heterosexual and homosexual behavior. They may also have increased need for privacy while bathing and dressing (Pike, 2001).

In addition to increasing social interaction, there is more curiosity about the world in general and this extends to sexual realms. For example, three and four-year-olds are curious about where babies come from and ask these difficult questions (Pike, 2001).

Increasing Curiosity About Sex/Heterosexual Behavior

During this timeframe, and most specifically around the ages of 4 to 5, children's sexuality becomes social. This is most frequently exhibited in play, with children holding hands and kissing, likely imitating the adults around them or media they are exposed to. In early childhood, children become more curious and they explore other children and adults' bodies because of their curiosity. At this age children have increased interest in the differences between adult and children's bodies. Pretending to be mommy or daddy and "playing doctor" and become more common activities. The latter can be a somewhat controversial sexual milestone. "Playing doctor" generally involves children examining one another's genitals or engaging in fondling or touching. This behavior is considered normative if children are willing participants and are close in age, although it can be uncomfortable for some parents, who see it as a prelude to more adult sexuality (Heins, 2004; Kennedy, 2004; Pike, 2001.)

By about age 5, most children have formed a concept of what marriage is. This comes from direct observation in their own households as well as the influence of media. The concept of marriage is specifically a platonic one at this age. Children also seem to understand the idea that people marry those of another gender, and "playing house" is common. By about age four, girls may become intensely attached to their fathers and boys to their mothers (Hyde & DeLamater, 2003; Pike, 2001), a primary factor in Freud's phallic stage of development (to be discussed later in this section).

Some children first learn about sexual behavior by seeing or hearing parents engaged in sexual intercourse, the so-called *primal scene experience*. Freud and other psychoanalytic theorists proposed that such premature sexual exposure was harmful. Although many agree with this, subsequent research may not bear it out. Studies suggests that about 20 percent of middle class children have seen their parents engaged in intercourse.

Is exposure to the primal scene harmful? Researchers at the UCLA Family Lifestyles Project attempted to study this question. The researchers studied 200 male and female children in an 18-year longitudinal outcome study. At age 17 to 18, participants were assessed for levels of self-acceptance, relations with peers, parents, and other adults; antisocial and criminal behavior; substance use; suicidal ideation; quality of sexual relationships; and problems associated with sexual relations. No harmful “main effect” correlates of the predictor variables were found (Okami et. al, 1998).

Sexual Knowledge and Interests

At age 3 to 4 children first begin to recognize that there are genital differences between boys and girls. They notice these differences and may question them. There may be “marriage proposals to the parent of the opposite sex (Hyde & DeLamater 2003.)

At about the age of 4 there is an increased interest in bathrooms and concerns about elimination. Children this age may frequently use words that refer to bowel movements and urination.

It is at about the age of 5 to 6 that children in this age group begin to have more contacts outside the family. Other children may bring up new ideas about sex. Five- to seven-year-olds often increase their use of sexual or obscene language, and this is frequently to test parental reaction.

At about the age of 7, children generally give up wanting to “marry” mom or dad. They begin to become closer to the parent of the same sex. Children in this age group become more reticent about asking questions (Pike, 2004).

Homosexual Behavior

During later childhood, sexual play may involve members of the same gender. This generally involves touching or fondling (Martinson, 1994). Such play is normative and does not appear to mediate the development of adult sexuality.

Freud's Phallic Stage of Development

The phallic stage (ages 3–6) of development is probably the most well-known of Freud's stages due to his theory of the Oedipus/Electra complex. In this stage, the child's erogenous zone is the genital region. It is within the context of the child's natural curiosity about his and other people's genitals that the essential conflict — the Oedipus complex — arises. The Oedipus complex involves the child's unconscious desire to possess the opposite-sexed parent and to eliminate the same-sexed one (Freud, 2010; Gabbard, 2010).

According to Freudian theory, the child's identification with the same-sex parent is the successful resolution of the Oedipus complex and of the Electra complex. This is also a key psychological experience in developing a mature sexual role and identity. Freud thought that fixation at the phallic stage causes a person to be afraid or incapable of close love or a cause of homosexuality.

Sexuality in Preadolescence (Ages 8 to 12)

The ages of 8 to 12 reflect a transition from childhood to adolescence. For most children, it is during this timeframe that puberty occurs. While once thought to be a stage of latency in which sexual drive is dormant, Freud saw latency as a period of repression of sexual desires and erogenous impulses. According to the psychosexual theory, children transfer this repressed libidinal energy into asexual pursuits such as school, athletics, and same-sex friendships. Freud thought that it was only with the onset of puberty that sexuality reawakens and the genitals once again become a central focus of libidinal energy (Freud, 2010; Gabbard, 2010).

Although many parents would like to believe that preadolescence is a latency period, this does not actually seem to be the case. Children's interest in sexuality appears to remain active during this time (Martinson, 1994).

Puberty and pre-puberty

Puberty is the physical process of sexual maturation. The term puberty is derived from the Latin word *puberatum* (age of maturity) and refers to the bodily changes of [sexuality](#). In girls, puberty usually begins at 11 years of age, but may start as early as age 7. A recent study published in *Pediatrics* found that by age 7, about 10 percent of white and 23 percent of African-American girls had started developing breasts. A study published in 1997 found that 5 percent of white females and 15 percent of black females had reached puberty. Puberty, then, is occurring earlier.

Puberty is initiated by hormone signals from the brain to the gonads (the ovaries and testes). These hormones (estradiol and testosterone) stimulate the growth and function of the brain, skin, hair, breasts and sex organs. The most obvious of these changes are referred to as secondary sex characteristics, the most evident being breast development in females and facial hair in males.

Masturbation

During preadolescence, masturbation continues to be common. This is something of a learning tool for more adult sexuality. A study conducted by Bancraft et. al. (2002) found that 40 percent of college women and 38 percent of men reported masturbating during these years. For young women the road to masturbation is generally self-discovery; males learn about masturbation from peers.

Sexuality in Preadolescence

Research continues to confirm that the preadolescent years are not ones in which most children actually engage in sexual behaviors. The percentage of children who had initiated sexual intercourse before age 14 has actually decreased in recent years, from a high of 8 percent of girls and 11 percent of boys in 1995 to a low of 6 percent of girls and 8 percent of boys in 2002 (Abma et. al, 2004).

There is some thought that the separation of young men and women into social groups is one mediating factor in preventing premature sexual contact. This is a time period in which young men and women hear about sex and learn about sex but do not engage in sex (Hyde & DeLamater, 2003).

Because children are socializing primarily with others of the same sex, sexual exploration with same sex peers is normative. These activities involve masturbation, exhibitionism and fondling of one another's genitals (Hyde & DeLamater, 2003).

During preadolescence, many children begin "dating" for the first time. Dating is generally a group activity. Boys, who mature less quickly, are often slow to initiate kissing or other physical activities, although games involving kissing may be part of social gatherings such as mixed gender parties.

Sexuality in Adolescence (Age 13 to 19)

Of all the developmental timeframes discussed so far, adolescence is indisputably the time in which sexual maturation, interest and experience surge. This increased interest is caused by continued focus and awareness of body changes and rising hormone levels. There is also the cultural expectation that teens begin to prepare for more adult roles through dating and some degree of more intimate contact, which may or may not be sexual intercourse.

In fact, over ten years, the percentage of all high school students who report ever having had sexual intercourse has declined. Fewer than half of all 9-12th grade students report having had sexual intercourse, reflecting a decline from 53 percent in 1993 to 47 percent in 2003. Not surprisingly, young men are more likely than females to report having had sexual intercourse (CDC, 1993, 2003). At the same time, among sexually active teens, rates of contraceptive use have increased. These factors have helped to decrease teen pregnancy rates in recent years. Despite these trends, about a third (34%) of young women become pregnant at least once before they reach the age of 20 – about 820,000 a year (Henshaw, 2003) and approximately four million teens contract a sexually transmitted disease (STD) each year (American Social Health Association/Kaiser Family Foundation, 1998).

For both young men and young women testosterone level seems to have an affect on sexual activity. For young men this relationship is very strong. For young women it appears that testosterone levels, rather than levels of estrogen or progesterone levels,

was related to sexuality. For girls, pubertal development (developing a womanly figure) also had an effect on sexuality (Hyde & DeLamater, 2003).

Freud's Genital Stage of Development (puberty onwards)

In the genital stage libidinal energy once again focuses on the genitals and interest turns to relationships, specifically to romantic and sexual relationships with peers. This stage spans both adolescent and adult years.

Masturbation

One of the most important sources for statistics on sexuality is the *Kinsey Report*. Kinsey's data indicated that among the people surveyed 92% of males and 62% of females reported having masturbated. Kinsey stated: "Masturbation was the most important sexual outlet for single females and the second most important sexual outlet for married females, providing 7-10% of orgasms for those 16-40. Although these numbers include data that spans a wider age group than only adolescents age group (Gebhard, & Johnson 1979/1998; Kinsey, 1948/1998; Kinsey, 1953/1998).

According to the Kinsey data, there is a rise in masturbation in boys between the ages of 13 and 15, with about 85-90% of young men between these ages reporting masturbation. At about this age boys actually masturbate to orgasm. The Kinsey studies also found that although some girls also began to masturbate at that age, only about 20%. Masturbation in women actually peaks at age 30 and remains level from this point (Kinsey, 1948/1998; Kinsey, 1953/1998).

Homosexual Behavior

About 10 percent of college-age men and 6 percent of women report having one homosexual partner in high school (Bancroft, Herbenick & Reynolds, 2002). This does not necessarily indicate that such experiences will translate into adulthood. Troiden (1979) proposes a state model for development of gay identity. Troiden's model, based on a qualitative study, looks at how men learn that they are homosexual and how they integrate this preference into their identity or self-conception.

The first stage of Troiden's (1979) model, which he labels *Sensitization*, occurs during adolescence, specifically between the ages of 13 and 17. During this time men gain experiences that later serve as the sources for interpreting their feelings as homosexual. They may not be fully aware at this point of their sexual orientation. Some of the aspects of this stage include a general sense of alienation, warmth and excitement while in the presence of other males, effeminacy, and guilt over sexual activities. They may have homosexual fantasies or report developing a "crush" on another young man.

During Stage 2, *Dissociation and Signification*, which occurs at about age 17, the person may actually partition these feelings, but they also begin to question the

nature of their sexual orientation. Stage 3, *Coming Out*, involves labeling one's sexual feelings as homosexual.

First Sexual Experience

The teen years are often the time when young men and women have their first sexual experience. The median age at first intercourse is 16.9 years for boys and 17.4 years for girls (Alan Guttmacher Institute, 2002). The percentage of 9-12th grade students who report having had four or more sexual partners has declined in recent years from 19 percent in 1993 to 14 percent in 2003. Males (18%) are more likely than females (11%) to report having had four or more sexual partners.

That is not to say that all teens are engaging in sexual intercourse. In 2003, 66 percent of high school students were currently abstinent, meaning they had not engaged in sexual intercourse over the last 3 months. Among teens aged 15-17 who have never had sexual intercourse, 94 percent said that concern about pregnancy influenced their decision to wait. Similar numbers said that concern about HIV/AIDS (92%), other STDs (92%) and feeling 'too young' (91%) contributed to their choice (CDC, 2003; Kaiser Family Foundation and Seventeen, 2003).

For those who are sexually active, the first sexual intercourse is a major transition both psychologically and socially (Hyde & DeLamater, 2003). There appear to be gender difference in the experience of first sexual intercourse with young men reporting more sexual pleasure and less guilt than young women. Attitudes towards premarital intercourse generally fall into four categories (Reiss, 1960).

1. Abstinance: a standard in which premarital sexual intercourse is considered wrong, regardless of circumstances
2. Double Standard: a standard in which males are considered to have greater right to premarital intercourse.
3. Permissiveness without affection: a standard in which premarital intercourse is considered right for both sexes regardless of emotional involvement
4. Permissiveness with affection: a standard in which premarital intercourse is considered right for both sexes if part of a committed relationship

There seems to be somewhat of a trend towards more casual sexual encounters beginning during adolescence and continuing in college. This phenomenon is colloquially known as *friends with benefits*, in which two people may have a sexual relationship without demanding or expecting the commitment of a romantic relationship.

Grello, Welsh, and Harper (2006) studied the circumstances associated with casual sex encounters, in order to identify the link between casual sex, depressive symptoms, and infidelity among college students. They found that casual sex was a common occurrence. First sexual experiences took place more frequently with a

casual sex partner was frequently connected with drug use and alcohol consumption. Casual sex occurred more often between “friends” than with strangers. Males who engaged in casual sex reported the fewest symptoms of depression, and females who had a history of casual sex reported the most depressive symptoms.

Another frequently seen occurrence was that of *serial monogamy* in which premarital sex occurred with the intention of being faithful to that partner; when the relationship ended, however, one or both partners moving on to another relationship (Wright, 1994).

Teen Pregnancy

The U.S. teen pregnancy rate (the number of pregnancies per 1,000 females aged 15-19) decreased 28 percent between 1990 and 2000, dropping from 117 pregnancies per 1,000 females aged 15-19 in 1990, to 84 per 1,000 in 2000. Teen pregnancy rates vary widely by racial/ethnic group. While teens of all races have experienced steady declines in pregnancy rates since the 1990s, African Americans (154 per 1,000) and Latinas (140 per 1,000) have higher rates of than their white counterparts (Henshaw, 2003).

While these numbers are encouraging, the issue of teen pregnancy remains an important one. Furstenberg, Brooks-Gunn and Morgan (1989) studied adolescent mothers in later life. They found that up to 5 years after their pregnancies 49% had not graduated from high school and one-third were on Welfare. Many of these young mothers do recover from the initial problems, going on to graduate from high school and college. Some remain impoverished. The factors that played the most importance were that women whose parents were more educated tended to do better. Those women who were more successful prior to the pregnancy, such as being good students, tended to do better than those who were not.

Summary

Childhood and adolescence is a time of burgeoning sexuality. Each stage has its own developmental sexual milestones and problems. Understanding of the biological and psychological aspects of sexuality informs of understanding among children, adolescents and adults.

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Topics in Human Sexuality: Sexuality Across the Lifespan Adulthood/Male and Female Sexuality

Introduction

The development of sexuality is a lifelong process that begins in infancy. As we move from infancy to adolescence and adolescence to adulthood, there are many sexual milestones. While adolescent sexuality is a time in which sexual maturation, interest and experience surge, adult sexuality continues to be a time of sexual unfolding. It is during this time that people consolidate their sexual orientation and enter into their first mature, and often long term, sexual relationships. This movement towards mature sexuality also has a number of gender-specific issues as males and females often experience sexuality differently. As people age, these differences are often marked. In addition to young and middle age adults, the elderly are often an overlooked group when it comes to discussion of sexuality. Sexuality, however, continues well into what are often considered the golden years.

This course will review the development of sexuality using a lifespan perspective. It will focus on sexuality in adulthood and in the elderly. It will discuss physical and psychological milestones connected with adult sexuality.

Educational Objectives

5. Discuss the process of attaining sexual maturity, including milestones
6. Compare and contrast remaining singles, getting married and cohabitating
7. Discuss sexuality in marriage including factors that lead to lack of marital satisfaction
8. Discuss marital or partnered sexuality including frequency of sexual intercourse, common sexual acts, and masturbation patterns
9. Review physical and emotional factors in sex after pregnancy.
10. Discuss infidelity, including statistics, behaviors, and risk factors.
11. Discuss factors related to aging.

Milestones in Adult Development

As in many cultures, the United States has various norms for sexuality. Adolescence is a time when teens try on many "sexual hats" in order to determine what is sexually pleasing. In the adolescent years, most adolescents are not engaging in partnered sexual behavior; solo masturbation is the most prevalent teenage sexual activity with rates as high as 43% of males and 37% of females (NSSHB, 2010). In early adulthood, people move toward mature, adult sexuality. Hyde and DeLamater (2003) term this a period of sexual unfolding, and include several factors in this process.

First is the development of sexual orientation. It is estimated that 10% of people are exclusively homosexual (Elmore, 2006), making heterosexuality the more prevalent sexual orientation. According to a research by Chandra et al (2011), who looked at

sexual contacts by gender, about 4%–6% of males have had same-sex contact. For females, the percentage of people who have had same-sex contact ranges from about 4% to 11%–12%. It is likely that many people explore these feelings in early adulthood, but many do not act on them due to strong societal prohibitions against homosexuality. Men more than women seem to struggle with these societal norms. Hyperheterosexuality an established part of the male role (Hyde & DeLamater, 2003) and homosexual feelings are often ignored as a result.

The trend towards more mature sexuality can be seen in data from a 2010 Kinsey survey. More than half the participants in the 2010 national sex survey ages 18-24 indicated that their most recent sexual partner was a casual or dating partner. For other age groups, the majority of study participants indicated that their most recent sexual partner was a relationship partner.

Another task of adult sexual development is learning sexual likes and dislikes and effectively communicating these to a partner (Hyde & DeLamater, 2003). This is often a process of sexual experimentation.

Singles, Marrieds and Cohabitators

During adulthood, people choose to enter into intimate or sexual relationships or to remain uncoupled. The U.S. government defines marriage as a social union or contract between people that creates kinship. Marital relationships involve many components: legal, social, spiritual, economic and sexual. The institution of marriage predates recorded history, and has primarily been defined as a partnership between two people of the opposite gender.

A relatively new practice involves same-sex couples being granted the legal marital recognition as commonly used by mixed-sex couples. The federal government does not recognize same-sex marriage in the United States, but such marriages are recognized by some individual states. As of January 2010, 29 states had constitutional provisions restricting marriage to one man and one woman, while 12 others had laws "restricting marriage to one man and one woman."

The term *never married* refers to adults who have never been married. Thirty percent of Americans have never been married — the largest percentage in the past 60 years, according to the latest U.S. Census (2010). Among those ages 25 to 29, the never-marrieds increased from 27% in 1986 to 47% in 2009.

Given these statistics, it appears that most people in our society do eventually marry. Prior to making a marital commitment, many young adults engage in a pattern of serial monogamy, dating one exclusive partner, ending the relationship, then dating another. Males 30-44 report an average of 6-8 female sexual partners in their lifetime, while females 30-44 report an average of 4 male sexual partners in their lifetime. 56% of American men and 30% of American women have had 5 or more sex partners in their lifetime (Mosher, Chandra, & Jones, 2005).

There has been some change in dating patterns with the surge of Internet dating sites. This has vastly expanded the dating pool, which previously had included couples meeting through the introductions of family and friends and through institutions such as church and school.

In early adulthood, it is common for couples to experiment with commitment at varying degrees, such as from an exclusive dating relationship to living together. Cohabitation refers to an arrangement whereby two people decide to live together on a long-term basis in an emotionally or sexually intimate relationship. From a sexuality perspective, it is interesting that cohabitation is a public declaration of a sexual relationship (Hyde & DeLamater, 2003). Cohabitation has become more common, and is sometimes an end to itself and not a precursor to marriage.

Cohabitators do appear to engage in sexual behavior with more frequency than married persons. A sample of 7,000 adults found that married couples had sexual intercourse 8 to 11 times per month while those who lived together engaged in sexual intercourse 11 to 13 times per month (Call et al, 1995).

Sex and the Married Couple

Case Vignette

Kevin and Marie, ages 28 and 26 respectively, have been married for 7 years and are seeking marital counseling. In assessing their degree of intimacy, Dr. Janey found that a frequent source of conflict between the couple was what Kevin viewed as a rejection. The couple reported engaging in sexual intercourse approximately once a week; Kevin, however, felt that anything less than 2-3 times per week was insufficient and a cause of the other problems in the marriage. How much is "normal," asks Kevin.

Questions such as this are a frequent source of discussion in marital as well as individual counseling. Although it is difficult to identify a norm, it appears that engagement in sexual intercourse is mediated by age (see chart below). As would be expected, frequency declines as both men and women get older. The explanation for this is both biological, such as decrease in vaginal lubrication and poor health, and psychological, habituation to sex with the same partner. As with the case vignette, research has found that sexual inactivity has been associated with unhappiness in the marriage (Donnelly, 1993; Huston et al, 1996). Sexual dissatisfaction is associated with increased risk of divorce and relationship dissolution. (Karney, 1995).

A large-scale study by Donnelly (1993) analyzed marital sexuality. Donnelly interviewed 6,029 married people to determine which factors are related to sexually inactive marriages and if sexually inactive marriages are less happy and satisfying than those with sexual activity. Donnelly measured nineteen independent variables including: life satisfaction, religious fundamentalism, gender role traditionality, individualism, marital interaction variables, and marital happiness. She found that

the lower the marital happiness and shared activity, the greater the chance of sexual inactivity and separation. Sexual inactivity was found to be associated with old age, the presence of small children, poor health, and in males, duration of marriage. Sexually inactive marriages are not happy, therefore, are not satisfying marriages.

Another study of married couples found age and marital satisfaction to be the two variables most associated with amount of sex. As couples age, they engage in sex less frequently with half of couples age 65-75 still engaging in sex, but less than one fourth of couples over 75 still sexually active. Across all ages couples that reported higher levels of marital satisfaction also reported higher frequencies of sex. (Call, 1995).

The results of a large-scale study of married men and women is reported below.

Kinsey Institute (NSSHB, 2010)

Percentage of Married Men Reporting Frequency of Vaginal Sex, N=2396 Age Group

	18-24	25-29	30-39	40-49	50-59	60-69	70+
Not in past year	4.2	1.6	4.5	9.1	20.6	33.9	54.2
A few times per year to monthly	12.5	9.3	15.6	16.2	25.0	21.2	24.2
A few times per month to weekly	30.0	36.4	32.5	24.1	31.8	20.5	63.2
2-3 times per week	26.0	27.1	39.0	25.3	18.8	38.6	0.0
4 or more times per week	10.0	6.3	6.5	11.5	4.7	2.3	0.0

Percentage of Married Women Reporting Frequency of Vaginal Sex, N=2393 Age Group

	18-24	25-29	30-39	40-49	50-59	60-69	70+
Not in past year	11.8	3.5	6.5	8.1	22.0	37.0	53.5
A few times per year to monthly	14.7	11.6	16.3	21.7	23.7	20.0	25.4
A few times per month to weekly	14.7	47.7	50.2	46.6	36.2	35.9	18.3
2-3 times per week	35.3	35.2	21.9	20.8	16.9	6.2	1.4
4 or more times per week	23.5	2.0	5.1	2.7	1.1	0.0	1.4

Marital and Partnered Sexuality

The chart above describes the frequency of vaginal sexual intercourse. According to the National Survey of Sexual Health and Behavior (NSSHB), there is much variability in the sexual repertoires of U.S. adults, with more than 40 combinations of sexual activity described at adults' most recent sexual contact. It is rare that adult men and women engage in just one sex act when they have sex. While vaginal intercourse is still the most common sexual behavior reported by adults, many sexual events do not involve intercourse and include only partnered masturbation or oral sex (NSSHB, 2010). Determining what marital sexuality will be like has sometimes been described as a "mating dance," or as the process of "negotiating sex."

Sexual Practices

So what is "having sex"? In a recent study at The Kinsey Institute, nearly 45% of participants considered performing manual-genital stimulation to be "having sex," 71% considered performing oral sex to be "sex," 80.8% for anal-genital intercourse. Considerations of "sex" also varied depending on whether or not a condom was used, female or male orgasm, and if the respondent was performing or receiving the stimulation (NSSHB, 2010).

One sexual behavior that is often considered to be more taboo is anal intercourse. Part of the taboo concerns the perception that anal sex is generally a homosexual act. Anal sex commonly refers to the sex act involving insertion of the penis into the anus of a sexual partner. The term can also include other sexual acts involving the anus, anilingus (anal-oral sex). Anal sex it is not rare, although it is reported by fewer women than other partnered sex behavior. Partnered women in the age groups between 18-49 are significantly more likely to report having anal sex (NSSHB, 2010).

Masturbation

While many people think that the trend to mature sexuality means that masturbation is unusual in adulthood, this is not the case. Many people masturbate, even while they are married and have access to consensual sex. This behavior is normal, but can sometimes be kept secret due to feelings of guilt. According to one study of the masturbation habits of men and women, nearly 85% of men and 45% of women who were living with a sexual partner reported masturbating by themselves in the past year (Laumann, Gagnon, Michael, Michaels, 1994). Masturbation, then, appears to be a healthy sexual outlet.

Within relationships, another pattern involves partnered or mutual masturbation. Mutual masturbation is a sexual act where two or more people stimulate themselves or one another sexually, usually with the hands. Across all age groups, partnered women are significantly more likely to report having engaged in partnered masturbation as compared to nonpartnered women (NSSHB, 2010).

Changes in Sexual Patterns

Case Vignette

Sarah and John are presenting for counseling. John feels like his whole world has turned upside down following the birth of his son, who is now 8 months old. "Sarah and I used to be so close, and had a great sex life," he says. "Since the baby has been born we've had sex a total of one time. She's just not interested."

Within marriage and partnerships, there are changes in sexual patterns. There is often a decrease in the number of sexual encounters due to habituation □ couples becoming accustomed to one another sexually, which results in decreased interest in sex.

Pregnancy

Another time in which there is much change in sexual patterns is following a pregnancy. These changes are at least initially motivated by physical parameters, but may also be psychological.

After pregnancy, sexual contact is often delayed for several weeks or months, and may be difficult and painful for women. Injury to the perineum or episiotomy are common reasons, as is vaginal dryness may occur following giving birth for about three months due to hormonal changes. Women who breast-feed are more likely to report painful sex and reduced libido, both due to hormonal changes such as a reduction in levels of estrogen. A water-soluble lubricant, such as K-Y jelly or AstroGlide, may be helpful in reducing dryness and discomfort. Although sexual activity other than intercourse is possible sooner, some women experience a prolonged loss of sexual desire after giving birth. Although this is not uncommon, it is always advisable to consult with a physician.

Infidelity

Case Vignette

Joslyn and Eric have been married for 8 years. Joslyn has recently noticed that Eric has become more distant. She was shocked to find that he had been exchanging text messages with a female co-worker. Although Eric denies that the relationship was in any way physical, Joslyn feels angry and hurt. She expresses uncertainty that she will be able to move past her feelings of betrayal.

Within intimate, partnered, and marital relationships, there is generally a belief in the exclusivity of the relationship, particularly sexual exclusivity. Infidelity is a breach of this expectation. Infidelity tests relationships and results in feelings of betrayal and mistrust. In our culture there is also a strong prohibition against infidelity, which includes both sexual breaches and emotional unfaithfulness. Smith (1994) surveyed Americans about infidelity and found that 90% of the general public agree that it is

“always” or “almost always” wrong for a married person to engage in extramarital sex. The prohibition against infidelity also extends across cultures. Betzig (1989), for example, found Infidelity to be the most cited cause of divorce in over 150 cultures. Within the counseling relationship, many couples seeking counseling are presenting due to one partner’s unfaithfulness.

How common is infidelity? Two studies of extramarital sex found similar statistics: approximately 20-25% of men and 10-15% of women engage in extramarital sex at least once during their marriage (Laumann, 1994; Wiederman, 1997). These studies did not include a sampling of cohabitating individuals. Treas and Giesen (2000) looked at infidelity among couples that are married or living together in a partnered relationship. The researchers found that 11% of adults who have ever been married or cohabited have been unfaithful to their partner (Treas & Giesen, 2000).

The faces of infidelity

There is some variability in what is considered infidelity. Certainly, sexual contact outside of a marital or partnered relationship is considered infidelity (except, of course, if the couple has the understanding that that is acceptable to both of them, such as in the case of an “open” marriage). There is less consensus, however, about other things that may be considered infidelity.

One such argument involves the idea of emotional infidelity □ emotional involvement with another person, which leads to the channeling of emotional resources, such as time and attention, to someone else.

Another area that leads to disagreement is the use by one partner of pornography. This has become a particular concern in the age of the Internet. In a recent national study of Internet pornography, 14% of people reported having used a sexually explicit website ever, men more so than women. 25% of men reported visiting a pornographic site in the previous 30 days; 4% of women reported visiting pornographic sites in the same timeframe. (Buzzell, 2005). Additionally Mitchell et al. (2005) found that overuse, pornography, infidelity, and risky behaviors are among the most frequently treated Internet-related problems by mental health professionals. Although these areas are ones that merit further study, such statistics cannot be ignored.

Factors that contribute to infidelity

Infidelity is influenced by many social and demographic factors. (Treas & Giesen, 2000) looked at these factors in a recent study. These researchers attempted to determine why some people are sexually exclusive while others have sex with someone besides their mate. Previous research had linked personal values, sexual opportunities, and quality of the marital relationship to extramarital sex. Treas and Giesen (2000) conducted a national survey of married and cohabitating couples. The researchers found that there is a higher likelihood of sexual infidelity among those with stronger sexual interests, more permissive sexual values, lower subjective

satisfaction with their union, weaker network ties to partner, and greater sexual opportunities. Infidelity was also associated with having been part of a couple for a long time; having had a high number of prior sex partners and being male.

Sexuality and Aging

Case Vignette

Benjamin, age 74, and Jeanette, age 66, have been married for 47 years. They have weathered many challenges during this time, but are now really struggling. Their sex life, which had been mutually satisfying, has deteriorated due to Benjamin's impotence. Although Jeanette has been patient, she is upset that her proud husband will not tell him doctor about the problem.

Sexuality occurs across the lifespan. Although there is some decline in the frequency of sexual contact as men and women age, many older men and women continue to be sexual (see the chart below). Many of the issues previously discussed, such as sexual communication issues and relational problems, apply to aging people. There are, however, specific, aging related issues that require some adaptation. While these do not apply to all older adults, it is helpful to understand some of the physical and psychological changes associated with aging.

Kinsey Institute

Frequency of Sexual Intercourse

Frequency	Men 50-80+	Women 50-80+
Not in past year	46.4	58.0
A few times per year	17.8	13.5
2 or 3 times per week	24.6	20.3
A few times per month	10.2	6.8
4 or more times per week	0.9	1.4

People over 50 are the fastest growing segment of the U.S. population. According to a recent factsheet on aging, the number of Americans age 55 and older will almost double between now and 2030 – from 60 million today to 107.6 million as Baby Boomers reach retirement age.

The current population of older adults is one of the most highly educated and financially sound groups in history. It is also a very active group: nearly half of all Americans age 55 and over volunteered at least once in the past year. Even among those age 75 and older, 43 percent had volunteered at some point in the previous year. Older Americans no longer see retirement as an “endless vacation,” but

increasingly as an active, engaged phase of life that includes work and public service (Fact Sheet on Aging, Experience Corps, <http://www.experiencecorps.org>).

Although this is clearly a vibrant group of men and women, there are certain aspects of aging that can negatively affect sexual interest, activity and satisfaction. Among these factors are losses, changes in body image, changed living arrangements and physical changes associated with aging.

Psychological Changes

Societal Prohibitions against Sexuality/Reactions to Aging

Ageism extends to our beliefs about sexuality. Older adults are often indirectly told that sexuality is for the young. Images in the media equate sexuality with youth. Sexual attractiveness, then, is often connected with the young. For women in particular there is a sexual double standard. Men are often thought to maintain their sexual activity, while older women are not. Sexually appealing women are depicted as young, and the importance of maintaining youth is supported by cosmetics that hide gray hair, wrinkles, etc. Women then are more prone to developing concerns about the physical aspects of aging, such as drooping breasts, weight gain, etc. There has been a rise in the number of late stage eating disorders, and these body image issues play a role in the increase. Body image, of course, affects sexuality (Crooks & Baur, 2000).

Loss of a Partner

Loss of a partner is a life crisis that many men and women will face over the course of their lifetime. Although people react to this crisis in many ways, some eschewing further relationships and some open to them. Women statistically have a longer life expectancy than men. More men than women, however, go on to remarry. One problem sometimes seen in this situation is the aptly named “widowers syndrome” in which a man can become sexually aroused by a new partner but cannot maintain an erection (Rossi, 1999) and which is often a result of survivor’s guilt. Women can experience the same problem.

Changes in Living Environment

With increasing medical needs, many elderly people need to enter nursing homes or assisted living facilities. These environments often fail to address the sexual needs of older men and women. There may be restrictions on behavior or the inability to live with a spouse or partner. There are sometimes similar issues when an aging parent goes to live with a child. These issues need to be considered in making choices about living situations.

Physical Changes

There are many physical changes associated with healthy aging which are described below. Additionally there are illnesses that may limit a person's ability to relate sexually.

Physical Changes in Women (Zeiss & Kasi-Godley, 2001)

- Reduced levels of hormones (estrogen, progesterone, androgen)
- Thinning of vaginal walls
- Decreased vaginal lubrication
- Changes in the labia, making penetration more difficult
- Reduction in vaginal contractions

Physical Changes in Men (Zeiss & Kasi-Godley, 2001)

Reduced levels of hormones (testosterone)

Decreased firmness during erections

Reduction in amount of ejaculate

Longer refractory period

Need for more direct stimulation to support erection

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Topics in Human Sexuality: Fertility

Introduction

Case Vignette

Joanne, who is 24 and her husband John, age 28 have been trying to conceive a child for the past year. Joanne is particularly upset about the fact that she is not pregnant as she has always seen herself as a mother. John is more ambivalent, stating that they are happy as a couple, and a child isn't essential. Joanne has become increasingly more depressed, and is crying when she sees another couple with a baby. This has created a great deal of friction with John, who thinks she needs to "relax more." Joanne is angry, and questions whether John will support her in her quest to have a baby.

This case vignette illustrates many of the factors seen in individuals and couples experiencing fertility issues. Many men and women assume that the ability to become pregnant when they are ready is a given. In fact, pregnancy is a complex process, and can become derailed at any point. Infertility is actually a common problem. According to the Centers for Disease Control and Prevention (CDC, 2002), approximately ten percent of women, or 6.1 million women in the United States have difficulty getting pregnant or staying pregnant. Of these women, many seek fertility treatment.

Infertility may be the result of many causes. Fertility concerns may be related to the male or female partner. There are currently many effective therapies for overcoming infertility.

The process of fertility treatment is quite stressful, physically as well as emotionally. Many women and couples experiencing infertility keep the struggle private, and do not have sources of support. Couples need to learn a new language rife with medical terminology. Treatment demands may add stress to the relationship. Even with treatment, there are not guarantees that the couple will be successful in achieving a pregnancy. For this reason, counselors need to be aware of the issues surrounding infertility and fertility treatment.

This module will provide an overview of fertility. After completing this module, clinicians will be more aware of the factors associated with fertility treatment.

Objectives

1. Define infertility, and list the stages of conception.
2. List common fertility problems in women.
3. Describe fertility testing in women.
4. Discuss factors contributing to male factor infertility.
5. Describe components of a sperm analysis.
6. Discuss infertility treatment options.
7. Describe the use of Intrauterine Insemination (IUI).

8. Discuss the various types of Assisted Reproductive Technologies (ART).
9. Define and discuss selective reduction.
10. Discuss the use of surrogacy/gestational carriers.

Defining Infertility

Infertility is defined as the inability to become pregnant after one year of not being able to get pregnant despite having frequent, unprotected sex for at least a year. If a woman is 35 years of age or older she would be considered to be infertile after six months. Women who can become pregnant but are unable to stay pregnant may also be considered to be infertile.

For couples in which there are no fertility issues, most achieve pregnancy within the first six months of actively trying to conceive. After 12 months of unprotected intercourse about 90 percent of couples will become pregnant.

Conception

In order to better understand infertility and the treatment processes that accompany fertility treatment, it is important to review what occurs during conception.

Conception involves six primary processes. These are:

- Production of follicle stimulating hormone (FSH)
- The release an egg or eggs from the ovaries (ovulation).
- Development of the follicle into the corpus luteum (luteal phase)
- The egg is released through a fallopian tube and travels toward the uterus (release)
- The man's sperm penetrates the egg resulting in the zygote (fertilization).
- The fertilized egg attaches to the inside of the uterus (implantation).

Infertility can occur if there are problems with any of these steps. That said, infertility is not always due to physiological problems with the woman (female factor infertility). In fact, about one third of fertility issues are due to the woman; another one third of fertility problems are due to the man. Another one third of cases are caused by a mixture of male and female problems or cannot be traced to a cause (unexplained infertility).

Conception

Role of FSH

The body begins to produce follicle-stimulating hormone (FSH) several days after the onset of menses. The increased levels of FSH result in the formation of a mature egg-containing follicle on one of the ovaries.

Ovulation

A woman's ovaries contain about 400,000 small fluid-filled cysts, known as ovarian follicles by the time she reaches puberty. Each ovarian follicle contains a hollow ball of cells with an immature egg in the center. Each month, between ten and 20 follicles begin the process of maturation. Generally only one of the follicles actually develops completely (maturation). The dominant follicle contains the growth of any other less mature follicles. These stop growing and break down.

The Corpus Luteum (Luteal Phase)

Following ovulation, the ruptured follicle develops into a structure called the corpus luteum. The corpus luteum secretes progesterone and estrogen. These hormones, particularly the progesterone, cause changes in the lining of the uterus. The lining thickens, which makes it more suitable for implantation of the fertilized egg and the nourishment of the embryo.

Release of Egg

When the follicle has adequately matured, a surge of luteinizing hormone (LH) is triggered. This surge will prompt the follicle to burst and release the egg into the fallopian tube, where fertilization may take place. Fertilization can take place for about a 24-hour period after ovulation. On average, ovulation and fertilization occurs about two weeks after the woman's last menstrual period. If the egg is not fertilized, the corpus luteum becomes inactive after 10–14 days and menstruation occurs. This causes the endometrium, the inner membrane of the uterus, to slough off, resulting in menstrual bleeding.

Fertilization

If sperm does meet and enter a mature egg after ovulation, it will fertilize it. When the sperm enters the egg, changes occur in the protein coating around it. These changes prevent other sperm from entering the egg. At the time of fertilization, the resulting baby's genetic make-up is complete and contains all genetic information, including the child's gender.

Implantation

Within 24-hours after fertilization, the egg begins dividing rapidly into many cells. The egg remains in the fallopian tube for approximately three days. The fertilized egg, now called a zygote, continues to divide as it passes through the fallopian tube. It then enters the uterus attaches to the endometrium. The zygote first becomes a solid ball of cells, then changes into a hollow ball of cells called a blastocyst. Before implantation, the blastocyst ruptures its protective covering. The blastocyst then establishes contact with the endometrium, an exchange of hormones helps the blastocyst attach. The endometrium then becomes thicker and the cervix (neck of the uterus) is sealed by a plug of mucus. Within three weeks, the blastocyst begin to grow and the baby's first nerve cells form. The developing baby is called an embryo from the moment of conception to the eighth week of pregnancy.

Fertility Problems in Women

Although it is impossible to provide an exhaustive list of what causes fertility problems in women, there are a number of more commonly seen concerns. These are:

Ovulation Disorders. Without ovulation, there are no eggs to be fertilized. Signs that a woman is not ovulating normally include irregular or absent menstrual periods. Ovulation problems are often caused by *polycystic ovarian syndrome* (PCOS) a hormonal imbalance that can interfere with normal ovulation. *Primary ovarian insufficiency* occurs when a woman's ovaries stop working normally before she is 40. This differs from early menopause, as women with primary ovarian insufficiency are able to become pregnant with treatment; women who have gone through menopause cannot. The exact cause of primary ovarian insufficiency is unknown, but it does appear to run in families. Ovulation disorders are discussed in more detail below.

Blocked fallopian tubes. If fallopian tubes are blocked, it will prevent the egg from being available to be fertilized. Blocked fallopian tubes may be the result of pelvic inflammatory disease, endometriosis, or surgery for an ectopic pregnancy.

Physical problems with the uterus. A healthy uterus or womb is where the embryo will reside. Physical problems of the uterus may include uterine fibroids, non-cancerous clumps of tissue and muscle on the walls of the uterus. Uterine fibroids do not always result in infertility.

Other things that can contribute to female factor infertility include:

- **Age.** As women age, their ovaries become less able to release eggs, there are a smaller number of eggs left, and egg quality is diminished.
- **Excess alcohol use.** Alcohol abuse is associated with hypothalamic-pituitary-ovarian dysfunction resulting in amenorrhea (absence of menses), anovulation (lack of ovulation), and luteal phase defect (abnormal development of the endometrial lining).
- **Excessive stress.** Chronic stress affects the hypothalamus, the part of the brain that controls the release of hormones.
- **Poor diet.** If diet is poor, the body does not have the proper nutrients necessary to maintain reproductive health.
- **Weight.** Excessively high or low weight can affect fertility. Weight loss of 5% to 10% may dramatically improve ovulation and pregnancy rates. Overweight

women are at increased risk for infertility and miscarriage. Both under and overweight women may have irregular menstrual cycles (American Society For Reproductive Medicine).

- Some health problems also increase the risk of infertility:
 - Irregular periods or no menstrual periods
 - Endometriosis
 - Pelvic inflammatory disease

Ovulation Disorders

Ovulatory disorders are one of the leading causes of infertility. In *anovulation* eggs do not develop properly, or are not released from the follicles of the ovaries. Women with anovulation may not menstruate for several months. Others may menstruate, although they are not ovulating. Anovulation may result from hormonal imbalances, eating disorders, and other medical disorders. Often, however, the cause is often unknown.

Oligo-ovulation is a disorder in which ovulation doesn't occur on a regular basis. In oligo-ovulation the menstrual cycle may be longer than the normal cycle of 21 to 35 days.

The treatment for ovulation disorders generally involves medication to stimulate ovulation. A commonly prescribed medication is Clomid. Ovulation is generally carefully monitored through ultrasound and blood tests.

Luteal Phase Defect

Luteal phase defect is a common but misunderstood condition that frequently affects fertility. The luteal phase of the menstrual cycle spans the time between ovulation and the onset of the next menses. Luteal phase defect is a failure of the uterine lining to be in the right phase at the right time. Since embryo implantation is highly dependent on the state of the lining, Luteal phase defect can consistently interfere with a woman's ability to get pregnant and carry a pregnancy successfully.

A normal cycle can be disrupted in several places: poor follicle production, premature demise of the corpus luteum, and failure of the uterine lining to respond to normal levels of progesterone. These problems can also be found in conjunction with each other.

Diagnosis of Female Infertility

Diagnosis of female factor infertility generally involves a thorough medical history and tests:

- *FSH blood level* - measures the amount of follicle stimulating hormone (FSH) in the blood. FSH stimulates production of eggs and a hormone called estradiol during the first half of the menstrual cycle.
- *Progesterone blood level* - Serum progesterone is a test to measure the amount of progesterone in the blood. Progesterone is a hormone produced in the ovaries. Progesterone helps ready the uterus implantation of a fertilized egg.
- *Ultrasound* - Used to determine if follicles developing; time follicles are released and to evaluate ovarian function.
- *Endometrial biopsy* - a procedure in which a sample of endometrial tissue is examined to determine if it is developed enough to support a pregnancy. This is often used in diagnosing luteal phase defects.
- *Hysterosalpingography*. An x-ray of the uterus and fallopian tubes. Doctors inject a special dye into the uterus through the vagina. The physician can then watch to see if the dye moves freely through the uterus and fallopian tubes in order to look for physical blocks that may be causing infertility.
- *Laparoscopy*. A minor surgery to look inside the abdomen. With the laparoscope, the doctor can check the ovaries, fallopian tubes, and uterus for disease and physical problems.

Male Infertility

Infertility in men is most often caused by problems that affect the sperm. Sperm production is actually a complex process that involves the testicles and hypothalamus and pituitary glands. Sperm is first produced in the testicles, until they combine with semen and are ejaculated from the penis. Problems with any of these systems can affect sperm production. In addition, abnormal sperm shape (morphology) and movement (motility) may also negatively impact fertility.

Some commonly seen problems are:

Varicocele. In this condition the veins on a man's testicle(s) are too large. This heats the testicles, which in turn can lead to reduced sperm count and fewer moving sperm.

Sperm duct defects. The tubes that carry sperm can be damaged by illness or injury. Some men are born with a blockage in the part of the testicle that stores sperm or a

blockage of one of the tubes that carry sperm out of the testicles. Men with cystic fibrosis and some other inherited conditions may be born without sperm ducts.

Infection. Some infections can interfere with sperm production and sperm health or can cause scarring that blocks the passage of sperm. These include some sexually transmitted diseases, such as Chlamydia and gonorrhea; inflammation of the prostate; and inflamed testicles due to mumps.

Lack of ejaculation. *Some men with spinal cord injuries or certain diseases can't ejaculate semen, even though they still produce sperm.*

Hormone imbalances. Low testosterone (male hypogonadism) and other hormonal problems can lead to infertility.

Seminal fluid abnormalities. If the seminal fluid is very thick, it may be difficult for the sperm to move through it and into the woman's reproductive tract.

Drugs. There are a number of common drugs that may have a negative effect on sperm production and/or function. They include:

- Antibiotics: Nitrofurantoin, Erythromycin, Gentamicin
- Methotrexate (cancer, psoriasis, arthritis)
- Cimetidine (for ulcer or reflux)
- Calcium Channel Blockers (anti-hypertensives)

Other things that can contribute to male factor infertility include:

- *Excessive alcohol use.* Moderate alcohol use does not affect male fertility. Excessive alcohol is toxic to the gonads. It may also cause liver dysfunction and nutritional deficiencies, which harm sperm production.
- *Drugs* (marijuana, cocaine, anabolic steroids). These can lead to decreased sperm count, motility, and problems with morphology (sperm shape).
- *Cigarettes.* Regular smoking causes a 23% decrease in sperm density and a 13% decrease in motility (The American Society for Reproductive Medicine, 2003).
- *Exercise.* Long-distance runners and cyclists have decreased spermatogenesis, causing sperm cells to divide abnormally.
- *Age.* Appears to reduce sperm quality (Lawrence Livermore National Laboratory, 2006).
- Radiation treatment and chemotherapy for cancer.

Diagnosis of Male Infertility

The primary test of male infertility is a semen analysis. The semen analysis is used to determine the quality of the man's semen. Since a semen analysis is non-invasive, this is generally one of the first tests performed and may help to reduce the need for more complicated interventions for the female partner. It is also important to rule out significant medical problems that may contribute to a poor semen analysis.

The semen analysis looks at the following:

Sperm Count: Measures of how many million sperm there are in each milliliter of fluid. Average sperm concentration is more than 60 million per milliliter. Counts of less than 20 million per milliliter are considered sub-fertile.

Motility. Determines the percentage of sperm that are moving. The norm is fifty percent or more.

Total motile count. This is the number of moving sperm in the ejaculate. There should be more than 40 million motile sperm.

Morphology: This determines the shape of the sperm. Most laboratories use (use World Health Organization (WHO) criterion. Thirty percent of the sperm should be normal by these criteria.

Volume. This is a measurement of the volume of the ejaculate. Normal is two milliliters or greater.

Standard semen fluid tests: Looks at color, viscosity (thickness), and the time until the specimen liquefies.

While many sperm problems can be treated using medication or through surgery, others will require use of advanced reproductive technologies (ART).

Fertility Treatment

Infertility can be treated with medication, surgery, intrauterine insemination, or assisted reproductive technology. Often these treatments are combined.

Common Fertility Medications

Fertility medications are used to stimulate ovulation in women with ovulatory disorders or to support the use of intrauterine insemination or assisted reproductive technologies by controlling the process of ovulation.

- **Clomiphene citrate (*Clomid*):** Acts on the pituitary gland to stimulate ovulation. Often used in women who have PCOS, and because it is given orally is a firstline medication for infertility. Clomid can cause changes in the cervical mucus, which may inhibit the sperm from entering the uterus.
- **Human menopausal gonadotropin or hMG (*Repronex, Pergonal*):** hMG acts directly on the ovaries to stimulate ovulation. It is an injected medicine.
- **Follicle-stimulating hormone or FSH (*Gonal-F, Follistim*):** FSH works much like hMG. It causes the ovaries to begin the process of ovulation. These medicines are injected.
- **Gonadotropin-releasing hormone (Gn-RH) analog:** Gn-RH analogs act on the pituitary gland to change when the body ovulates. These medicines are usually injected or given with a nasal spray.

These medications can cause hot flashes, blurred vision, nausea, bloating, and headache, and moodiness. They also increase the chances of twins, triplets or multiple births.

Other Medications

- **Metformin (*Glucophage*):** Used for women who have insulin resistance and/or PCOS. This drug helps lower the high levels of male hormones in women with these conditions, which helps the body to ovulate. Sometimes clomiphene citrate or FSH is combined with metformin. This medicine is usually taken orally.
- **Bromocriptine (*Parlodel*):** This medicine is used for women with ovulation problems due to high levels of prolactin.

Intrauterine insemination (IUI)

Intrauterine insemination (IUI) is fertility treatment that uses a catheter to place a washed sperm directly into the uterus. The goal of IUI is to increase the number of sperm that reach the fallopian tubes and increase the chance of fertilization. Sometimes the woman is also treated with medicines that stimulate ovulation before IUI.

IUI is often used to treat:

- Mild male factor infertility (low sperm count, decreased mobility)
- Women who have problems with their cervical mucus
- A unreceptive cervical condition, such as cervical mucus that is too thick
- Couples with unexplained infertility

- Use of donor sperm

Younger women usually have higher rates of success compared to women over age 35. The average success rate for IUI ranges from 10-20% in one cycle. With IUI, the success is dependent on the health of the sperm and the woman's body.

Assisted Reproductive Technology (ART)

Assisted reproductive technology (ART) methods work by removing eggs from a woman's body. The eggs are then mixed with sperm to produce embryos. The embryos are then put back in the woman's body. ART procedures sometimes involve the use of donor eggs (eggs from another woman), donor sperm, or previously frozen embryos.

Success rates vary and depend on many factors including (CDC, 2006):

- Age of the partners
- Reason for infertility
- Type of ART
- Fresh or frozen ART cycle

Some methods of ART include:

- *In vitro fertilization (IVF)* means fertilization outside of the body. IVF is considered to be the most effective type of ART. IVF is often used when a woman's fallopian tubes are blocked or when a man produces too few sperm. In a typical IVF cycle, the woman is given medication acts directly on the ovaries to stimulate ovulation with the goal of producing multiple eggs. Injected medications such as Repronex or Pergonal are common choices. Once mature, the eggs are removed. In a laboratory setting, the eggs are combined with sperm for fertilization. After 3 to 5 days, healthy embryos are implanted in the woman's uterus.
- *Zygote intrafallopian transfer (ZIFT)* or Tubal Embryo Transfer is similar to IVF. Fertilization occurs in the laboratory. Then the very young embryo is transferred to the fallopian tube instead of the uterus. ZIFT is used when there is a tubal blockage/significant tubal damage or there is an anatomic problem with the uterus, such as severe intrauterine adhesions.
- *Gamete intrafallopian transfer (GIFT)* involves transferring eggs and sperm into the woman's fallopian tube. One of the main differences between this procedure and in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT) procedures is that the fertilization process takes place inside the fallopian tubes rather than inside the laboratory.

- *Intracytoplasmic sperm injection (ICSI)* is often used for couples in which there are significant problems with the sperm. Sometimes it is also used for older couples or for those with failed IVF attempts. In ICSI, a single sperm is injected into a mature egg. Then the embryo is transferred to the uterus or fallopian tube.

Selective Reduction

With fertility medications there is a greater likelihood of conceiving twins or triplets. Additionally many ART procedures implant more than one embryo in order to increase the likelihood of a successful pregnancy. Selective reduction (or fetal reduction) is a procedure in which one or more fetuses is aborted in a in a multifetal pregnancy. The purpose of selective reduction is to lessen the medical issues related to multiple births. The most common risk involved with multiple births is pre-term labor. Nearly half of all twins are born prematurely, and the risk of having a premature delivery (prior to 37 weeks) increases with triplets, quadruplets, etc. Babies born prematurely may have numerous health challenges.

Premature babies can have numerous health challenges. Prematurity accounts for 10% of neonatal mortality worldwide. Premature births have also been associated with (American Pregnancy Association, n.d.):

- Neurological problems including developmental disability, cerebral palsy and intraventricular hemorrhage
- Cardiovascular complications
- Respiratory problems are common, specifically respiratory distress syndrome and chronic lung disease
- Gastrointestinal and metabolic issues such as feeding difficulties and hypoglycemia
- Infections, including sepsis, pneumonia, and urinary tract infection

Despite some of the difficulties associated with preterm labor and delivery, selective reduction is a decision that is very emotional for a couple to make. Couples considering selective reduction should be provided with counseling to support them in this decision.

Surrogacy/Gestational Carrier

Women with no eggs or unhealthy eggs may choose surrogacy. A surrogate is a woman who agrees to become pregnant using the man's sperm and her own egg. The child is genetically related to the surrogate and the male partner. After birth, the surrogate agrees give up the baby for adoption by the parents.

Women with ovaries but no uterus may choose a gestational carrier. This is also an option for women who shouldn't become pregnant because of a serious health problem. In this case, IVF is performed and the resulting embryo is transferred to the gestational carrier. The carrier will not be genetically related to the baby and gives him or her to the parents at birth.

Resources

Resolve, the National Infertility Association, <http://www.resolve.org/>

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Topics in Human Sexuality: Menstruation

Introduction

Although menstruation is a biological event and an integral part of female sexuality it is more complex than just the physiology. Menstruation, the culmination of the monthly cycle in which the body prepares itself for a possible pregnancy is also the start of womanhood and of female sexuality. Many cultures celebrate the first menarche with a moon ritual in which the newly menstruating young woman is joined by important females to mark her entry into womanhood and to celebrate menarche. Understanding the biological and psychological aspects of menstruation will allow mental health professionals to have a deeper understanding of human sexuality.

Educational Objectives

- Define puberty and list changes the female experiences.
- Discuss the psychological effects of precocious puberty.
- Define menstruation and the phases of the menstrual cycle.
- List the symptoms of toxic shock syndrome.
- Discuss common menstrual problems.
- Describe psychological aspects of the menstrual cycle (PMS/PMDD)
- Discuss treatment of PMS/PMDD.

Defining Puberty

Puberty is the physical process of sexual maturation. The term puberty is derived from the Latin word *puberatum* (age of maturity) and refers to the bodily changes of sexuality. In girls, puberty usually begins at 11 years of age, but may start as early as age 7. A recent study published in *Pediatrics* found that by age 7, about 10 percent of white and 23 percent of African-American girls had started developing breasts. A study published in 1997 found that by age 7, only 5 percent of white females and 15 percent of black females had reached puberty. Puberty, then, is occurring earlier.

Puberty is initiated by hormone signals from the brain to the ovaries. The first sign of puberty in girls is breast development. As growth of the breasts continues, females develop contours of the hips and buttocks, distinguishing them from their male counterparts. Growth of pubic hair begins shortly after breast development, followed two years later by underarm hair growth. There is some variability in this process, such as some young women developing breasts but showing no other signs of sexual maturation.

Girls also generally experience a growth spurt during the ages of 9.5 to 14.5. This growth gradually slows as estrogen levels increase.

Precocious (early) puberty is defined as puberty that occurs before age 7-8. In girls, this is signaled by the growth of breasts and pubic hair. In many cases, there is no identifiable cause for precocious puberty, and it may be considered a variation of normal puberty. It is always best to consult with a physician, however, because early puberty can be caused by medical conditions such as adrenal gland abnormalities or ovarian abnormalities. The most likely factor determining age of menarche is percentage of body fat (Hopwood et. al, 1990). In other words, the percentage of body weight that is fat (such as breast tissue) must rise for menstruation to occur.

Precocious puberty does have psychological effects. Many females who start puberty early tend to view their bodies negatively (Simmons and Blyth, 1987.) This may be due to the societal pressures that focus on thinness. Girls who has gone through puberty early tend to be bigger than peers. Early developers are less satisfied with their bodies and are more likely to care about how they look. These girls stand out in comparison to friends and this may result in low self esteem. There is also some evidence that girls who reach puberty early may be rejected by peers, and may seek older and more mature friends, which can lead to premature experiences, particularly within the sexual realm (Ge et al, 1996). Ge theorizes that these young women may not have had enough time to complete the necessary childhood developmental tasks before entering the world of the older crowd. They have had less time to form a sense of self, which could lead to poor decision-making.

Delayed puberty is usually defined as puberty that occurs later than the norm. If a young woman does not develop breast tissue by age 14 or begin menarche by 5 years after breast development, puberty is considered delayed. Hopwood's explanation of body fat also explains why girls with anorexia and those that engage in excessive exercise may not menstruate within the norm or why there may be a cessation in menstruation.

At about ages 12-13 **menarche**, first menstruation begins. Menstruation is the shedding of the lining of the uterus (endometrium) accompanied by bleeding. Menstruation occurs in monthly cycles throughout a woman's reproductive life. Menstruation starts during puberty and stops permanently at menopause.

Women cannot actually become pregnant until about two years after menarche.

Menarche is an important biological event but also an important psychological one. Girls display a range of reactions to menarche, which range from acceptance and pride to shame and disgust. The most negative reactions occur in girls who have not been prepared for menarche.

Phases of Menstruation

The menstrual cycle begins with the first day of bleeding, which is counted as day 1. The cycle ends just before the next menstrual period. Menstrual cycles normally range from about 25 to 36 days. Only 10 to 15% of women have cycles that are exactly 28 days long. Usually, cycles vary the most and the intervals between periods are longest in the years immediately after menarche and before menopause. Menstrual bleeding lasts 3 to 7 days, averaging 5 days.

The menstrual cycle is regulated by hormones. Luteinizing hormone and follicle-stimulating hormone are produced by the pituitary gland and promote ovulation and stimulate the ovaries to produce estrogen and progesterone. Estrogen and progesterone stimulate the uterus and breasts to prepare for possible fertilization.

The menstrual cycle has three distinct phases. These are:

Follicular Phase: This phase begins on the first day of the menstrual cycle. The primary process that occurs in the follicular phase is the development of follicles in the ovaries.

At the beginning of the follicular phase, the lining of the uterus is thick with nutrients that are intended to nourish an embryo. If no egg has been fertilized, estrogen and progesterone levels are low. The top layers of the uterus is shed, and menstrual bleeding occurs. The follicular phase lasts about 13 or 14 days. This phase ends when the level of luteinizing hormone surges. The surge results in release of the egg.

Ovulatory Phase: This phase begins when the level of luteinizing hormone surges. Luteinizing hormone stimulates the dominant follicle to bulge from the surface of the ovary and finally rupture, releasing the egg. The ovulatory phase usually lasts 16 to 32 hours. It ends when the egg is released.

Luteal Phase: This phase begins after ovulation. It lasts about 14 days (unless fertilization occurs) and ends just before a menstrual period. In this phase, the ruptured follicle closes after releasing the egg and forms a structure called a corpus luteum, which produces increasing quantities of progesterone. If the egg is not fertilized, the corpus luteum degenerates after 14 days, and a new menstrual cycle begins.

Toxic Shock Syndrome

Toxic shock syndrome is a life-threatening bacterial infection that has been associated with the use of tampons. Toxic shock syndrome results from toxins produced by *Staphylococcus aureus* (staph) bacteria, but the condition may also be caused by toxins produced by *group A streptococcus* (strep) bacteria. Symptoms of toxic shock syndrome develop suddenly, and the disease can be fatal.

Researchers don't know exactly how tampons cause toxic shock syndrome. It may be that when tampons are left in place for a long time, they become a breeding ground for bacteria. Another hypothesis is that the superabsorbent fibers in the tampons can scratch the surface of the vagina, making it possible for bacteria or their toxins to enter the bloodstream.

Symptoms of toxic shock syndrome include:

12. Sudden high fever
13. Low blood pressure
14. Vomiting or diarrhea
15. A rash resembling a sunburn
16. Confusion
17. Muscle aches
18. Redness of the eyes, mouth and throat
19. Seizures
20. Headaches

To reduce chances of contracting toxic shock syndrome women should change tampons frequently, at least every four to eight hours. Using lower absorbency tampons also reduces risks.

Menstrual Problems

Dysmenorrhea. Dysmenorrhea or painful menstruation is the most common menstrual problem. Its prevalence is estimated at 25% of women and up to 90% of adolescents (Durain, 2004). The most common symptom of dysmenorrhea is cramping pain in the pelvic region but may also include headaches, backaches, nausea, and pelvic bloating and pressure.

Although there are many possible causes of dysmenorrhea, one common hypothesis involves prostaglandins, hormone-like substances produced in the lining of the uterus. These chemicals cause the uterine muscles to contract. Women with severe menstrual pain generally have higher levels of prostaglandins.

Treatment generally involves the use of over-the-counter medications, such as aspirin, or Midol. Naprosyn, which is a prescription medication, is also widely used for symptoms of dysmenorrhea. Dietary changes such as a decrease in caffeine intake, and aerobic exercise may also be helpful.

Endometriosis. Endometriosis is the abnormal growth of endometrial cells similar to those that form the inside of the uterus, but in a location outside of the uterus (such as in the fallopian tubes, bladder, vagina or cervix). Symptoms of endometriosis vary depending on the location of the growth. Many women who have endometriosis do not have symptoms. The common symptoms are pelvic pain, which usually occurs during or just menstruation and lessens after menstruation. Some women also experience painful sexual intercourse or cramping during intercourse, or pain during bowel movements or urination. The pain intensity can change from month to month. Many with endometriosis also have fertility issues.

Endometriosis can be treated with medications and/or surgery. Nonsteroidal anti-inflammatory drugs (NSAIDs) can be used to help relieve pelvic pain and menstrual cramping. Oral contraceptive pills are also used to treat endometriosis. Surgery is more of a last resort when symptoms of endometriosis are severe or when there has been an inadequate response to other treatment.

Amenorrhea. Another common menstrual problem is amenorrhea, or the absence of menstruation. Primary amenorrhea is the absence of any menstrual cycle (generally age 18 is used as a guideline). Secondary amenorrhea is the absence of menstruation for 6 or more months in a woman who has already started menstruation and who is not pregnant, breastfeeding or in menopause. Secondary amenorrhea can be related to medical conditions such as hormonal imbalances, disease, stress, nutritional deficits (such as an eating disorder), excessive body weight, or more than 8 hours of vigorous exercise a week.

Psychological Problems Associated with Menstruation

In addition to the biological aspects of menstruation, mental health professionals also need to be aware of psychological problems. Psychological and cultural attitudes towards menstruation have alternated between repulsion and celebration. Some cultures revere menstruation as intimately connected with the renewal of life. Others fear menstruation and separate menstruating women as a way not to contaminate men.

The biological process of menstruation is neither physically nor psychologically debilitating. That does not mean, however, that it is a time in which there are not challenges. The term "premenstrual tension" was coined in 1931 and used to refer to the mood changes that happen during the luteal phase of the menstrual cycle. Symptoms of premenstrual tension are numerous, and include depression, irritability,

fatigue and headaches. Many women experience these symptoms to a greater or lesser extent.

The term **premenstrual syndrome** (PMS) is reserved for symptoms that are incapacitating enough to interfere with performance of daily activities. More common symptoms include mood swings, irritability, abdominal bloating, breast tenderness, changes in appetite, headache, anxiety and crying spells. Many causes of PMS have been suggested, including progesterone deficiency, fluid balance abnormalities, and nutritional deficiencies. However, there is no scientific evidence to unequivocally support any of these as the sole cause of PMS. Treatment of PMS may include dietary changes, exercise or prescribed medications (oral contraceptives, antidepressants, NSAIDs)

Premenstrual dysphoric disorder (PMDD) is a severe form of [premenstrual syndrome](#), affecting 3% to 8% of women. Women with a personal or family history of [depression](#) or [postpartum depression](#) are at greater risk for developing PMDD. Although the exact cause of PMDD is not known, most researchers believe that PMDD is brought about by hormonal changes related to the [menstrual cycle](#). Studies have shown a connection between PMDD and low levels of serotonin.

The PMDD criteria of the DSM-IV-TR require the presence of 5 of 11 symptoms to make the diagnosis of PMDD. At least 1 of the first 4 symptoms must occur during the last week of the luteal phase, begin to remit within a few days of the onset of menstrual flow, and be absent in the week after menses. The symptoms must be severe enough to interfere with social, occupational, sexual, or scholastic functioning. Symptoms must be discretely related to the menstrual cycle and must not merely be a worsening of preexisting depression, anxiety, or personality disorder.

DSM criteria for Premenstrual Dysphoric Disorder

A. In most menstrual cycles during the past year, at least 5 of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least 1 of the symptoms being either (1), (2), (3), or (4):

1. Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
2. Marked anxiety, tension, feelings of being "keyed up" or "on edge"
3. Marked affective lability (eg, feeling suddenly sad or tearful or increased sensitivity to rejection)
4. Persistent and marked anger or irritability or increased interpersonal conflicts
5. Decreased interest in usual activities (eg, work, school, friends, hobbies)
6. Subjective sense of difficulty in concentrating
7. Lethargy, easy fatigability, or marked lack of energy
8. Marked change in appetite, overeating, or specific food cravings
9. Hypersomnia or insomnia
10. A subjective sense of being overwhelmed or out of control

11. Other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain

Many of the same strategies used to treat [PMS](#) are also helpful in relieving symptoms of PMDD. The four main forms of treatment are:

Nutrition. Limit intake of salt, caffeine, refined sugar, and alcohol. Natural supplements, such as calcium, vitamin B6, vitamin E, and magnesium may be helpful although, their effectiveness has not been well-studied.

Exercise. Regular aerobic exercise such as walking or swimming appears to improve premenstrual symptoms.

12.

Antidepressant Medications. Several antidepressants may be used to treat PMDD. The drugs approved by the FDA for the treatment of PMDD are Sarafem (Fluoxetine), Paxil CR, and Zoloft. These medicines can be taken continuously or intermittently, just during the 14-day premenstrual period. Taking them intermittently may decrease the side effects of these drugs.

Hormones can be used to treat PMDD. Ovulation can be stopped either using medication or surgically (as a last resort). Medicines used to stop ovulation include birth control pills, Danazol, Zoladex, Synarel, and Lupron. The second hormonal approach to treat PMDD is the use of progesterone or estrogen to relieve symptoms. It's unclear whether this approach is effective.

13.

Counseling. Therapy to help women with PMDD develop effective coping strategies may help some with PMDD. Relaxation therapy, meditation, reflexology, and yoga may also help.

Summary

Menstruation is an important biological and psychological event in the lives of women. Understanding these processes allow mental health professionals to better work with women of all ages. Challenges such as Premenstrual Syndrome and Premenstrual Dysphoric Disorder are of particular interest as counseling can be effective in their treatment.

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Topics in Human Sexuality: Sexually Transmitted Diseases

Case Vignette

Marla is a 15-year-old high school sophomore. She has been sexually active since age 13 and has had multiple sexual partners. Although she tries to do the “responsible thing” by using protection, she has had unprotected sex at times, particularly when she has been drunk or high. Marla has recently been experiencing lower abdominal pain and foul smelling vaginal discharge and has noted that intercourse with her current boyfriend has been painful. She has her first gynecological examination and is dismayed to find that she has pelvic inflammatory disease (PID).

No discussion of human sexuality is complete without consideration of sexually transmitted diseases (STDs). Sexually transmitted diseases are infections that can be transferred from one person to another through sexual contact. According to the Centers for Disease Control and Prevention, there are over 15 million new cases of sexually transmitted diseases in the United States each year (CDC, 2008). There are more than 25 varieties of STDs. Although HIV remains the most well known STD with approximately 40 million people are currently living with HIV infection, other common STDs include chlamydia, gonorrhea, genital herpes and genital warts.

Adolescents and young adults are at great risk for contracting an STD because they are more likely to have multiple sexual partners (CDC, 2002). Of the new infections, almost half occur among people ages 15 to 24.

Many STDs can have serious consequence, both physical and emotional. For example, some STDs can lead to pelvic inflammatory disease, pelvic inflammatory disease, which can cause infertility. Other STDs, such as HIV, can be fatal. On an emotional level, people with illnesses such as genital herpes, which is incurable, often feel like outcasts and shun relationships due to shame around the disease.

It is important for mental health professionals working with people of all ages to be aware of STDs, their symptoms, treatments and the difficulties surrounding them.

Objectives:

After finishing this course, the participant will be able to:

Discuss Chlamydia including symptoms, complications and treatment.

Define Pelvic Inflammatory Disease (PID).

Discuss gonorrhea, including symptoms, complications, pregnancy and treatment.

Discuss syphilis, including stages, symptoms, complications, pregnancy and treatment.

List the medical issues associated with HPV, as well as prevention and treatment of this virus.

Describe the symptoms, psychological consequences and prevention of genital herpes.

Discuss symptoms, diagnosis and treatment of pubic lice.

Discuss HIV infection, including populations affected, transmission, symptoms and treatment

Describe the signs, symptoms and treatment of trichomoniasis

Discuss other genital infections

Describe the incidence and reasons for STDs among adolescents

List safe sex guidelines

Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2008, 1,210,523 Chlamydial infections were reported to the CDC. Chlamydia is caused by the bacterium, *Chlamydia trachomatis*. The disease is particularly dangerous for women and can cause serious complications that result in irreversible damage. Men with Chlamydia infection in the urethra are said to have *nongonococcal urethritis* or NGU (Webmd, 2010).

Symptoms

Chlamydia is known as a "silent" disease because the majority of infected people have no symptom. When they do occur, symptoms usually appear within 1 to 3 weeks after exposure.

In women, the bacteria initially infect the cervix and the urethra. Women might have an abnormal vaginal discharge or a burning sensation when urinating. If the infection spreads from to the fallopian tubes, women may have lower abdominal pain, low back pain, nausea, fever, or bleeding between menstrual periods. Chlamydial infection of the cervix can spread to the rectum.

Men are also generally asymptomatic (only 50% experience symptoms). Those who do have signs may have a discharge from their penis, a burning sensation when urinating or burning and itching around the opening of the penis.

Complications/PID

The complications of Chlamydia are of particular concern for women. Because the disease is often asymptomatic, women may not be treated for the disease. In about 10-15 % of women with untreated infection, Chlamydia spreads to the uterus or fallopian tubes, causing pelvic inflammatory disease (PID). PID is also common in gonorrhea. Each year about one million women develop PID. PID can cause infertility, ectopic pregnancy (a pregnancy in the fallopian tube or elsewhere outside of the

womb), abscess formation, and chronic pelvic pain. Chlamydia may also increase the chances of becoming infected with HIV.

Treatment

Chlamydia is treated with antibiotics, most commonly Azithromycin or Doxycycline. Alternative antibiotic treatment is used for those with sensitivity to these drugs. It is important for partners to both be treated concurrently.

Gonorrhea

Gonorrhea (“the clap”) is the oldest STD on record. Symptoms of gonorrhea are described in the Old Testament. There has been a recent resurgence of this disease and the CDC estimates that more than 700,000 persons in the U.S. contract gonorrheal infections each year.

Gonorrhea is caused by *Neisseria gonorrhoeae*, a bacterium that can grow and multiply in warm, moist areas of the reproductive tract, including the cervix, uterus, fallopian tubes and urethra. Gonorrhea can also grow in the mouth, throat, eyes, and anus.

Gonorrhea is spread through contact with the penis, vagina, mouth, or anus. Ejaculation need not occur for gonorrhea to be transmitted. The disease can also be spread from mother to baby during delivery.

Symptoms

People who are infected with gonorrhea may be asymptomatic. Most women are either asymptomatic or have mild symptoms. Symptoms can be mistaken for a urinary tract infection, and may include a painful or burning sensation when urinating, increased vaginal discharge, or bleeding between periods. Women with gonorrhea are at risk of developing complications from the infection, regardless of the severity of symptoms. Gonorrhea is a common cause of PID.

Men may also be asymptomatic. When symptoms do appear, they generally occur within five to eight days of infection but can take as long as 30 days. Symptoms include a burning sensation when urinating, or a white, yellow, or green discharge from the penis. Some men experience painful or swollen testicles. Gonorrhea can cause epididymitis, a painful condition of the ducts attached to the testicles causing infertility.

Symptoms of rectal infection include discharge, anal itching, soreness, bleeding, or painful bowel movements.

Additional Complications

Gonorrhea can spread to the blood or joints, causing a potentially life threatening condition. People infected with gonorrhea can also more easily contract HIV

Pregnancy

Women who have gonorrhea during pregnancy have higher rates of [miscarriage](#), infection of the amniotic sac and fluid, preterm birth, and [preterm premature rupture of membranes \(PPROM\)](#).

Gonorrhea can be transmitted to the baby during delivery, and can cause serious complications including blindness. Most states require that all babies be treated with medicated eye drops soon after birth as a preventive measure.

Treatment

Gonorrhea is very treatable. Treatment generally involves either an injectible or oral antibiotic. A single dose is usually all that is required, but some antibiotics require longer courses. Ofloxacin, Cefixine, and Ceftriaxine are commonly prescribed.

Syphilis

Syphilis is a STD caused by the bacterium *Treponema pallidum*. It has been called "the great imitator" because so many of the signs and symptoms are indistinguishable from those of other diseases. Historically syphilis was also known as "the great pox." It first appeared in Europe during the 1400s and became a pandemic by 1500.

According to the CDC, there were 36,000 reported cases of syphilis in 2006. Most occurred in people ages 20 to 39. Reported cases of congenital syphilis in newborns increased from 2005 to 2006, with 339 new cases reported in 2005 compared to 349 cases in 2006.

Although syphilis is less common than many of the other STDs, its affects are quite serious. It can cause sterility, and if left untreated result in damage to the nervous system and death.

Transmission

Syphilis is transmitted through direct contact with a syphilis sore. Sores can occur on the external genitals, vagina, anus, or in the rectum. Sores also can occur on the lips and in the mouth. Syphilis can also be transmitted from pregnant women to their babies.

Symptoms

Many people infected with syphilis do not have any symptoms for years, which is

quite problematic given the serious complications that can ensue from leaving the disease untreated. Although transmission occurs contact with a syphilis sore (carriers in the primary or secondary stage these sores may not be evident). Transmission may occur from persons who are unaware of their infection.

The stages are:

- *Primary Stage* Marked by the appearance of a single sore (called a chancre), but there may be multiple sores. The time between infection and the start of the first symptom can range from 10 to 90 days (average 21 days). The chancre is generally firm, round, small, and painless, lasts 3 to 6 weeks, and heals on its own. However, if the syphilis is not treated, the infection progresses to the secondary stage.
- *Secondary Stage* This stage is characterized by skin rash and mucous membrane lesions. This stage typically starts with the development of a rash on one or more areas of the body. The rash generally consists of reddish brown spots both on the palms of the hands and the bottoms of the feet. Sometimes rashes associated with secondary syphilis are so faint they are barely noticeable. In addition an infected person may experience fever, swollen lymph glands, patchy hair loss, headaches, weight loss, muscle aches, and fatigue.
- *Late and Latent Stages.* The late stages of syphilis can develop in about 15% of people who have not been treated. They can appear as long as 10–20 years after the person was first infected. In the late stages of syphilis, the disease may damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Signs and symptoms of this stage include difficulty coordinating muscle movements, paralysis, numbness, gradual blindness, and dementia. The person may die in this stage of the illness.

Treatment

In its early stages syphilis is easy to cure. For a person who has had syphilis less than a year, treatment involves a single intramuscular injection of penicillin. Additional doses are needed to treat someone who has had syphilis for longer than a year. Penicillin (or another antibiotic for those who are allergic) will kill the syphilis bacterium and prevent further damage, but it will not repair damage already done.

People who receive syphilis treatment must abstain from sexual contact with new partners until the syphilis sores are completely healed.

HPV (Human Papilloma Virus)

HPV stands for human papilloma virus, and is the most common sexually transmitted disease. Approximately 20 million Americans are currently infected with HPV. 50% of sexually active men and women get it at some point in their lives.

HPV is transmitted through genital contact, most often during vaginal and anal sex. HPV may also be passed on during oral sex and genital-to-genital contact.

Most people who contract HPV do not develop symptoms or health problems. But other, more aggressive strains of HPV can cause significant problems including:

14. **Genital warts.** Small warts in the genital area. Warts can appear within weeks or months after sexual contact with an infected partner, even if the partner has no signs of genital warts. Genital warts are not dangerous, but they can increase in number if left untreated.
15. **Cervical cancer** can be caused by untreated HPV. Women should receive regular screenings for cervical and other gynecological cancers.
16. **Other HPV-related cancers** include cancers of the vulva, vagina, penis, anus, and head and neck.
17. **RRP.** The HPV virus can cause warts to grow in the throat, a condition called *recurrent respiratory papillomatosis* or RRP. These warts can block airways, causing troubled breathing.

Prevention

Vaccines are effective protection against HPV. These vaccines are given in three shots, and are most effective prior to a person's first sexual contact.

- Girls and women: Cervarix and Gardasil protect females against the types of HPV that cause most cervical cancers. Gardasil also protects against most genital warts. Both vaccines are recommended for 11 and 12 year-old girls, and for females 13 through 26 years of age, who were not previously vaccinated
- Boys and men: Gardasil protects males against most genital warts. This vaccine is available for boys and men, 9 through 26 years of age.

Latex condoms also lower the risk of HPV infection.

Treatment

Generally people with HPV are treated for the symptoms of the disease, such as genital warts. Medications for warts include Podophyllin. Cryocautery can freeze warts. In harder to treat cases, laser therapy or surgical excision may be recommended.

Genital Herpes

Case Vignette

Jennifer is a 35-year-old woman who contracted genital herpes during college. She has struggled emotionally since contracting the illness and has generally avoided relationships, fearing that they could lead to sexual contact. The illness has caused severe emotional pain and distress.

Genital herpes is an STD caused by the herpes simplex viruses, most frequently type 2. Genital herpes infection is common in the United States. Herpes is passed through genital contact and can occur even when an infected partner does not have visible signs of the virus.

Nationwide, 16.2%, or about one out of six, people 14 to 49 years of age have genital HSV-2 infection. Over the past decade, the percentage of Americans with genital herpes has remained stable (CDC, 2010). Of all STDs, genital herpes is one of the most devastating as there is no cure. Outbreaks of the disease are unpredictable, and have significant consequences on a person's sexual freedom, frequency and spontaneity.

Most individuals have no or only minimal signs HSV infection. Symptoms may appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender sores that may take two to four weeks to heal the first time they occur. Typically, another outbreak can appear weeks or months after the first, but it generally is less severe. Although the infection can stay in the body indefinitely, the number of outbreaks tends to decrease over the years.

Complications

Regardless of severity of symptoms, genital herpes frequently causes psychological distress in people who know they are infected.

Genital HSV can lead to potentially fatal infections in babies. If a woman has active genital herpes at delivery, a cesarean delivery is usually performed.

Treatment

There is no known drug that will kill HSV. Acyclovir can be used to prevent or reduce recurring symptoms.

Prevention

The most effective prevention for genital herpes is abstinence from sexual contact, or a mutually monogamous relationship with an uninfected partner.

Although latex condoms reduce the risk of genital herpes, genital ulcers in both male and female genital areas can occur in areas that are not covered by condoms.

Persons with herpes should abstain from sexual activity with uninfected partners when they have lesions or other symptoms. Even if a person does not have symptoms he or she can still infect sex partners. Sex partners can seek testing to determine if they are infected with HSV.

Pubic Lice

Pubic Lice (*Phthirus pubis*,) are also called crab lice or "crabs," are parasitic insects found primarily in the pubic or genital area of humans. These lice can also be found in armpit hair and eyebrows. The primary age group infected by pubic lice are teenagers. Lice infestation is usually spread during sexual activity. Less commonly can be spread through contact with objects such as toilet seats, sheets, blankets, or bathing suits.

Risk factors for public include having multiple sexual partners, sexual contact with an infected person and sharing bedding or clothing with an infected person.

Symptoms

The most common symptom of pubic lice is itching in the pubic area. The itching often intensifies at night). This itching may start soon after being infected with lice, or it may not start for up to 2 to 4 weeks after contact. Other symptoms include skin reaction that is bluish-gray in color, and in the genital area due to bites and/or scratching. Scratching the skin in this area could also result in irritation leading to a secondary infection.

Treatment

Public lice are very treatable using a prescription wash containing permethrin. Two of these washes are Elimite and Kwell. Following the wash, the person must comb the pubic hair with a fine-toothed comb to remove nits. Generally a single treatment is all that is necessary. In addition to this treatment, all clothing and linens should be thoroughly washed in hot water.

Human Immunodeficiency Virus (HIV)

HIV or Human Immunodeficiency Virus is the retrovirus responsible for AIDS. While initially HIV was thought to be a disease that was limited to the homosexual population and IV drug users, this impression has changed in the past ten years. Approximately one-third of new HIV diagnoses are among heterosexuals. Male-to-male sexual contact accounts for approximately half of new diagnoses and intravenous drug use contributes to the remaining cases. The biggest change in the HIV picture is women, who are increasingly contracting the virus. In the United States, approximately 25% of new diagnoses are in women, and this proportion continues to rise (World Health Organization, 2007).

Among younger people, minorities and teen girls have been hard hit by HIV/AIDS. Younger African Americans represented 65% of AIDS cases reported among 13-19 year olds in 2002; Latino teens represented 20%. In 2002, girls represented 51% of HIV cases reported among 13-19 year olds, compared to 30% of cases reported among people over age 25 that same year (Kaiser Family Foundation and Seventeen, 2003).

Transmission

There are a number of possible routes of transmission for HIV.

1. Most commonly, HIV is spread by having sex with an infected partner. The virus enters the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex. Unprotected anal intercourse carries a higher risk than most other forms of sexual activity.
2. HIV can be spread among injection-drug users who share needles or syringes that are contaminated with blood from an infected person.
3. Women can transmit HIV to their babies during pregnancy or birth. For women who are pregnant and HIV positive, doctors generally recommended anti-HIV medications to prevent babies from becoming infected.
4. HIV can spread through accidental needle sticks or contact with infected fluids. It is rare nowadays that HIV would be spread from contaminated blood products.

HIV cannot be spread by casual contact. HIV is not an airborne, water-borne or food-borne virus, and does not survive for very long outside the human body. Ordinary social contact such as kissing, shaking hands, coughing or sharing silverware does not result in the virus being passed from person to person.

Symptoms

There are typically a number of phases of HIV symptoms. There is a symptom-free period, a period of early infection. The disease may then progress to AIDs (acquired immune deficiency disorder).

Many people with HIV do not know they are infected. Symptoms may not occur immediately. Some people who are exposed to HIV do not show any signs of the illness for up to 10 years. In other cases people have flu-like symptoms within days of exposure, but these symptoms remit quickly. During this asymptomatic phase, the virus continues to multiply and infects and kills the cells of the immune system. The HIV virus destroys the cells that are the primary infection fighters, a type of white blood cell called CD4 cells. Although there are no symptoms associated with this stage of the disease, it is still contagious and can be passed along to others.

The later stage of the disease is AIDS. In this stage the body loses its ability to fight infections. People who have AIDS may contract a number of serious and potentially illnesses. These illnesses are known as opportunistic infections because they occur as a result of the weakened immune system. Opportunistic infections associated with AIDS include:

- Pneumonia
- Toxoplasmosis
- Yeast infections of the esophagus

The weakened immune state of AIDs can also lead to cancers. These cancers are difficult to treat and may be fatal.

- lymphoma in the brain
- Kaposi's sarcoma. This cancer was rare prior to AIDs and its incidence helped the CDC first identify AIDs as a medical condition.

Treatment

Treatment of HIV has progressed considerably since it was first recognized in the 1980s primarily due to newer antiretroviral therapies. HAART (highly active antiretroviral therapy) is a potent drug cocktail used to suppress the growth of HIV, the retrovirus responsible for AIDS. A combination of at least three drugs is the recommendation to keep the virus from replicating. The following medications are widely used in treatment (EMedicine Health, 2010):

The following are the different classes of medications used in treatment.

Reverse transcriptase inhibitors (AZT/Retrovir): Inhibit the ability of the virus to make copies of itself and to keep the virus from multiplying.

[Protease](#) inhibitors (PIs): Interrupt virus replication at a later step in its life cycle, preventing cells from producing new viruses. When used in a cocktail they also reduce the chances that the virus will become resistant to medications.

Fusion and entry inhibitors: Newer agents that keep HIV from entering human cells.

Integrase inhibitors stop HIV genes from becoming incorporated DNA. This is a newer class of drugs recently approved to help treat those who have developed resistance to the other medications.

These medications are helpful in allowing a person who is infected with HIV to live longer and be less symptomatic. They do not cure HIV or AIDS.

Trichomoniasis

Trichomoniasis is a sexually transmitted disease that affects both women and men, although symptoms are more common in women. It is the most common curable STD in young, sexually active women. There are an estimated 7.4 million new cases each year.

Trichomoniasis is caused by the parasite, *Trichomonas vaginalis*. The vagina is the most common site of infection in women, and the urethra is the most common site of infection in men.

Symptoms

Most men with trichomoniasis do not have symptoms, but some may experience a mild irritation inside the penis, discharge, or burning after urination or ejaculation. Signs of the infection in women include a frothy, yellow-green vaginal discharge with a strong odor. The infection may cause discomfort during intercourse and urination, and irritation and itching of the vagina. Symptoms usually appear within 5 to 28 days of exposure.

Other Genital Infections

Vaginitis. Vaginitis is not considered an STD because it is not transmitted by sexual contact. Vaginitis is an inflammation of the vagina that can result in discharge, itching and pain. It is common among women, particularly those of college age. Vaginitis is generally caused by a change in the normal balance of vaginal bacteria or an infection. Vaginitis can also result from reduced estrogen levels after menopause.

The most common types of vaginitis are:

Bacterial vaginosis, which results from overgrowth of one of several organisms normally present in the vagina. Women with bacterial vaginosis are also at a greater risk of contracting HIV and other sexually transmitted infections.

Monilia or yeast infections, which are usually caused by a naturally occurring fungus called *Candida albicans*.

Vaginal atrophy (atrophic vaginitis), which results from reduced estrogen levels after menopause

Vaginitis symptoms may include a change in color, odor or amount of vaginal discharge, itching or irritation, pain during intercourse or urination or spotting. Treatment options depend on the type of vaginitis and may include prescription and OTC suppositories.

Adolescents and STDs

Most STDs are found in all age groups, with the exception of pubic lice, which is found primarily in adolescents. Compared to older adults, adolescents (10- to 19-year-olds) are at higher risk for acquiring STDs for a number of reasons, including limited access to preventive and regular health care and physiologically increased susceptibility to infection. Approximately one in four sexually active teens contracts an STD every year. An estimated half of all new HIV infections occur in people under age 25.

Given these statistics, education and prevention efforts are key.

Safe Sex Guidelines

With all STDs, and particularly HIV, the most effective counsel is safe sex or abstinence. Hyde and DeLamater (2003) provide the following safe sex guidelines:

21. For those who choose to be sexually active, have sex only with one consistent stable sexual partner.
22. For those who are active with multiple partners, use a latex condom, which is the most effective protection against HIV.
23. If there is risk that a partner is infected, abstain from sex or use alternative forms of sexual expression that do not involve genital contact.
24. Abstain from being sexually active with people who have had multiple sexual partners.
25. Do not engage in anal sex if there is any chance that a partner has an STD.
26. If there is any chance of having been exposed to an STD, have a blood test to verify.

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Topics in Human Sexuality: Sexual Deviation

Case Vignette

Carl V., age 20, entered therapy at the urging of his wife, Melissa. Melissa has been increasingly concerned with Carl's inability to become sexually aroused by "traditional" sexual foreplay. This has been a change in their relatively young marriage. Carl has asked for her to wear various shoes during sex, and while that had not initially been that alarming, she was concerned when she caught him masturbating with a pair of her heels.

As the case illustrates, human sexuality spans a range of behaviors, and varies from culture to culture. It is hard to define what type of sexual expression is acceptable. Researchers often look to religion, culture, and the legal system to define "normal" sexual behavior. Schwartz (1996) defines atypical sexual behavior as sexual fantasies and activities that are not commonly practiced by most people and may cause adverse physical, emotional, and social consequences. Such behaviors can range from mild, occasional behaviors, to more severe and frequent. From a clinical perspective, there has been some effort to define atypical sexual behavior under the umbrella of the sexual paraphilias. The term "paraphilia" was first coined by Wilhelm Stekel in the 1920s, and expanded upon by sexologist John Money (1993). Money used the term paraphilia to indicate unusual sexual interests. There is some degree of controversy surrounding the label of a "paraphilia," as it indicates that certain behaviors are somehow deviant (Moser & Kleinplatz, 2005) when in fact they may be just at different ends of the spectrum. An example of a behavior once considered a paraphilia but now no longer classified as a psychiatric disorder, is homosexuality.

As defined in the DSM-IV-TR, paraphilias are "recurrent, intense, sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations." What is key in this definition is that such behavior must cause significant distress to the individual or harm to others in order to be considered a psychiatric illness. Such paraphilias include exhibitionism, fetishism, frotteurism, pedophilia, masochism, sadism, transvestitism and voyeurism.

In addition to paraphilias, there are also paraphilia-related disorders. Paraphilia-related disorders involve normative sexual expression that interfere with a person's social or occupational functioning due to frequency or intensity of their expression (Kafka & Hennen, 1999). These include cyber-sex, compulsive masturbation, and sexual addiction. Such behaviors are described in the module on sexual addiction. This material will describe sexual deviations including their etiology, expression and treatment.

Educational Objectives

1. Describe sociocultural aspects of sexually deviant behaviors, including cultural views of paraphilias.
2. Discuss the development of atypical sexual behavior.
3. Define fetishism and list common fetish objects.

4. Discuss transvestism and its features, including why it is considered a fetish.
5. Define exhibitionism and list characteristics of exhibitionists.
6. Define frotterism and list characteristics of frotterists.
7. Discuss voyeurism and the range of normal versus deviant behaviors.
8. Discuss the proposed DSM-V diagnosis, hypersexual disorder.
9. Discuss the characteristics of sadism and masochism.
10. Define asphyxiophilia and list common features of the disorder.
11. Compare and contrast treatment approaches.
12. Discuss medications useful in treating paraphilias.

Sexuality Across Cultures

In looking at sexual deviance, it is first important to consider the issue of culture. Cultures define and describe what is normal within the culture and what is abnormal or deviant. Definitions of normality, then, vary across cultures and are influenced by a many factors, including religion, media, and laws. A *taboo* is a strong social prohibition or ban relating to any area of human activity or social custom that is forbidden based on moral judgment or religious beliefs. There are many taboos related to sexuality, as demonstrated by the following training material. Some taboos, such as pedophilia, are also prohibited by law and may lead to strict penalties when such lines are crossed. Other taboos result in embarrassment and shame for the one breaking the taboo.

Researchers Burgha et. al. (2010) have used culture to look at sexual paraphilias. They describe cultures as either sex-positive, meaning sexual acts are seen as important for pleasure, or sex-negative, meaning that sexual acts are seen as only as for procreative purposes. U.S. culture would be considered a sex-positive culture overall.

The Development of Atypical Sexual Behavior

Sexuality experts have proposed a number of possible explanations for sexually deviant behaviors.

Psychodynamic Perspective

From a psychodynamic perspective, sexual variations are a defense mechanism that enables people to avoid the anxiety of engaging in more normative sexual behavior and relationships (Comer, 2009). In this schema, a person's sexual development is generally quite immature. An example of this approach would be that the view of sexual exhibitionism is as a defense against castration anxiety.

Behavioral Perspective/Learning Theory

The behavioral perspective theorizes that abnormal sexual behavior is a conditioned response. The person learns to become aroused in a way that deviates from sexual norms. Carl's shoe fetish, for example, may have started as a teen when he masturbated to a DVD of a provocative woman wearing high heels.

Developmental Approach

Developmental approaches look at early factors that influence the development of atypical sexual behaviors (Kafka, 2000). Such factors include childhood sexual abuse, being exposed to sexuality at an early age (including pornography), or family pathology related to sexuality. Psychosexual development becomes hindered by these experiences. An example of this would be that a woman who is sexually abused may become fearful of sexual experiences, or conversely, may become sexually promiscuous (Sanderson, 2006).

Other

A childhood history of attention-deficit/hyperactivity disorder (ADHD) is also thought to increase the likelihood of developing a sexual paraphilia. The reason for the connection is not yet known, but researchers at Harvard have discovered that patients with multiple paraphilias have a much greater likelihood of having had ADHD as children than men with only one paraphilia (Encyclopedia of Mental Disorders, n.d.).

Fetishism

The case vignette provided at the start of this training material provides an example of fetishism. Fetishism is the use of an inanimate object or a specific part of the body for physical or mental sexual stimulation. Often the person masturbates while touching, smelling or rubbing the fetish object. In some cases, the person may ask their partner to wear the object while engaging in intercourse. In a media fetish, the material out of which an object is made is the source of arousal. In a form fetish the object and shape are important. (Hyde & DeLamater, 2010).

Some common fetish objects include shoes (particularly those with heels), women's lingerie, rubber items and leather. People may also have fetishes that involve particular body parts, such as feet or breasts. Fetishes are an example of behavior in which some aspects are normative, and that deviation occurs on a continuum. Many men, for example, are aroused by sexy lingerie, but the primary object of their desire is the female wearing the lingerie. In fetishism, the object of desire is the lingerie. Fetishes generally develop in adolescence. A common view of fetishism is found in learning theory and is that fetishes are the result of classical conditioning, in which there is a learned association between the fetish object and sexual arousal and orgasm (Hyde & DeLamater, 2010).

For the most part, fetishes are harmless and do not upset others. It is unusual that people seek therapeutic intervention without the urging of others, such as a partner, or unless they become disturbed by the social isolation associated with some fetishes.

Transvetism

Case Vignette: Mary G is a lesbian woman. She has always identified more with the masculine, strong role in her relationships with other women. She often dresses in tight blue jeans and leather jackets and has been misidentified as a young man as times.

Mary believes that her fashion choices are not sexually motivated; it's just what she prefers. Is Mary a transvestite?

Transvestism (or Transvestic Fetishism as it is called in the DSM) refers to dressing as a member of the opposite gender in order to achieve sexual gratification. Like many of the paraphilias, there is a great deal of variability in the act of cross-dressing, and it is not necessarily considered a clinical disorder in all cases. In the case vignette, for example, Mary would not be considered to have a clinical disorder, because she does not gain sexual satisfaction from the act of cross-dressing, nor does she fantasize about cross-dressing. Similarly, those who cross-dress for entertainment purposes, such as male homosexuals (drag queens) are not considered to have a clinical disorder, nor would entertainers such as Robin Williams or Dustin Hoffman, who have appeared in movies in female roles.

The essential feature of transvestism, then, is recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing. These fantasies or behaviors cause clinically significant distress or impairment. Since the person derives sexual gratification from cross-dressing, an clothing is the object of sexual desire, transvestism is considered a to be a type of fetish. The behavior occurs almost exclusively in males.

Case Vignette: George M., a happily married father of two, would occasionally, and with his wife's knowledge, dress in her clothing. He admits that he finds the behavior to be arousing, and enjoys fantasizing about how and when he can do so. His wife is not concerned about the fantasies, and feels that George is a good husband and father.

Usually the male with transvestic fetishism keeps a collection of female clothes that he intermittently uses to cross-dress. While cross-dressed, he generally masturbates, imagining himself to be both the male and the female object of his sexual fantasy. Some males with this disorder wear a single item of women's clothing, such as a bra or underwear beneath their masculine attire. Others dress entirely as females and wear makeup. When not cross-dressed, males with Transvestic Fetishism are generally unremarkably masculine, and are heterosexual, although sexual contacts may be limited and he may occasionally engage in homosexual acts.

In a large-scale study of transvestites, Docter and Prince (1997) surveyed one thousand and thirty-two male cross-dressers. Eighty-seven percent described themselves as heterosexual. All except 17% had married and 60% were married at the time of this survey. Of the present sample, 45% reported seeking counseling. The study also attempted to distinguish between nuclear (stable, periodic cross-dressers) and marginal transvestites (more transgendered, please see section on gender identity disorder).

Research indicates that there are four basic motivations for transvestism (Talamini, 1982):

18. *Sexual arousal*

19. *Relaxation*: taking a break from male roles and pressures and connecting to emotionality

20. *Role playing*: satisfaction in being able to pass as a woman

21. *Adornment*: sense of being “beautiful”

Families of transvestites are often accepting of this sexual deviation (Talamini, 1982), and again, appear quite normative in other ways.

Exhibitionism

Case Vignette: Lewis R., a 16-year-old is seeking counseling at the urging of his parents. They are concerned to have received a phone call from a neighbor, accusing Lewis of exposing himself to a 13-year-old girl. Lewis had initially denied that he had done so, but later admitted that he had done so previously. He felt as if he “couldn’t stop.”

The key feature of exhibitionism is intense, recurrent and sexually arousing fantasies involving the exposure of the individual's genitals. Colloquially referred to as “flashing,” the individual exposes his or her private body parts to another person. The exhibitionist does not typically initiate any type of sexual contact with the person to whom they may expose themselves, but may masturbate during the act of exposing themselves. Some exhibitionists are aware of a conscious desire to shock or upset their target; while others fantasize that the target will become sexually aroused by their display.

Exhibitionism is another example of differing cultural views of a behavior being deviant. For example, when women wear sexually revealing clothing are rarely considered deviant. When a male exposes himself, however, it is considered offensive. This is behavior that is also considered illegal in most states.

Males who engage in exhibitionism typically begin the behavior prior to age 18. In that way they are not engaging in age-appropriate or normative sexual behavior. They may also be shy, or feel inadequate about their sexuality (Crooks & Bauer, 2002; Levine, 2000).

There are a number of theories about the origins of exhibitionism (Encyclopedia of Mental Disorders, n.d.). They include:

Biological theories. These theories state that imbalances in testosterone increase the susceptibility for males to develop exhibitionism. Some medications used to treat exhibitionists are given to lower testosterone levels.

Developmental theories. History of emotional abuse in childhood and family dysfunction are both significant risk factors in the development of exhibitionism.

Head trauma. There are a small number of documented cases of men becoming exhibitionists following traumatic brain injury without previous histories of sexual offenses.

Frotteurism

Frotteurism refers to intense, recurrent fantasies of, and/or actual touching and rubbing the genitalia against a non-consenting person, in association with sexual arousal (Comer, 2009). The behavior usually occurs in crowded places, public places.

Most commonly a man rubs his penis against a woman's buttocks or legs (Crooks & Bauer, 2002) or may touch her breasts. The person engaging in the behavior often fantasizes about having an exclusive relationship with the person he is touching. People who engage in frotteurism are generally males between the ages of 15 and 25.

They are similar to exhibitionists in that they have feelings of sexual and social inadequacy (Levine, 2000) and find this type of behavior to be safe. Although there is not consensus on what causes frotteurism, a often cited theory is the behavior stems from an initially random or accidental touching of another's genitals that the person finds sexually exciting. Successive repetitions of the act tend to reinforce the behavior.

Frotteurism is a criminal act in most jurisdictions. It is generally classified as a misdemeanor. As a result, legal penalties are often minor and repeated offenses are likely without some other sort of intervention.

Voyeurism

Case Vignette: Thomas, a 24-year-old male was arrested after being caught masturbating outside of a neighbor's window. He revealed to the arresting officer that he found it arousing to watch his neighbor undress. This was Thomas' third such arrest.

Voyeurs (also referred to as "peeping Toms") derive sexual pleasure and gratification from secretly looking at the naked bodies and genital organs or observing the sexual acts of others. Voyeurs may also listen to sexually explicit conversations between others. The person being observed is usually a stranger to the observer. There must also be an element of risk associated with the act of observing the other person. For example, a voyeur would not be sexually excited by going to an exotic dance club. Voyeurs generally do not seek to have sexual contact or activity with the person being observed.

The prevalence of voyeurism is not known. It is generally more common in men than in women and generally begins in the teen years, often prior to age 15. There is often a history of multiple offenses, totaling in the hundreds.

Because voyeurism is considered a misdemeanor in most jurisdictions, penalties are generally quite light and there is a strong rate of recidivism.

Hypersexual Disorder

Case Vignette

Donna, a 35-year-old woman presented for therapy due to problems in her relationship. She reported that she was very upset that her husband of 6 months was so sexually demanding. If it were up to him, she said, the couple would have sexual relations multiple times a day. She also stated that he would often keep her up at night, despite the early demands of her job, and that he would masturbate for several hours each night. Donna loves her husband, but is not sure she can take much more.

Pornography, cybersex, Internet chat rooms. These are readily available in our face-paced society, and are factors in a disorder currently under proposal for the DSM-V: hypersexual disorder. In the vernacular, hypersexual disorder is sometimes referred to as sexual addiction, and a component of this training module discusses sexual addiction in depth. As hypersexual disorder is a sexual deviation, it is also briefly explained in this chapter.

The proposed criteria for hypersexual disorder includes recurrent and intense sexual fantasies, sexual urges, and sexual behavior. Such sexual behaviors include, but are not limited to masturbation, viewing pornography, sexual behavior with consenting adults, cybersex, engaging in telephone sex, or frequenting strip clubs

In order to meet criteria for this disorder, the sexual behavior must be characterized by four or more of the following: excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior; repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability); repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events; repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior; repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

As with other disorders, there must be clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the disorder (frequency and intensity of these sexual fantasies, urges, and behavior).

Hypersexual disorder is frequently seen in the manic stages of bipolar disorder.

Sadism and Masochism

Case Vignette

Marla M., age 20, has been in treatment for childhood abuse. She recently revealed to her trusted therapist that many of her sexual liaisons involve meeting men online for the purpose of engaging in masochistic behavior, such as being spanked or humiliated. She recognizes that this likely stemmed from her past, but this insight has not allowed her to stop engaging in the behaviors.

A sadist is a person who derives sexual satisfaction from inflicting pain, suffering or humiliation on another person. The pain, suffering, or humiliation inflicted on the other person may be either physical or psychological in nature. The person receiving the pain may or may not be a willing partner. When the sexual activity is consensual, the behavior is sometimes referred to as sadomasochism.

The name “sadism” derives from the name of the historical character the Marquis de Sade, a French aristocrat who published novels about these practices. Sadistic acts generally reflect a desire for domination of the other person. This can include behavior that is not physically harmful but may be humiliating to the other person (such as being urinated upon). Some acts of sadism may be very harmful. Examples of sadistic behaviors include restraining or imprisoning the partner, spanking, administering electrical shocks, biting, urinating or rape.

A masochist is a person who is sexually aroused by experiencing pain. The term “masochism” is named after Leopold von Sacher-Masoch, who was a masochist and wrote novels about his masochistic fantasies. An individual with sexual masochism often experiences significant impairment or distress in functioning due to masochistic behaviors or fantasies. Sadistic fantasies often begin in childhood and the onset of sexual sadism typically occurs during early adulthood. These behaviors are generally chronic and continue until the person seeks treatment. Often people with sadistic fantasies do not seek treatment due to the social unacceptability of these thoughts.

Masochistic acts include being physically restrained or receiving punishment or pain. Psychological humiliation and degradation can also be involved. Masochistic behavior can occur in the context of a role-play. Masochists may also inflict the pain on him or herself, such as through self-mutilation. Like with sadism, masochistic fantasies often begin in childhood and the onset of sexual masochism typically occurs during early adulthood. These behaviors are generally chronic and continue until the person seeks treatment.

Sadomasochistic behavior is the consensual use of sadistic and masochistic behaviors. Bondage and discipline refers to the use of physically restraining devices or psychologically restraining commands as a central part of sexual interaction. Dominance and submission refers the use of power consensually given to control the sexual stimulation and behavior of the other person (Hyde & DeLameter, 2010).

There is not consensus on the causes of sadism and masochism. There is a small body of research that has looked at historical factors in men and women with

sadistic/masochistic fantasies and has found a link to early sexual abuse (see for example Messman & Long, 1999).

Asphyxiophilia

Asphyxiophilia is the desire to induce in oneself a state of oxygen deficiency in order to create sexual arousal or enhance sexual excitement. The person with asphyxiophilia may employ a variety of techniques such as a pillow against the face, a rope around the neck or a plastic bag over the head. This is, of course, very dangerous behavior and can lead to death. Little is known about the disorder and there are not accurate statistics on prevalence. Most of the deaths attributed to the disorder have been seen in men. Some of these also involved the practice of cross-dressing (Hyde & DeLameter, 2010).

Men and women who engage in asphyxiophilia believe that arousal and orgasm are intensified by reduced oxygen. There is no evidence that this is actually the case. People who engage in asphyxiophilia may be compulsive with this behavior or seek escalating thrills to achieve arousal. More study of this disorder is needed.

Counseling for Sexual Deviance

Treatment for sexually deviant behaviors is complex. There is often a great deal of secretiveness and shame around the atypical sexual behaviors. A number of techniques have been used to treat paraphilias:

Individual Therapy: Cognitive behavioral methods, including relapse prevention strategies, appear the most effective. CBT programs include (Abel et. al, 1992). The goal of CBT is to modify the person's sexual deviations by addressing distorted thinking patterns and making them aware of the irrational justifications that lead to their sexual variations.

1. Behavior therapy to reduce inappropriate sexual arousal and enhance normal sexual arousal.
2. Social skills training.
3. Modification of thought distortions: challenging justifications for deviant behavior.
4. Relapse prevention: avoidance of control of triggers to behaviors; helping the person to control the undesirable behaviors by avoiding situations that may generate initial desires.

In *covert sensitization*, the person's negative sexual variation is paired with an unpleasant stimulus in order to deter them from repeating the act. This approach has been proven effective in cases of pedophilia and sadism.

In *orgasmic reconditioning*, the person is conditioned to replace fantasies of exposing himself with fantasies of more acceptable sexual behavior while masturbating. To employ this approach, the person is told to masturbate to his or her typical, less socially acceptable stimulus. Then, just prior to orgasm, the person is directed to concentrate on a more acceptable fantasy. This is repeated at earlier times before

orgasm until, soon, the patient begins his masturbation fantasies with an appropriate stimulus.

Group therapy. This form of therapy is used to get patients past the denial that is frequently associated with paraphilias, and as a form of relapse prevention. The goal of this type of therapy is to lead the person to a "healthy remorse."

Social skills training. The impetus for social skills training is the belief that paraphilias develop in individuals who lack the ability to develop relationships. Social skills training focuses on such issues as developing intimacy, carrying on conversations with others, and assertiveness skills. Many social skills training groups also teach basic sexual education.

Twelve-step groups. These groups offer social support and emphasis on healthy spirituality found in these groups, as well as by the cognitive restructuring that is built into the twelve steps. Many individuals with paraphilias benefit from Twelve-step programs designed for sexual addicts. These programs are generally peer-facilitated. Examples of Twelve-step groups include Sexual Addicts Anonymous, Sex and Love Addicts Anonymous and Sexaholics Anonymous.

Couples therapy or family therapy. This approach is helpful for patients who are married and whose marriages and family ties have been strained by their disorder.

Medications. Medications that can be helpful in working with sexual deviations can include:

27. Antidepressants (such as Prozac) Fluoxetine (Prozac) and lithium help people with paraphilias control their impulses.
28. Gonadotropin-releasing hormones like triptorelin reduce the levels of testosterone and may lower sex drive.
29. Phenothiazines, such as fluphenazine (Prolixin) can lower aggression and related fantasies.
30. Mood stabilizers such as divalproex sodium (Depakote) treat underlying conditions such as bipolar disorder (which can sometimes lead to hypersexuality).
31. Antiandrogens (drugs that are used to suppress or block the action of testosterone and DHT, dihydrotestosterone, the primary masculinizing hormones in the human body. Antiandrogens like medroxyprogesterone (Depo-Provera) lower sex drive.

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Topics in Human Sexuality: Sexual Addiction

Introduction

No study of human sexuality is complete without a discussion of sexual addiction. For most people, sex enhances their quality of life. However, about 6% to 8 % of Americans have sexual problems indicative of an addiction (Ewald, 2003). Sexual compulsivity and sexual anorexia, which Patrick Carnes (2001) describes as “sex in the extremes,” affects all facets of individuals’ lives. Addiction to sexual activities can be as destructive as addiction to chemical substances. Sexual addicts may experience psychological distress, lose their livelihoods, and ruin meaningful relationships.

The literature on sexual addiction provides important insights into treating these difficult disorders. There are many facets to treatment, including helping clients to recognize the function of this behavior in order to decrease the tremendous shame around it. Carnes (2001) attributes the etiology of this disorder to a combination of psychodynamic and cognitive-behavioral factors. He stresses abstinence, shame reduction, and rebuilding the capacity for healthy intimacy as primary tasks of the first three years of treatment. The following discussion will expand upon these concepts.

Educational Objectives

- Define sexual addiction and the sexual addiction cycle.
- Define sexual anorexia.
- Describe prevalence and gender differences in sexual addiction.
- Discuss the role of trauma in the development of sexual addiction.
- List the components of healthy sexuality.
- Discuss Internet sex and pornography addiction.
- Describe treatment of sexual addiction.

Defining Sexual Addiction

Although the current version of the Diagnostic and Statistical Manual (IV-TR) has a definition for hypoactive sexual disorder it does not contain a category related to hyperactive sexual disorders. Sexual addiction is categorized under “Sexual Disorders Not Otherwise Specified.” The DSM provides as an example of this broad category “distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used.” Although this definition provides a starting point, it is helpful to look at definitions that are broader in scope.

Goodman (1998) defines sexual addiction as a condition in which some form of sexual behavior is employed in a pattern that is characterized by two key features: 1) recurrent failure to control the sexual behavior, and 2) continuation of the sexual

behavior despite significant harmful consequences. Goodman also points out that no form of sexual behavior in itself constitutes sexual addiction. The significant features that distinguish sexual addiction from other patterns of sexual behavior are: 1) the individual is not reliably able to control the sexual behavior, and 2) the sexual behavior has significant harmful consequences and continues despite these consequences. Examples of sexually addictive behaviors are multiple sexual partners, compulsive masturbation, increasing reliance on pornography to meet sexual needs, engaging in compulsions in public and or risky sexual behavior.

According to Carnes (2001), another important part of this definition involves the Core Beliefs that sex addicts hold:

22. "I am basically a bad, unworthy person."
23. "No one would love me as I am."
24. "My needs are never going to be met if I have to depend on others."
25. "Sex is my most important need."

Case Vignette

John, a 28-year-old homosexual man spent evenings "cruising" local parks, public restrooms, and pornographic bookstores for sexual contacts. This activity consumed several hours a day. His primary outlet was sex with multiple anonymous partners. When he learned of a recent increase in the number of local gay men that had tested positive for HIV, he began to worry constantly about his risk of contracting the virus. Still, he was unable to change his unsafe sexual practices despite repeated promises to himself to do so.

Cycle of Sexual Addiction

Sexual behavior that is compulsive or continues despite adverse consequences, is an addiction. There are a number of additional components to this cycle of sexual addiction:

32. Sex addicts tend to sexualize other people and situations, finding sexual connotations in the most ordinary incident or remark.
33. They spend great amounts of time and/or money in pursuit of a "quick fix."
34. Any sexual behavior can be part of the addictive cycle: The context of the behavior must be considered to ascertain whether the behavior is compulsive.
35. What is healthy sexual behavior for many people may be unhealthy for others, just as use of alcohol causes no adverse consequences for most people but severe problems for some.

36. Sex addicts describe euphoria with sex similar to that described by drug addicts.
37. This may be an effect of endorphins and other endogenous brain chemicals, whereas the drug-induced state is externally produced.
38. The addiction's effects on the brain are similar to the effects of cocaine, amphetamines, compulsive gambling, and risk-taking behaviors.
39. Sex addicts engage in distorted thinking, rationalizing, and defending and justifying their behavior while blaming others for resulting problems. They deny having a problem and make excuses for their behavior.

Sexual Anorexia or Hypoactive Sexual Desire Disorder

Sexual addiction is one end of the addictive spectrum; at the other end of sexual anorexia. The DSM identifies a sexual disorder known as Hypoactive Sexual Desire Disorder. The features are a deficiency or absence of sexual fantasies and desire for sexual activity. This is considered a disorder if it causes distress for the patient or problems in the patient's relationships. If the sexual partner of a patient with suspected hypoactive sexual desire disorder feels that this is a problem within the relationship, that concern should be sufficient for the individual to seek support.

Carnes (1998) first coined the term sexual anorexia, which is similar to the DSM disorder but broader in scope. He uses the term to describe a loss of "appetite" for romantic-sexual interaction (Carnes, 1998). Sexual anorexia is an obsessive state in which the physical, mental, and emotional task of avoiding sex dominates one's life. Like self-starvation with food, sexual deprivation can make one feel powerful and defended against all hurts.

Like other addictions the preoccupation with avoiding sex can become a way to cope with life's difficulties. For the sexual anorectic, the aversion to things sexual is a way to manage anxiety and avoid more painful life issues. Food anorexia and sexual anorexia share a number of similarities including the essential loss of self, distortion of thought, and struggle for control over self and others.

The sexual anorexic typically experiences the following:

- A dread of sexual pleasure
- A morbid obsession and persistent fear of sexual contact
- Obsession and hypervigilance around sexual matters
- Avoidance of anything connected with sex
- Preoccupation with being sexual
- Distortions of body appearance

Extreme shame and loathing about sexual experiences, their bodies, and sexual attributes.

Obsessive self-doubt about sexual adequacy

Rigid, judgmental attitudes about sexual behavior

As with the sexual compulsive, the sexual anorexic's aversion affects their work, hobbies, friends and families. They obsess about sex so much it interferes with normal living. They may also have periods of sexual bingeing or periods of sexual compulsivity.

Case Vignette

Anne, a 32-year-old divorced, mother of two women, also a compulsive eater, entered treatment due to what appeared to be a generalized anxiety disorder. Within the course of therapy she revealed that this anxiety was actually due to constant fears of men's potential sexual advances. She would interpret relatively benign conversations with male co-workers as containing frequent sexual innuendo, and was fearful of leaving her cubicle at work. She would often think about these conversations late into the evening.

Prevalence and Gender Differences

Case Vignette

Naomi, a 27-year-old woman is seeking treatment due to severe depression. During her assessment, she shared with her therapist that she does not seem to have trouble finding relationships, but does have difficulty sustaining them. Naomi has had "relationships" with 10 men this month alone, all of them sexual and none of them lasting more than two weeks. She seems confused when her clinician suggests that she may have a sexual addiction.

Due to the secrecy and shame associated with sexual addiction, it is difficult to get a reliable estimate of the rate of sexual addiction and prevalence statistics are likely underestimated. The National Association of Sexual Addiction Problems estimates that 6 to 8 percent of Americans are sex addicts. (Ewald, 2003). About 8% of men and 3% of women from the population in the US are sexually addicted. This constitutes over 15 million people. The literature suggests that like other addictions sexual compulsivity is nonselective and spans all ages, religions, and social stratas, and that both genders and all sexual orientations are represented.

In working with male and female sex addicts, one anecdotal difference often cited by clinicians is male addicts' objectification of sexual partners (e.g., exploitive sex, paid sex), and their use of sex as a way to feel powerful (Carnes, Nonemaker, and Skilling, 1991). In contrast, some women appear to seek "relationships" through their sexual activities. A National Council on Sex Addiction and Compulsivity position paper

(2000) on female sex addicts suggests that most sexually compulsive women have not had appropriate role models to teach them how to achieve emotional intimacy in nonsexual ways.

Sexual Compulsivity and Trauma

Case Vignette

James, a 40-year-old man struggling with Internet addiction has been in treatment working on the behaviors. In looking at the types of sites and pornography he is seeking, his therapist comments that there seems to be a pattern of him selecting older women with fair complexions. In asking whether that reminds him of anyone, James breaks down and talks about his relationship with his mother, who was overly sexual, such as wearing only underwear around the house when James was a young boy. He often wonders if that had affected him in any way.

The beginnings of sexual addiction are usually rooted in adolescence or childhood, especially in experiences of abuse. Sixty percent of sexual addicts were abused by someone in their childhood (Book, 1997). Children who become sexually addicted may have grown up in harsh, chaotic or neglectful homes, or they may have been emotionally starved for love and affection. Boundaries in the family may have been overly rigid or permissive, which inhibited personal growth and individuality. For children growing up in these environments, sex may become a replacement for any kind of need, from escaping boredom, to feeling anxious, to being able to sleep at night. Sexual addiction often begins as the child turns to masturbation for diversion (Ewald, 2003). In other cases, the child may be introduced to sex in inappropriate ways, such as through sexual abuse by a trusted adult or by an older child (Carnes, 2001).

Oftentimes, early trauma results in confusion about sexuality and sexual expression. People with sexual addiction are acting on a compulsion to act out sexually. Those struggling with sexual addiction often do not understand why they are acting out.

Trauma also affects one's ability to be intimate sexually and the act of sex become confusing. Sexual addiction instead recreates the original act of abuse by misusing power or exploitation (Ewald, 2003). There is also little comprehension among many abuse survivors that certain behaviors are risky or degrading. There is often a secretive aspect to sexual addiction.

Sexual addiction and compulsivity may also be used as a means of self-soothing. "Contrary to enjoying sex as a self-affirming source of physical pleasure, the addict has learned to rely on sex for comfort from pain for nurturing or relief from stress" (Carnes, 1991, pp 34). The need for excitement distracts from the survivor's internal pain.

Internet Sexual Addiction

With the growing popularity of the Internet, the Internet provides an endless source for those with sexual addictions. In addition to other risks, the Internet is filled with material such as pornography, sex chat rooms, and child pornography.

Rosenberg (2010) lists the following signs of Internet Sexual Addiction

- Spending progressive amounts of time on the Internet
- Behavior begins to affect other areas of the individuals life, such as work, family, hobbies
- Binge-style of sexual or Internet behavior
- Unsuccessful efforts to cut down, or stop altogether
- Experiencing guilt and shame following the sexual behavior
- Others indicate that the person spends too much time on the Internet
- Experiencing money or legal problems because of Internet use
- Thoughts of "getting online", or of sexual behavior, are compulsive even when not online or engaged in sexual behavior (i.e. work, with family, etc.)
- Telling lies or making excuses for behavior

Dimensions of Healthy Sexuality

Due to the difficulties that those with sexual addiction have in understanding healthy sexuality, it is important to help them create a schema for what healthy sexual expression entails. Carnes (1997) presents the following dimensions of healthy sexuality:

- Nurturing □capacity to receive care from others and provide care for self.
- Sensuality □mindfulness of physical senses that create emotional, intellectual, spiritual, and physical presence.
- Self image □positive self-perception that includes embracing the sexual self.
- Self-definition □clear knowledge of oneself (both positive and negative) and the ability to express boundaries and needs
- Comfort □capacity to be at ease about sexual matters
- Knowledge □knowledge base about sex and one's unique sexual patterns.
- Relationship □capacity to have intimacy and friendship with both those of the same gender and opposite gender.
- Partnership □ability to maintain an interdependent, equal relationship that is intimate and erotic.
- Nongenital sex □ability to express erotic desire without the use of the genitals.
- Genital sex □ability to freely express erotic desire with the use of the genitals.
- Spirituality □ability to connect sexual desire and expression to the value and meaning of one's life.

- **Passion** □ capacity to express deeply held feelings of desire and meaning about one's sexual self, relationships, and intimacy experiences.

Treatment of Sexual Addiction

Treatment of sexual addiction focuses on controlling the addictive behavior and helping the person develop a healthy sexuality and healthy interpersonal relationships. Treatment generally includes:

- **Education** about healthy sexuality, including the dimensions discussed above.
- **Defining sobriety.** The person seeking to recover from sexual addiction must learn to develop his or her own definition of "sobriety." This may mean not masturbating, not engaging in sexual relationships outside a committed relationship, or not accessing Internet sites.
- **Individual counseling,** to better understand the reasons behind sexual addiction, triggers to addictive behaviors, support abstinence from addictive behaviors, and reinforce coping skills. Individual counseling also involves helping with shame reduction and rebuilding the capacity for healthy intimacy
- **Marital and/or family therapy,** to resolve issues caused by the sexual addiction and to develop and strengthen family boundaries.
- **Support groups and 12 step recovery programs** for people with sexual addictions (like Sex Addicts Anonymous, Sexaholics Anonymous, Sex and Love Addicts Anonymous) are very helpful, especially in reducing shame around the addictive behaviors.

- **Medications** used to treat obsessive compulsive disorder may be used to treat the compulsive nature of the sex addiction. These include selective serotonin reuptake inhibitors (Prozac, Paxil) or medications specifically indicated for OCD such as Anafranil.

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Topics in Human Sexuality: Sexual Orientation

Introduction

Case Vignette

Neil is a 45-year-old man presenting for therapy. In the initial assessment Neil was open about his sexual orientation. He was quick to note this openness was hard won, and describes that in his teens, 20s and early 30s, he underwent a constant internal battle to deny his feelings for other men. He dated several women during those years, but “always knew” that he was not really attracted to them, but this did not stop his efforts to find an “acceptable” relationship. He describes attempting to subvert these feelings through involvement with a conservative church and through significant alcohol abuse. It was during one of his experiences in a treatment and through the efforts of a sensitive and accepting clergyman that he was finally able to embrace his sexuality. He has been able to establish connections with the local gay community, has dated several men, and has not had a drink since.

When many people think of sexual orientation, they often think of a simple definition: the gender to whom one is attracted. As Neil’s story illustrates, this is just part of the picture. The American Psychological Association (2008) defines sexual orientation as “an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes.” In addition, sexual orientation also refers to a person’s sense of identity based on those attractions including related behaviors, and membership in a community of others who share those attractions. The key word here is identity; there is often a misperception that homosexuality only applies to a person’s sexual attractions.

Research over has demonstrated that sexual orientation ranges along a continuum, from exclusive attraction to the other sex to exclusive attraction to the same sex. However, sexual orientation is usually discussed in terms of four categories: tendency to be attracted to people of the same sex (homosexual orientation), of the opposite sex (heterosexual orientation), or of both sexes (bisexual orientation) and lack of sexual interest and attraction (asexuality). This is not unique to the United States and many cultures describe sexual attraction in this way, and attempt to label these behaviors. In the United States the most frequent labels are *lesbians* (women attracted to women), *gay men* (men attracted to men), and *bisexual people* (men or women attracted to both sexes). However, some people may use different labels or none at all. Another term that is sometimes used is *queer*. This was originally a derogatory label used to insult lesbians and gay men, but has more recently been reclaimed by some lesbians, gay men, bisexual people, and transgender people as an inclusive and positive way to identify all people targeted by homophobia.

Homophobia, or hatred of people with same-sex attraction, is damaging. In 1997 The American Psychological Association issued a position statement on “conversion treatment,” approaches that involve trying to “force” someone to become heterosexual. The position statement says “. . . societal ignorance and prejudice about

same-gender sexual orientation put some gay, lesbian, bisexual and questioning individuals at risk for presenting for "conversion" treatment due to family or social coercion and/or lack of information (Haldeman, 1994). Since that time, educational efforts on behalf of the APA and other professional organizations have targeted educating others about homosexuality and decreasing prejudice and misunderstanding.

As of April 2011, approximately 3.5% of American adults identify as lesbian, gay or bisexual, while 0.3% identify as transgendered—approximately 11.7 million Americans.

This training material will look at the development of sexual orientation and provide a basis for caring therapeutic intervention.

Educational Objectives

1. Define the term "sexual orientation"
2. Discuss the development of sexual orientation.
3. Discuss instances and effects of prejudice and discrimination, including internalized homophobia.
4. Discuss the historical factors in the view that homosexuality is a mental disorder, and describe current beliefs.
5. List stages in the coming out process.
6. Describe tips for working with gay and lesbian clients.

Defining Sexual Orientation

As defined by the APA, sexual orientation is an enduring pattern of emotional, romantic, and/or sexual attraction. It also includes a person's self-identification and sense of who they are based on those attractions, as well as their community of supports. It is important to note that Sexual orientation is distinct from other components of sex and gender, such as biological sex, gender identity (the psychological sense of being male or female), and social gender role (norms that define feminine and masculine behavior). What is most important in this definition is that sexual orientation is not simply a trait, but should be defined in terms of relationships with others.

There is some debate as to how early people are aware of their sexual orientation. Herdt and McClintock (2000) believe that sexual orientation is formed by middle childhood. They state: "Accumulating studies from the United States over the past decade suggest that the development of sexual attraction may commence in middle childhood and achieve individual subjective recognition sometime around the age of 10. As these studies have shown, first same-sex attraction for males and females typically occurs at the mean age of 9.6 for boys and between the ages of 10 and 10.5 for girls." While other theorists look at early adolescence as the timeframe, it is likely

that sexual orientation emerges prior to any sexual experience. People can be celibate and still know their sexual orientation. Debate also continues as to whether sexual/romantic orientation is stable or can change over the course of a person's lifetime.

Development of Sexual Orientation

What influences a person to be gay, lesbian, straight or bisexual? Is sexual orientation a function of nature, nurture, or a combination of the two? Although numerous studies have attempted to answer this question, there is little consensus among researchers as to the definitive answer. Thus research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation. Our current thinking is that both nature and nurture play complex roles and that most people experience little or no sense of choice about their sexual orientation. This view is helpful in remediating the prejudice that gay men and lesbian women often encounter.

Prejudice, Discrimination, Scope and Impact

Case Vignette

Karina, an openly lesbian woman tells a shocking story about what she has experienced as a result of prejudice and misunderstanding. Karina's physical appearance is what may be considered more masculine. She describes going to a bar in her mid-twenties, and being regaled with comments from visibly intoxicated males about her appearance. When she left the bar, two men followed her and she was raped, while being told by these men that they could "change her."

This is a true experience that not surprisingly did not "change" Karina's sexual orientation, but did leave scars that took years to heal. Lesbian, gay, and bisexual people in the United States encounter extensive prejudice, discrimination, and violence because of their sexual orientation. Opinion studies over the 1970s, 1980s, and 1990s routinely showed that homosexuality was viewed negatively by the American public. Although there may be a shift in this thinking, expressions of hostility, such as the one described in the case vignette, remain common in contemporary American society.

There are a number of "myths" about homosexuality. As the sampling below illustrates, these myths are extremely destructive:

Myth: Homosexuality is a result of family dysfunction, such as an overprotective mother.

Myth: Homosexual parents are more likely to molest their same-gender children.

Myth: Homosexuality is a moral failing.

Myth: People choose to be homosexual as a way of rebelling.

Myth: Male homosexuals cannot form committed relationships and only engage in casual sex.

Myth: Lesbians are always “butch.”

Myth: Only homosexual therapists can be effective with gay clients.

It is important to remember that these beliefs continue to exist. Although many people know that these are untrue, gay men and lesbian women encounter these frequently.

Perhaps less overtly destructive, but certainly detrimental, is discrimination against lesbian, gay, and bisexual people in employment, housing and parenting issues. There are also pervasive stereotypes about gay men and lesbian women. Bisexual men and women often face the view that they just need to make up their minds about their sexual orientations. As a whole, such discrimination sends the message to gay men and lesbian women that they are “less than,” and this has lasting effects.

The following belief systems about homosexuality may be seen. There is distinct continuum in these beliefs (Tolerance, 2011). Mental health professionals need to be aware of their own beliefs and prejudices about gay, lesbian and bisexual behavior.

- *Abomination:* Homosexual behavior is profoundly immoral at all times; there are no exceptions.
- *Change is expected:* Gay men and lesbian women can and must make every effort to change their sexual orientation to become heterosexual.
- *Celibacy:* If a homosexual cannot change their orientation, they must remain celibate.
- *Marginally acceptable:* Loving committed same-sex relationships are somewhat acceptable, and much better than singles living promiscuously.
- *Affirmation:* Homosexuality is morally neutral. Persons of all sexual orientations deserve equal rights.
- *Liberation:* Full acceptance and valuing of persons of all sexual orientations.

Case Vignette

Maria and her girlfriend Terry had been in a committed relationship for ten. When they decided they wanted to start a family, Terry, the income earner in the family, adopted two children from Viet Nam. The two partners parented the children, but Maria was the primary caretaker, staying at home with them. When the partners split up acrimoniously, Maria found that she no longer had rights to see her children. A visit to a lawyer confirmed that she could challenge Terry's decision to keep the children from

her, but her lawyer was pessimistic that the courts would rule on her behalf. Fortunately Maria's lawyer proved to be a fierce advocate of Maria's rights as a parent, and an out-of-court arrangement was drafted.

Stories such as that of Maria can be found in the personal narrative of most gay men or lesbian women. Such discrimination has social and personal impact. As with Max's story, gay, lesbian and bisexual people may attempt to conceal or deny their sexual orientation, or may carefully choose whom they share their sexual orientation with. Although many lesbians and gay men learn to cope with the social stigma against homosexuality, this pattern of prejudice can have serious negative effects on health and well being, as well as their overall emotional health.

While coping with external prejudice is challenging, even more concerning is the internalization of societal messages. Theorists term this phenomena *internalized homophobia*. Internalized homophobia is defined as "the gay person's direction of negative social attitudes toward the self" (Meyer & Dean, 1998, p. 161). Studies have consistently demonstrated a relationship between internalized homophobia and depressive symptoms (e.g., Igartua, Gill, & Montoro, 2003; Szymanski, Chung, & Balsam, 2001). Research has also looked at how the combination of depression and internalized homophobia can result in relationship problems.

Although an exhaustive look at these issues is not possible here, it is important for mental health professionals to talk with gay and lesbian clients about their experiences and self-concept. Social support is critical in helping men and women deal with these stressors. In fact, the explanation of minority stress — stress caused from a sexual stigma, manifested as prejudice and discrimination — is often used to explain some of the mental health issues faced by gay and lesbian clients. This is a dramatic shift from previous ideas that homosexuality itself was a mental disorder, and which is discussed in the following section.

Homosexuality as a Mental Disorder: An Important Shift

Case Vignette

Barry, a 62-year-old gay male has recently consulted with Dr. Cherney. When questioned about the obvious trepidation he has in seeking counseling, Barry tearfully explains that as a young man he had worked with a therapist in order to try to change his sexual orientation. Although he is quick to point out that his experiences were similar to other men in his cohort, they left him feeling very shameful about his inability to repress his sexual attractions. Dr. Cherney validates that these experiences were very damaging, and that homosexuality is considered a normal and healthy sexual expression.

Freud and Psychoanalysis

Mental health, as a field, has undergone a shift in our understanding of homosexual behavior. A brief historical discussion is illuminating, with regard to our changing viewpoints of sexual attractions, and whether these were considered normative or pathological. Sigmund Freud was one of the earliest proponents of the idea that sexuality ranges on a continuum and has environment influences. He expressed the idea that all people are innately bisexual, and that they become heterosexual or homosexual as a result of their experiences with parents and others (Freud, 1905). In a now-famous letter to an American mother in 1935, Freud wrote:

"Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime, and cruelty too.... (reprinted in Jones, 1957).

Freud's liberal viewpoints were the target of much debate in the psychoanalytic world, with supporters and dissenters. Many of the later relegated homosexuals to a small minority, thus validating that it was an aberration. Kinsey's (1948) research challenged this, showing that 10% of the population has either engaged in or fantasized a about same-sex attraction.
Hooker

Evelyn Hooker (1957) is credited with publishing the first empirical research to challenge the prevailing psychiatric assumption that homosexuality was a mental illness. Her work is considered the cornerstone subsequent research that ultimately led to removal of "homosexuality" from the Diagnostic and Statistical Manual of Mental Disorders. Hooker administered projective tests to 30 homosexual males and 30 heterosexual males matched for age, IQ, and education. Independent raters attempted to say whether they could distinguish sexual orientation from responses and were unable to do so. The evaluator's adjustment ratings of the homosexuals and heterosexuals did not differ significantly. Hooker concluded that homosexuality is not inherently associated with psychopathology. These results were subsequently replicated.

DSM Diagnoses

In 1973, the American Psychiatric Association removed the diagnosis of "homosexuality" from the DSM-III. Subsequently, a new diagnosis, ego-dystonic homosexuality, was created for the DSM's-III (1980). The criteria for ego dystonic homosexuality was (1) a persistent lack of heterosexual arousal, which the patient experienced as interfering with initiation or maintenance of wanted heterosexual relationships, and (2) persistent distress from a sustained pattern of unwanted homosexual arousal. Therapy often centered on so-called "reparative" or

“conversion” therapies (American Psychiatric Association, 2000). Behavior therapists tried a variety of aversion treatments, such as inducing nausea, providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts. Such efforts were especially prevalent during the 1960s and 1970s

In 1986, the diagnosis of ego-dystonic homosexuality was removed entirely from the DSM-III-R. Following the removal of this diagnosis, behavior therapists became increasingly concerned that aversive therapies were inappropriate, unethical, and inhumane (see Davison, 1976, 1978; Davison & Wilson, 1973; M. King, Smith, & Bartlett, 2004; Martin, 2003; Silverstein, 1991, 2007). Such therapies reinforce stereotypes and contribute to a negative climate for lesbian, gay, and bisexual persons.

Homosexuality as one orientation

The consensus of the behavioral and social sciences and the health and mental health professions is the belief that homosexuality is a normal variation of human sexual and romantic orientation. In a report of the American Psychological Association task force on appropriate therapeutic responses to sexual orientation states “Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders.”

According to the American Psychological Association (n.d.):

- Research has found no inherent association between homosexual orientation and psychopathology.
- Both heterosexual behavior and homosexual behavior are normal aspects of human sexuality.
- Lesbian, gay, and bisexual orientations represent normal forms of human experience, and are normal forms of human bonding.

The same report states that helpful responses of a therapist treating an individual who is troubled about her or his same-sex attractions include helping that person actively cope with social prejudices against homosexuality, resolve issues associated with and resulting from internal conflicts.

The Coming Out Process

Case Vignette

Renee, a 32-year-old lesbian woman is from a conservative religious family. A major source of stress between her and her partner, Kay, is the fact that Renee has not disclosed their relationship to her parents. Although her parents are good about

inviting Renee's "roommate," Kay to family occasions, they do not "know" that Renee is lesbian. Kay has become more challenging of this, and Renee feels conflicted.

By this point in the training material, it is evident that most gay, lesbian and bisexual people have experienced prejudice and discrimination. This sometimes results in secrecy about sexual orientation, as illustrated in the case vignette above. Research, however, has shown that feeling positively about one's sexual orientation and integrating it into one's life fosters positive emotional adjustment. This often involves disclosing one's identity to others. This often increases the availability of social support, and connection with the gay and lesbian community, which enhances psychological functioning.

Coming out is the process of recognizing, accepting, and sharing one's sexual orientation with others. This is not a single event, but a life-long process, and may begin at any age. Although there are many "models" of the coming out process, it is not exactly the same for every person. Some gay, lesbian and bisexual people choose to keep their identity a secret; some choose to come out to a limited number of people; and some decide to come out publically.

Vivienne Cass (1979) developed the first formal model of homosexual identity. Her model is based on the idea that the acquisition of a homosexual identity is a developmental process resulting from the interaction between the individual and his or her environment. Cass identifies six stages of perception and behavior that starts out with little awareness or acceptance of a homosexual identity and the progress to a final stage in which one's homosexual identity is integrated. These stages are identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride and identity synthesis.

Although not the same for everyone, there aspects to the coming out process that Cass identifies and that are fairly universal. The process generally begins with the self-recognition a person is attracted to members of the same sex. A person may experiences "crushes," as a child or adolescent, or may know that they are not attracted to the same people as peers. These feelings may result in confusion or in attempts to deny or repress attractions. This may be met with anxiety, or trying to "be" heterosexual. Many gay men and lesbian women report dating others of the opposite sex, but often state that the experience was not fulfilling. There may also be sexual experimentation, such as when a person is intoxicated and freer in sexual expression. There is a general sense of uncertainty about one's sexuality. Cass calls this stage *identity confusion*.

In the *identity comparison* stage, the person accepts the possibility of being gay or lesbian and examines the wider implications of that tentative commitment. They may explore disclosure in a limited or "joking" sense, but have not yet taken the step of full commitment to their sexuality. Oftentimes, gay, lesbian, and bisexual people experience some degree of social alienation during this stage. This is part of the process of acknowledging one's sexuality as different from the mainstream.

Cass (1979) calls the next state of the coming out process *identity tolerance*. During this time acknowledgment and acceptance of one's sexual orientation develops. There may be some grief over the loss of a traditional heterosexual life. Gay and lesbian people may be fairly closeted at this point. However, most seek out information about being gay, and may begin to interact with other gay, lesbian and bisexual people. Such personal experience may begin to build a sense of community.

In the *identity acceptance* stage, the person accepts, rather than tolerates, his or her homosexual self-image. There is often increased contact with gay and lesbian subculture and less with heterosexuals. A person may also feel increased anger toward anti-gay society. The hallmark of the identity acceptance stage is greater self-acceptance.

Identity pride is Cass's next stage. At this point, a the person, who has accepted their sexual orientation, is fully immersed in gay and lesbian subcultures. There may be less interaction with heterosexuals, and a person may view the world divided as "gay" or "not gay". People who are here in their identity development may be more confrontational with the established heterosexual world; for example
-Disclosure to family, co-workers

The final stage is called *identity synthesis*. As the name implies, this is the stage in which the person's gay or lesbian identity is integrated with other aspects of their identity. There is greater recognition that there are supportive heterosexual people in their life. In this stage, sexual identity still important but not primary factor in relationships with others.

Tips for Working With Gay and Lesbian Clients

While there are many excellent therapists, it is not a given that everyone can be equally effective with gay, lesbian, and bisexual clients. Here are some "tips"

1. Assess your own prejudices. If you think that you cannot enter into a therapeutic relationship with a homosexual client without bias, do not do so. It also helps to remember that therapists all have biases. Be aware of your countertransference, and above all, do no harm.
2. Disclose, even prior to an initial meeting. If a gay or lesbian potential client asks for your sexual orientation, it is fine to ask why (e.g., have they had negative experiences in the past) and also fine to describe your own experience in working with gay and lesbian patients.
3. Continue to educate yourself on issues related to sexuality, prejudice and minority stress.

4. Know local resources for gay and lesbian clients.
5. Ask clients about their own experiences of discrimination and prejudice.
6. Choose words carefully. Some clients may be offended by certain word choices, such as sexual preference (a preferable word may be sexual or romantic orientation) and the term “alternative lifestyle” may be equally offensive.
7. Understand the stages of the coming out process. Never force your own beliefs about disclosure on others. Many clients, however, prefer direct feedback on this and other issues.
8. Although beyond the scope of this material, it is also important to understand differences between gay and lesbian couples and gay and lesbian parenting issues.
9. Be aware of practice guidelines for your professional affiliation.

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27.

Topics in Human Sexuality: Sexuality and Childhood Sexual Abuse

Case Vignette

Maria is a happily married 27-year-old woman. She and her husband, Jeff, share many common interests and values. They would like to begin their family, however, this presents a problem. Maria is a survivor of childhood incest. Her grandfather, who is now deceased, was the person responsible. Although Maria would like to be sexual with Jeff and tries to do so, he is acutely aware of her discomfort during lovemaking. He has stopped trying to initiate sexual intimacy because he feels like "a perpetrator." Maria is upset and unhappy about the situation.

Most mental health professionals are acutely aware of the profound effects of child sexual abuse. Childhood sexual abuse and incest have become increasing areas of concern for clinicians. This is in part due to the prevalence rates of abuse: 28 to 33 percent of women and 12 to 18 percent of men have been sexually abused during childhood or adolescence (Roland, 2002). These numbers do not account for the many, particularly men, who remain silent about their abuse.

Childhood sexual abuse presents many therapeutic challenges. Childhood sexual abuse is a betrayal of intimacy. As such, relational problems of many types may result from past abuse. One of the primary areas in which this is seen are within sexual relationships. Childhood sexual abuse often prevents survivors from achieving satisfying sexual relationships.

Understanding the impact of childhood sexual abuse and its effects on sexuality will help mental health professionals to better counsel individuals and couples.

Objectives:

- Define sexual abuse
- Discuss the non-sexual effects of abuse
- Describe myths of male victimization
- Discuss effects of trauma and sexual abuse connected to adult sexuality
- Describe techniques that can be used in counseling abuse survivors
- Define and describe sensate focus

Definition of Childhood Sexual Abuse and Incest

The American Medical Association defines child sexual abuse as "the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent" (American Medical Association, 1992). The most significant feature of child sexual abuse is that the dominant position of an adult allows him or her to coerce the child into sexual activity (American Psychological Association, 2001). Child sexual abuse may include fondling a child's genitals,

masturbation, oral-genital contact, digital penetration, or vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as making a child watch pornography or look at an adult's genitals. Sexual abuse may also include abuse by a child's peer.

Although all forms of sexual abuse are damaging, incest is particularly destructive. Landis and Wyre (1984) view incest as a result of impaired intimacy of an adult perpetrator. Often the perpetrators of incest fear adult intimacy and misuse their power by seeking inappropriate closeness with the victim. The results of incest and other forms of sexual abuse may not be evident until the survivor reaches adulthood and seeks his or her own relationships.

Effects of Trauma and Sexual Abuse

Childhood sexual abuse is damaging. The effects of sexual abuse include those related to emotional/psychological health and physical health. A brief discussion of these effects is included because it is important to see the survivor holistically and not to focus only on relational and sexual problems. Although many of the things described below are not immediately related to adult sexuality they have less direct effects.

Sexual abuse impacts the survivor's sense of safety and well-being. As a result, those who have been sexually victimized are more likely to develop psychological problems. The most common of these are disorders along the depressive spectrum, including major depressive disorder and dysthymia (Molnar, Buka & Kessler, 2001) and anxiety disorders (Levitan, et. al, 2003).

Victims of child sexual abuse are also at higher risk for developing addictive behaviors including substance abuse problems (Day, Thurlow, & Woolliscroft, 2003) and eating disorders (Kendler et. al, 2000). There are many reasons for this. Substance use and abuse results in emotional numbing and may be a way to modulate emotions or to decrease painful feelings. People who develop eating disorders often describe similar functions to the disorder. Survivors are often uncomfortable with their bodies and do not want others to see them. This certainly impacts their abilities to be sexual with partners and those with eating disorders may eschew sexual experiences due to these body image concerns.

Some abuse survivors also exhibit somatic concerns such as migraine headaches, other aches and pains, asthma, and gastrointestinal upsets. Some gastrointestinal and respiratory problems may symbolically relate to the abuse, such as nausea being related to forced oral sex. Other physical symptoms include tension, heart palpitations, trembling, poor sleep, sweating and loss of appetite. Fibromyalgia and Chron's disease are also found more frequently in trauma survivors (Miller, 2005). When physical problems occur, survivors are less likely to show interest in sexual intimacy. It is difficult to want to be sexual, for example, when a person is experiencing a flare up of Chron's disease.

Case Vignette

Kathy, a 29-year-old sexual abuse survivor has been in an out of treatment for a severe eating disorder since childhood. The bulimia began as a teen and after disclosing that her older brother had molested her. Kathy's psychological problems have prevented her from holding down a consistent job, and her social network is quite limited as she is often seen as "draining" and "needy" in relationships. Her sexual relationships mirror her problems with food — she is restrictive and not interested in sexual relationships sometimes, and has other times when she is promiscuous, "binging" on sex.

Male Survivors

Although many of the issues described above are pertinent to male and female survivors of sexual abuse, there are some special issues to consider when working with male survivors. Johaneck (as cited in Renken, 2000) describes three myths of male victimization:

- "Real men" would fight or resist the abuse
- Sexual response to abusive behaviors "shouldn't happen."
- Offenders are homosexual and forever "taint" the victim.

Males tend to struggle with issues of homophobia and vulnerability. They may direct feelings of anger about the abuse outwardly or engage in sexual acting-out behaviors.

Effects of Trauma and Sexual Abuse Connected to Adult Sexuality

Case Vignette

Joe is a married father of two. He describes a history of sexual molestation by a male clergyman when he was 9. Joe is vocal in his homophobia and expression of hatred for gays and lesbians. It came as a shock to everyone when Joe was arrested for soliciting an undercover officer posing as a male prostitute. Joe is ashamed of his behavior and fearful that he will continue to act out in this compulsive way.

It is no surprise that childhood sexual abuse has an impact on adult sexuality. Just as survivors of childhood sexual abuse exhibit many different types of concerns that relate to the abuse, there is no single presentation with regard to adult sexuality. Broadly defined, the effects of sexual abuse on adult sexuality fall into one of the following categories:

- Difficulty establishing intimate relationships
- Avoidance behaviors

- Intense emotional reactions or numbing
- Physical problems related to sexuality
- Intrusive thoughts or fantasies
- Sexually risky behaviors

Establishing Intimacy

In addition to problems with sexual intimacy, survivors of sexual abuse also experience difficulties in close relationships. Bass & Davis (2008) define intimacy as a “bonding between two people based on trust, respect, love, and the ability to share deeply.” It is no question that sexual abuse damages a person’s ability to trust others. Many see trust as an all-or-nothing experience, rather than being able to develop trust in another person. In relationships, trauma survivors may be hypervigilant to any sign that the person is not trustworthy. Although this is protective, it also impedes the ability to establish a relationship, especially one that will be sexual.

Another common impediment to establishing intimacy is confusing the past with the present. Although a partner may loosely share some characteristics with an abuser, that does not mean that he or she *is* abusive. A survivor may react by distancing, or by merging — creating a state of dependency. Neither of these extremes is solid ground for an intimate or a sexual relationship.

Avoidance Behaviors

Sexual abuse survivors may also go to lengths to avoid sexual expression and intimacy. This may manifest in lack of sexual interest or inhibited sexual desire. Maltz (2001) identifies this as the most common sexual problem in this population. Sometimes sexual avoidance behaviors are hidden by other, more overt behaviors, such as an abuse survivor who self-injures or overeats with the intention of making herself unattractive to a potential partner. This may be due to fears about sexual intimacy and which developed in childhood. There may also be strong negative reactions when touched. Some abuse survivors approaching sex only as an obligation.

Intense Emotional Reactions Or Numbing

Another common sexual problem for abuse survivors is the intensity of emotional reactions when engaging in sexual behaviors. Survivors often report negative reactions, such as fear, guilt, anger or disgust. These feelings are generally rooted in the past rather than the present and are one of the most challenging things for couples to work on. Other abuse survivors describe a sense of emotional numbing, such as in the first vignette presented in this material, or a feeling of being dissociated or distant during sexual activities. Another difficult experience is that of having a flashback during sexual experiences.

Physical Problems Related To Sexuality

With the close connection between mind and body makes sense that those with a history of abuse may experience physical problems related to sexuality. Adult abuse survivors often report difficulties with sexual arousal (in women, lack of lubrication, in men, inability to develop or maintain an erection), difficulty with intercourse (muscle pain, spasm, fear of penetration), difficulty experiencing orgasm (anorgasmia), or difficulty averting orgasm (premature ejaculation in men, rapid orgasm in women). Some of these problems, such as lack of ability to achieve orgasm, may be related to messages that trauma survivors received from their abusers, such as that they are somehow sexually inadequate.

Intrusive Thoughts Or Fantasies

Sexual abuse survivors often have difficulty with their sexuality. They may have intrusive thoughts or fantasies about sex, such as fantasies or the reality of sexual pleasure being linked to pain. They may also fantasize about being in power or control during sex or other types of aggressive sexual behavior. Intrusive thoughts and fantasies are defenses, and require delicacy on the part of the counselor.

Sexually Risky Behaviors

Some survivors of sexual abuse report risky or inappropriate sexual behaviors. This may include sexual compulsivity, promiscuity, or acting-out behaviors. These indiscriminate sexual behaviors may actually be accompanied by a lack of physical pleasure. Another sequelae of sexual abuse may be sexual behaviors such as exotic dancing or prostitution. This is often seen in situations in which a child was rewarded for sexual favors, and gained esteem and power through these rewards.

Many survivors have difficulty setting boundaries, especially those of a sexual nature, and may be unable to “say no” to sex, even when they do not desire it. Boundary-setting and communication are key parts of counseling.

Other Sexual Problems

Other sexual problems may include:

40. Compulsive masturbation
41. Sexualizing relationships and situations
42. Believing that sex is dirty or disgusting
43. Confusion about sexual orientation
44. Lack of sexual knowledge

Sexuality Counseling

Counseling for couples in which one member has a history of abuse is challenging and requires specialized knowledge and skills. Long, Burnett, & Thomas (2006) describe a stage model that they term integrative couples counseling. They include the following interventions in their approach:

28. Detailed history of sexual abuse experiences
29. Reasons for seeking counseling
30. Use of sexual genograms
31. Exploration of feelings about abuse
32. Communication about sexual needs and desires
33. Exploration of guilt and shame issues
34. Journaling feelings about sexuality
35. Sensory exercises that include non-sexual touch
36. Initiation of sex/ability to decline sex
37. Relaxation techniques for anxiety
38. Direct feedback about likes and dislikes
39. Physical exercise as a way to increase control
40. Sensate focus activities and masturbation training

Sensate Focus

Sensate focus exercises were originally introduced by Masters and Johnson. The goal is to increase awareness of each [other's](#) needs. One of the key components of this approach is the lack of outcome orientation — the goal is to become aware of responses and feelings rather than to reach orgasm.

The first stage of sensate focus involves non-genital touch. In this stage the couple is encouraged to touch each other's bodies and to be aware of feelings and sensations. Should the survivor become scared, overwhelmed or dissociative, the experience is terminated. Couples are told that no intercourse is allowed, and that it is a way to gain appreciation of one another. Touching, talking, and hugging are encouraged. Use of techniques such as relaxation and breathing techniques and grounding are important to counteract anxiety.

The next stage of sensate focus increases focus on touch. Genital touch is still not allowed. Couples are taught during this stage to put their hand over the other's hand to demonstrate what is pleasurable and what is not. The experience can be stopped at any time if the survivor needs to do so.

Touch is gradually increased at the pace the couple needs and to include genital contact and finally intercourse.

Summary

Sexual abuse has lingering effects on adult behavior, relationships and sexuality. Helping abuse survivors to recognize these effects and providing a caring supportive environment in which the individual and couple can heal is key to recovery.

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Topics in Human Sexuality: Sexual Disorders and Sex Therapy

Introduction

Sexual disorders, such as erectile disorder in men, and orgasmic disorder in women, cause much psychological stress, both to the person with the disorder and to his or her partner. These disorders are also a primary reason that couples seek counseling. Although these disorders have been around for quite some time, psychological understanding of sexual disorders is relatively new. As with much of psychology, clinicians used Freud's theories to explain sexual behavior. Sexual disorders were seen as pathological in nature and there was little distinction between difficulties in function and sexual "perversions."

This changed in the 1970s with the publication of Masters and Johnson's *Human Sexual Inadequacy*. Unlike prior explanations of sexuality, which were based on theory, Masters and Johnson studied the psychology and physiology of sexual behavior in a laboratory. They also recorded physiological data from the sex organs during sexual excitation, and framed their findings using language that described sex as a healthy and natural activity that was also source of pleasure and intimacy. Their work is pivotal to our understanding of sexuality and sexual disorders. Many of our cognitive behavioral treatments and techniques extend from this body of work.

This training material will define the term "sexual disorder," and will discuss various kinds of sexual disorders. It will examine the physical and psychological causes of sexual disorders and will discuss therapies for sexual disorders.

Educational Objectives

7. Define the term "sexual disorder"
8. List the characteristics of male erectile disorder
9. Define Premature/Early Ejaculation, including proposed DSM V changes and use of the squeeze technique
10. Describe Male Orgasmic Disorder, and list causes and treatment
11. Describe Female Orgasmic Disorder, and list causes
12. Define Female Sexual Arousal Disorder, state common causes of the disorder, and describe treatment alternatives
13. List symptoms and causes of dyspareunia
14. List symptoms and causes of vaginismus
15. Discuss sexual desire disorders
16. Discuss commonly used approaches to sex therapy

Defining Sexual Disorders

A sexual disorder (or sexual dysfunction) is a problem with sexual response that causes a person psychological distress. Sexual dysfunction generally refers to a difficulty experienced during any stage of a normal sexual activity as described below.

These stages of normal sexual activity are:

- **Desire:** Desire to participate in sexual activity, including fantasies about sexual activity
- **Excitement phase (initial arousal):** Combines the psychological sense of sexual pleasure as well as physiological changes, in men, erections, and in women, vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitals
- **Orgasm:** Peak of sexual activity.
- **Resolution phase (after orgasm):** Sense of muscular relaxation and well-being. Males have a refractory period during which further erection and orgasm is not possible. Women are capable of additional stimulation and multiple orgasm.

Sexual disorder, then, involves difficulties with desire, arousal and orgasm and in women also include sexual pain disorders (dyspareunia, vaginismus). In looking at these examples, it follows that there is a continuum; many people experience problems like this from time to time, and part of the difficulty is in determining when a problem is considered a disorder. Some factors to consider in making a judgment as to whether a disorder is problematic is the age and experience level of the person, the frequency and chronicity of symptoms, and effect on overall functioning. Another important factor in assessing sexual disorders is the determination of whether such a disorder is purely physical or whether there are psychological factors. There may also be a combination of the two.

Male Erectile Disorder

Case Vignette

Laura and John had been in couples counseling for a number of sessions when they began to open up about recent sexual activities. The couple had been married for 9 years, and had a satisfactory sexual relationship to this point. Recently, however, John and begun to experience difficulty sustaining an erection. Laura felt devastated, and as if she was unattractive.

One of the most psychologically distressing male disorders is erectile disorder. Erectile disorder is the persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection. Most men experience transient episodes of erectile disorder that are temporary and usually associated with

fatigue, anger, depression or stressful emotions.

Basically, an erection occurs when blood fills the penis. Erections begin with a sexual signal or stimulus such as a partner's touch, erotic visuals, sexual sounds, certain smells, fantasies or other stimuli. During arousal, the blood vessels of the penis dilate, and muscles around the penis relax, allowing for an increase in blood flow and resultant penile erection. Erectile disorder can occur at any stage during this process.

There are varying patterns of erectile disorder. Men with erectile disorder may report the inability to experience any erection from the beginning of a sexual experience, while others experience an erection that is not maintained at penetration. Other men may lose the erection during sexual intercourse, and others can only experience erection upon awakening or during self-masturbation. There are a number of causes of erectile dysfunction including drugs and alcohol, age, fatigue, certain medications, medical problems (diabetes, cardiovascular disorders) and psychological factors (stress, anxiety).

Men with erectile dysfunction should be evaluated medically to determine any physiological factors in erection problems. Sometimes erectile problems can be addressed through lifestyle changes, or the use of Kegel exercises strengthen the pelvic floor, which can lead to stronger erections and enhanced ejaculatory control or through medications such as Viagra, Cialis or Levitra.

Premature Ejaculation

Premature ejaculation is defined as persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Premature ejaculation is also known as *rapid ejaculation*, *rapid climax*, *premature climax*, or *early ejaculation*. When assessing for the presence of premature ejaculation the clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity. Thus, both psychological and biological factors can play a role in premature ejaculation.

Premature ejaculation is a common sexual complaint. Estimates vary, but as many as 1 out of 3 men may be affected by this problem at some time. There are a number of subtypes of this disorder, including lifelong/acquired type, and generalized/situational type.

Although we know that premature ejaculation is relatively common, one of the difficulties in establishing accurate prevalence statistics is the absence of an agreed upon definition of what timeframes constitute premature ejaculation (Beutel, 2006). The DSM V Workgroup has looked at these issues, and proposed the following criteria for Early Ejaculation (previously called Premature Ejaculation):

- A. The symptom must have been present for at least 6 months and be experienced on all or almost all (approximately 75%) occasions of sexual activity: Persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute of beginning of sexual activity and before the person wishes it.
- B. The problem causes clinically significant distress or impairment.
- C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due to the effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Another interesting change proposed for the DSM V is the attempt to specify the possible causes of the disorder. Although physiological factors are represented here (e.g., medical conditions) the majority of potential causal factors are psychological. These specifiers include:

- 1) With concomitant problems in sexual interest/sexual arousal
- 2) Partner factors (partner's sexual problems, partner's health status)
- 3) Relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity)
- 4) Individual vulnerability factors (e.g., poor body image, history of abuse experience) or psychiatric comorbidity (e.g., depression or anxiety)
- 5) Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity)
- 6) With medical factors relevant to prognosis, course, or treatment

There are a number of potential treatment options for Premature Ejaculation. These include Cognitive Behavioral Therapy, Medications (antidepressants and topical anesthetic creams). The most common treatment, however, is known as The Squeeze Technique (Mayo Clinic, n.d.):

- 1. The couple begins sexual activity as usual, including stimulation of the penis, until the male with early ejaculation feels the urge to ejaculate.
- 2. Partner squeezes the end of his penis, at the point where the head joins the shaft, and maintain the squeeze for several seconds, until the urge to ejaculate passes.
- 3. After the squeeze is released, the couple is instructed to wait for about 30 seconds, then go back to foreplay.
- 4. Repeat the squeeze process.

By repeating this process as necessary, the male can generally engage in sexual intercourse without ejaculating prematurely. After a few practice sessions, the problem generally remits.

Male Orgasmic Disorder (Retarded Ejaculation)

Male orgasmic disorder involves persistent or recurrent inability to achieve orgasm despite lengthy sexual contact or while participating in sexual intercourse. The affected man may regularly experience delays in orgasm, or may be unable to experience orgasm altogether. As with Early Ejaculation, Male Orgasmic Disorder may be lifelong/acquired or generalized/situational.

Male orgasmic disorder is found in all races and ethnic groups. The lifelong type of the disorder generally occurs around puberty. In the acquired type of male orgasmic disorder, the person will have had the previous experience of normal sexual function. In these cases, a situational factor generally precipitates the disorder (causes will be discussed below). Male orgasmic disorder is relatively rare, with prevalence studies of male orgasmic disorder placed at about 0 - 3% of the population (Simons & Carey, 2001).

Male Orgasm

To better define male orgasmic disorder, it is important to review male orgasm. Orgasm in the male includes emission followed by ejaculation. *Emission* refers to a sensation of approaching ejaculation produced by contractions of the prostate gland, seminal vesicles, and urethra. This is accompanied by muscular tension, perineal contractions, and pelvic thrusting. Following orgasm, there is a period of resolution characterized by feelings of well-being and muscular relaxation.

Causes of Male Orgasmic Disorder

The cause of male orgasmic disorders may be organic or psychological.

Organic causes:

- Use of antidepressant medications, especially SSRIs
- Substance abuse
- Thyroid disorders (both hyperthyroidism and hypothyroidism)
- Pituitary conditions (such as Cushing's syndrome)
- Hypogonadism, in which the testes do not produce enough testosterone.
- Diseases that affect the nervous system, such as strokes, multiple sclerosis, diabetic neuropathy and spinal cord injuries
- Surgery affecting the prostate and other pelvic organs

Psychological causes:

- Depression
- Feelings of guilt, anger, fear, low self-esteem, and anxiety
- Fear of getting partner pregnant or of contracting a sexually transmitted disease

- Severe stress
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma
- Having been raised in atmosphere of strict sexual taboos

Treatment

The most common cases of male orgasmic disorder are related to use of SSRIs. The course of action here is to try another medication or to try another medication as an antidote to the SSRI.

For male orgasmic disorder that is unrelated to SSRIs, standard treatment for inhibited orgasm involves eliminating performance anxiety and ensuring adequate levels of physical stimulation. Similar to the squeeze technique, the couple is instructed to caress the penis manually or orally until erection is attained, but told to cease stimulation when arousal approaches the point of orgasm. This reduces performance anxiety and allows the man to enjoy the sexual pleasure provided by touching. The eventual goal is to allow the man to reach orgasm.

Female Orgasmic Disorder

Female Orgasmic Disorder is the persistent or recurrent inability of a woman to have an orgasm after adequate sexual arousal and sexual stimulation. Inability to have an orgasm, discontent with the quality of orgasms, and the ability to have orgasms only with one type of stimulation are common sexual complaints among women. Some studies have found that about half of all women experience some orgasmic difficulties, but not of all these difficulties are considered Female Orgasmic Disorder. About 50% of women experience orgasm through direct clitoral stimulation but not during intercourse, thus not meeting the criteria for a diagnosis of Female Orgasmic Disorder. About 10% of women never experience an orgasm, regardless of the situation or stimulation.

Female Sexual Response and Orgasm

In order to better understand Female Orgasmic Disorder, it is helpful to review the physiological process of female orgasm. When a woman is sexually excited, the blood vessels in the pelvic area expand, allowing more blood to flow to the genitals. This is followed by a surge of fluid into the vagina, which provides lubrication before and during intercourse. These events are called the "lubrication-swelling response."

Body tension and blood flow to the pelvic area continue to build as a woman receives more sexual stimulation; this occurs either by direct pressure on the clitoris or as pressure on the walls of the vagina and cervix. This tension builds as blood flow

increases. When tension is released, pleasurable rhythmic contractions of the uterus and vagina occur; this release is called an "orgasm." The contractions carry blood away from the genital area and back into general circulation.

It is normal for orgasms to vary in intensity, length, and number of contractions from woman to woman, as well as in a single individual from experience to experience. Unlike men, woman can have multiple orgasms in a short period of time. Mature women, who may be more sexually experienced than younger women, may find it easier to have orgasms than adolescents or the sexually inexperienced. In orgasmic disorder, sexual arousal and lubrication occur. Body tension builds, but the woman is unable or has extreme difficulty reaching climax and releasing the tension. This inability can lead to frustration and unfulfilling sexual experiences for both partners.

The most effective form of therapy for female orgasmic disorder is a program of directed masturbation, which is used to maximize familiarity with pleasurable sensations. Use of erotic materials (videos, books) or vibrators. Many therapists also encourage erotic or nonerotic fantasy.

Kegel exercises (contraction of the pelvic floor) may also be used to strengthen vaginal muscles that have been stretched through childbirth. Kegel exercises also help to increased muscle tone, improve orgasmic intensity, correct of orgasmic urine leakage, provide distraction during intercourse and improve awareness of sexual response.

Female Sexual Arousal Disorder

Case Vignette

Maria and Jose had been married for 12 years. They had recently started to argue about sexual difficulties in the marriage. Since Maria had started the "change," she was no longer was easily aroused sexually. Although the couple would attempt to proceed with intercourse, it was uncomfortable, and Maria was increasingly avoiding sexual intimacy.

Female Sexual Arousal Disorder is a characterized by a persistent or recurrent inability to attain sexual arousal or to maintain arousal until the completion of a sexual activity, or an adequate lubrication-swelling response that otherwise is present during arousal and sexual activity. As the name and characteristics suggest, this disorder is specific to the physiological desire component of sexual activity, not in a loss of interest in sexual activity. Subtypes of this disorder include lifelong/acquired and generalized/situational.

Prevalence statistics for Female Sexual Arousal Disorder vary widely, with some sources reporting a lifetime prevalence of 5-10% of adult females, and some reporting up to 20% of adult females.

Causes of Female Sexual Arousal Disorder may be either physical or psychological. These include:

Physical causes

- Surgical procedures such as a hysterectomy may affect changes in blood flow, which can cause a lack of sensitivity and sexual arousal
- Decrease in estrogen levels associated with menopause may make the vagina dry and thin, even causing it to shrink
- Medications such as oral contraceptives, antihypertensives and antidepressants, benzodiazepines
- Chronic diseases such as diabetes; vascular disease associated with diabetes
- Surgical trauma or nerve damage to the pubic area

Psychological Causes

- Depression, stress
- Poor body image
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma
- Having been raised in atmosphere of strict sexual taboos

Dyspareunia

Dyspareunia refers to pain experienced during intercourse. It is a general term used to describe all types of sexual pain. Sexual pain may occur upon penetration, during intercourse, and/or following intercourse. It can exist anywhere in the genital area – the clitoris, labia, or vagina, etc. While dyspareunia is generally thought to be a female disorder, men can experience pain during intercourse.

Glatt et al, (1990) conducted a prevalence study of dyspareunia in women. They surveyed 428 women. 39.0% of those surveyed had never had dyspareunia; 27.5% had had dyspareunia at some point in their lives which resolved, either spontaneously or with specific treatment. Frequency of intercourse was not different among any of the groups analyzed, although 48.0% of the women reported a decrease in sexual frequency and 33.7% reported an important adverse effect on their relationships as a result of dyspareunia. Most of the women had not discussed their dyspareunia with a doctor and were unaware of the cause of their problem.

There are a number of possible causes of dyspareunia. These include:

Physical causes

- Insufficient lubrication
- Injury, trauma or irritation. Includes injury from pelvic surgery, episiotomy or a congenital abnormality.

- Inflammation, infection or skin disorder
- Reactions to birth control products. Allergic reactions to foams, jellies or latex or an improperly fitted diaphragm or cervical cap.
- Vaginismus (see below)
- Illnesses. Including endometriosis, pelvic inflammatory disease, uterine fibroids, cystitis, irritable bowel syndrome, hemorrhoids and ovarian cysts.
- Infections. An infection of the cervix, uterus or fallopian tubes.

Psychological causes

- Depression, stress
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma

A personal lubricant can make sex more comfortable. It is also important to treat underlying physical conditions. For postmenopausal women, dyspareunia is often caused by inadequate lubrication resulting from low estrogen levels, and can be treated with a prescription cream or oral medication.

Vaginismus

Vaginismus is a condition where there is involuntary tightness of the vagina during attempted intercourse. The tightness is actually caused by involuntary contractions of the pelvic floor muscles surrounding the vagina. In some cases vaginismus is so severe that the woman cannot have intercourse (Reissing et al, 2003/2004).

Vaginismus is not a common disorder in the general population, but it is common among couples seeking therapy, accounting for 12 to 17 percent of cases (Spector & Carey, 1990).

Physical Causes

- Medical conditions- including urinary tract infections or urination problems, yeast infections, sexually transmitted disease, endometriosis, genital or pelvic tumors, cysts, cancer, pelvic inflammatory disease
- Pain related to childbirth
- Age-related changes - Menopause and hormonal changes, vaginal dryness/inadequate lubrication

Psychological causes

- Fear - Fear or anticipation of intercourse pain, fear of not being completely physically healed following pelvic trauma, fear of getting pregnant, concern that a pelvic medical problem may reoccur, etc.
- Anxiety or stress
- Partner issues
- Traumatic events

Sometimes there is no identifiable cause (physical or non-physical)

Sexual Desire Disorders

Case Vignette

Mariah and John presented for couples counseling shortly after their son's first birthday. John was angry, stating that Mariah had been rejecting him since the baby's birth. The baby slept in bed with them, and Mariah always had an "excuse" as to why she did not want to be sexually intimate.

Inhibited sexual desire (sexual aversion, sexual apathy or hypoactive sexual desire) is characterized by a low level of sexual interest resulting in a failure to initiate or respond to sexual intimacy. Inhibited sexual desire may be a primary or secondary condition. Inhibited sexual desire may also be specific to the partner, or it may be a general attitude toward any potential partner.

A diagnosis of hypoactive sexual desire disorder refers to a persistent or recurring lack of desire or an absence of sexual fantasies. In hypoactive sexual disorder, sexual performance may be adequate once activity has been initiated. This disorder occurs in approximately 20 percent of the population and is more common in women, though it does affect both men and women.

Sexual aversion disorder refers to a condition in which sexual contact is repulsive. This disorder occurs less frequently than hypoactive sexual desire.

Sexual desire disorders are related to both physical and psychological causes. Many of these causes are similar to other sexual disorders discussed previously and include:

Physical causes

- Physical causes resulting in fatigue, pain, or general feelings of malaise
- Some medications, such as antidepressants
- Hormonal changes
- Insomnia, which can result in fatigue

Psychological causes

- Relationship or communication problems
- Relationships lacking in emotional intimacy
- Lack of affection between partners
- Power struggles
- Lack of one-on-one time for partners to be alone together

- A very restrictive upbringing concerning sex, or negative or traumatic sexual experiences
- Depression or excessive stress
- History of childhood sexual abuse and persons

Therapies for Sexual Disorders

Any therapeutic intervention for sexual disorders begins with an assessment of what underlies the condition. In the case of a psychological cause, therapy is indicated.

Behavior Therapy

The premise of behavior therapy is that sexual problems are the result of prior learning and that they are maintained by ongoing reinforcements and punishments. A key technique is systematic desensitization in which the client is led through exercises to reduce anxiety.

Master's and Johnson (1970) utilize a behavior therapy approach in many of the interventions they developed. A premise of their work is that anxiety is related to goal-oriented sexual performance. Spectatoring involves a person focusing on him or herself from a third person perspective during sexual activity, rather than focusing on one's sensations and/or sexual partner; can increase performance fears and cause deleterious effects on sexual performance.

Sensate focus exercises are aimed at increasing personal and interpersonal awareness of self and the other's needs. Each participant is encouraged to focus on his or her own senses rather than to view orgasm as the sole goal of sex.

Education is another important component of behavior therapy. Topics include information about normal anatomy, sexual function, normal changes of aging, pregnancy and menopause among others.

Cognitive-Behavioral Therapy

Many sex therapists use a combination of the behavioral techniques pioneered by Masters and Johnson (1970) and cognitive-behavioral therapy. Cognitive behavioral therapy is a therapeutic process that attempts to change feelings and actions by modifying or altering faulty thought patterns or destructive self-verbalizations."(Goldenberg & Goldenberg, 1991) Cognitive restructuring is particularly appropriate in situations in which negative attitudes towards sexuality contribute to sexual dysfunction.

Couples Therapy

The goal of couple's therapy is to address interpersonal issues in the relationship. Common interpersonal conflicts include relationship conflicts; extra-marital affairs; current physical, verbal or sexual abuse; sexual libido; desire or practices different from partner; poor sexual communication. In couples therapy, partners focus on resolving relationship issues, resolving conflicts and enhancing the relationship. Communication is also a key aspect of couples counseling. Communication training helps couples learn how to talk to one another, demonstrate empathy, resolve differences with respect for each other's feelings, express anger in a positive way, and demonstrate affection. Couples are also helped to learn to reserve time for activities together.

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