Sexual Dysfunctions and Gender Identity Disorder

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Lets talk about sex

Talking about sex can be difficult. It may be more difficult when you think something is wrong. Sexuality and sexual experiences are intimate and most people have times when things didn't go right, followed by disappointment, anxiety, embarrassment and burning questions of, "What is wrong with me?" or, "Am I Normal?" So when do normal sexual difficulties become a disorder?

What are Sexual Dysfunctions?

We have only recently gained a deeper understanding of the "normal" human sexual response. In doing so, we have learned that there are differences between people in their usual response. Nevertheless, it has been possible to highlight four phases: desire, arousal, orgasm, and resolution. People with sexual disorders are unable to complete the normal sexual response cycle or experience pain during intercourse.

> Sexual disorders are classified into four groups according to the sexual response phase they affect. These are: disorders of the desire phase, the arousal phase, the orgasm phase, and sexual pain disorders.

Disruption to the sexual response cycle can occur during any sexual activity. To have efficient sexual function, we require a certain degree of physical fitness such as having adequate hormone control and intact blood vessels and nervous system. If sexual dysfunction is due to a general medical condition, side effects from drugs or drug abuse, part of another disorder or is limited to a specific partner and worsens when the relationship is worse, it is a secondary sexual disorder.

Sexual desire disorders

Hypoactive sexual desire disorder is a low level or lack of sexual desire that results in a failure to initiate or respond to a partner's initiation of sexual activity. It is the most common sexual dysfunction. The most

common cause seems to be relationship problems. Sexual aversion disorder is like an extreme version of inhibited sexual desire wherein someone not only lacks sexual desire, but they actively avoids genital contact or may be repulsed or revolted by sexual experience.

Disorders of the arousal phase

Female sexual arousal disorder used to be known as frigidity but is usually caused through inadequate vaginal lubrication to allow comfortable intercourse. In men, if there is failure to attain or maintain an erection through to completion of the sexual activity, it is referred to as male erectile disorder. It appears more common as men get older. Disruptions to the desire phase account for almost half the complaints of both men and women seeking help with sexual dysfunctions.

Orgasm disorders

Females can experience *inhibited orgasm*, which refers to the absence of orgasm after a period of normal sexual excitement following stimulation. Between 5 and 10% of women have reportedly never experienced an orgasm. *Male orgasm disorder,* sometimes called ejaculatory incompetence, is the inability to ejaculate during intercourse, masturbation, or through manual or oral manipulation. *Premature ejaculation disorder* is an inability to inhibit an orgasm. Premature ejaculation is the most common sexual dysfunction among males and is often associated with anxiety.

Sexual Pain Disorders

Dyspareunia involves persistent or recurrent pain before, during, or after intercourse. It is more common in women. Dyspareunia may be caused by insufficient lubrication in the female. Insufficient lubrication may be due to breast feeding, lack of oestrogen in menopausal women, or anxiety. *Vaginismus* involves involuntary vaginal spasms that stop intercourse. Vaginismus can be caused by sexual trauma.

What causes sexual disorders?

Sexual disorders can result from past events. These events lead some people to have fears about their current sexual performance. It is also possible that people have not learned enough about sex and sexuality. In addition, other factors are important. These include communication difficulties, lack of intimacy or trust, power conflicts, physical well being, the role of anxiety, the effects of society and culture.

How can we treat sexual disorders?

The reasons for a sexual dysfunction are complex and specific to individuals. Thus, the best treatments are formulated following thorough assessment that may include the partner of the sufferer or a physical check-up.

Education:

Sex education involves discussions about sex, sexual intercourse, and physical anatomy. Sometimes sex education reduces anxiety by informing people what is happening to their bodies and why they feel the way they do. By not treating sex as a taboo, it may also lessen embarrassment.

Anxiety reduction:

The treatment involves teaching muscle relaxation. Once the person is relaxed, they are exposed to anxiety provoking material or situations in a graded fashion from least anxiety provoking up to most anxiety provoking. It is believed that a person who is relaxed cannot be anxious at the same time.

Directed Masturbation:

The masturbation program is based on a sexual skill learning model and usually involves both partners. This treatment includes self-exploration, body awareness, effective self-stimulation training and the use of "orgasm-triggers". Directed masturbation has been primarily used for

women who have never experienced an orgasm and is the most probable method of producing orgasm. Directed masturbation also implicitly says it is okay to seek sexual gratification that in turn is likely to result in improvements.

Skills and Communication Training:
Skills and communication training is useful when both partners are involved in treatment. This treatment involves written materials, videos, films and discussion of techniques to encourage expressing likes and dislikes. Some couples will need to learn conflict resolution and be helped to work through differences in non-sexual areas. Communication training such as talking on a feeling level, showing empathic understanding, resolving differences in a manner that reflects sensitivity and respect for the feelings of others, learning how to express anger constructively, and reserving time for couple activities, are particularly effective in treating sexual desire disorders.

Sensory Awareness procedures:
These procedures encourage sufferers to "tune-in" to pleasant sensations. They are aimed at changing attitudes and thoughts, making people more aware of sensual and sexual feelings.

Cognitive behaviour therapy:
It is a psychological therapy that focuses on behaviours, problem solving and cognitions (thoughts) related to roles, standards and experiences. It aims at changing sexual anxiety, attitudes, and teaching skills to enhance a better understanding of their own and their partner's feelings and thoughts.

Medical treatment:
Sometimes physical problems contribute to sexual dysfunction that can be helped by medication. For example, post menopausal women suffering dyspareunia may be helped by oestrogen and drugs can help with male erectile dysfunctions. Surgical procedures can be used in orgasmic

disorders and men can have implants and surgery to rectify erectile problems. When appropriate, drugs and surgery are important treatments.

Helpful reading

Heiman, J.R., & LoPiccolo, J. (1988). ***Becoming orgasmic: A sexual and personal growth program for women*** (2nd ed). New York:Prentice-Hall.

Zilbergeld, B. (1995). ***Men & Sex: A guide to sexual fulfilment.*** London: Harper Collins.

Gender Identity Disorder

Gender is how one feels inside; sex is a physical reality. Gender identity is one's sense of being male or female. Sometimes people feel their body conflicts with their gender. These people may have a gender identity disorder. They feel extreme discomfort with their physical sex. They feel and identify themselves as members of the opposite sex. It affects about one in seven hundred people and is more common in men. Physical disorders can produce confusion in one's physical gender, but these cases are not gender identity disorder.

Children who have gender identity disorder may insist that he or she is the opposite sex, an intense desire to dress and play as the opposite sex, strong preference for opposite sex playmates and sometimes a belief they will grow genitalia of the opposite sex. In adolescents and adults it is expressed as *transsexualism* and is characterised by lifelong distress and a belief they were born the wrong sex. Such individuals may dress and behave like the gender they believe themselves to be and wish to remove secondary sex characteristics.

The causes of gender identity disorders are poorly understood. Despite theories of hormonal imbalances from hormones taken in pregnancy,

chromosomal abnormalities, differences in brain structures and responses to cross-dressing as children, there has been no evidence why some people suffer from gender identity disorder. Some believe it results from unjustified stereotyping by assigning gender with culturally accepted behaviours. Despite little evidence about causes, there has been a considerable advance in treatment.

Some treatment has involved family interventions such as father-son interaction programs and athletic skills training. However, with innovations in surgery and hormonal treatment many transsexuals feel able to become a member of the opposite sex. Transsexuals undergo a 1-2 year preparation that includes living as a member of the opposite sex, taking hormones, understanding limitations and consequences of surgery and counselling in a gender identity program. During surgery, substitute genitals are constructed. During reassignment to a female, an artificial vagina is created and conventional heterosexual intercourse is possible but not pregnancy. During reassignment to a male, an artificial penis is constructed that is incapable of a normal erection.

An alternative is to alter gender perception to match the physical sex. Gender role components are identified and training targets each component. For example, if an individual's mannerisms were identified, these components may be trained through video feedback, modelling and rehearsal. Although successful, most prefer sex reassignment.

The Gender Dysphoria Foundation of WA is a support group.
Write to C/O WISH, PO Box 8140, Perth Business Centre WA 6849,
or email at http://www.gdfwa.unetix.com.au

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