SEXUAL DYSFUNCTIONS AND PARAPHILIAS

DSM-IV

SEXUAL DESIRE DISORDERS
302.71 Hypoactive sexual desire disorder
302.79 Sexual aversion disorder
SEXUAL AROUSAL DISORDERS
302.72 Female sexual arousal disorder
302.72 Male erectile disorder
ORGASMIC DISORDERS
302.73 Female orgasmic disorder
302.74 Male orgasmic disorder
302.75 Premature ejaculation
SEXUAL PAIN DISORDERS
302.76 Dyspareunia (not due to a general medical condition)
306.51 Vaginismus (not due to a general medical condition)
(Refer to *DSM-IV* manual for sexual dysfunctions due to a general medical condition)
PARAPHILIAS
302.4 Exhibitionism
302.81 Fetishism
302.89 Frotteurism
302.2 Pedophilia
302.83 Sexual masochism
302.84 Sexual sadism
302.82 Voyeurism
302.3 Transvestic fetishism

Sexual disorders include sexual dysfunctions and paraphilias. Sexual dysfunction is defined as persistent impairment/disturbance of a normal or desired pattern in any phase of the sexual response cycle. Paraphilias are more specific disorders in which unusual or bizarre imagery or acts are necessary for realization of sexual excitement. Because many paraphiliac behaviors are illegal in most states, individuals usually come for psychiatric treatment because of pressure from others, partners, or the authorities/judicial system.

ETIOLOGICAL FACTORS

Psychodynamics

Individual causes of sexual desire disorders may include religious beliefs, obsessive-compulsive personality, conflicts with gender identity or sexual preference, sexual phobias, fear of losing control over sexual urges, secret sexual deviations, fear of pregnancy, inadequate grieving following the death of a spouse, depression, and aging-related concerns. Psychological factors may also be involved in arousal disorders.

Psychoanalytical theories state that paraphilias are the product of childhood desires that survive into adulthood in their immature forms because emotional development has been inhibited, distorted, and diverted. These wishes are believed to be universal and are used to achieve arousal and release when ordinary forms of sexual activity are not available. Deviations arise when these immature forms of libido dominate adult sexual life. Fixation is thought to occur in Freud's oral, anal, and phallic phases when corresponding body parts provide sources of instinctual gratification. Conflict arises when an imperfect compromise occurs between these impulses and reality, resulting in fear, which the unconscious perceives as castration.

Behavioral theorists believe any paraphilia/sexual dysfunction can be acquired through conditioning, in which an initial pairing of an object is accidentally associated with/then becomes necessary for sexual release. This need may become generalized to other situations of tension/anxiety.

Biological

Sometimes the cause is clearly biological (e.g., temporal lobe epilepsy that may cause changes in sexual behavior between seizures). It has also been suggested that the problem arises out of interference with brain pathways governing rage and sexual arousal. Sex hormones have been studied. Rat studies have demonstrated that small, properly timed doses of androgens (male hormones) or estrogens (female hormones) in the fetus or newborn can influence sexual behavior. Various organic reasons, medication and other drug use, physical illnesses (most notably diabetes mellitus), surgery (such as prostatectomy), and degenerative neural disorders (e.g., multiple sclerosis) may be involved in sexual desire, arousal, and pain disorders.

It is generally accepted that abnormal hormonal activity and biological (genetic) predisposition interacting with social and family factors influence the development of these fantasies/sexual acts. Although these behaviors may occur in normal sexual activity, when they become the primary source of sexual satisfaction they may result in problems for the individual/others.

Family Dynamics

There appears to be some evidence that paraphilias run in families and may be the result of dysfunctional family interactions and social learning.

Sexual dysfunctions are believed to be influenced by what the individual has learned/not learned as a child within the family system and by values and beliefs that may be based on myths and misconceptions.

CLIENT ASSESSMENT DATA BASE
SEXUAL DYSFUNCTIONS

Neurosensory

Mental Status: Findings may indicate intense distress about situation/condition or coexisting psychiatric disorders

Mood and affect may reveal evidence of increased anxiety and depression

Sexuality

Problems may be lifelong or acquired after a period of normal sexual functioning

May report inhibition or interference with some part of the human response cycle (e.g., low sexual desire, aversion to genital sexual contact, arousal/erectile/orgasmic disturbances, premature ejaculation, genital pain during or after sexual intercourse, and involuntary spasm of the outer third of the vagina interfering with coitus)

May display negative attitude(s) toward sexuality

Social Interactions

Impairment may be noted in marital/conjugal relations but rarely affects job performance

Teaching/Learning

Most commonly occur in early adulthood, although male erectile disorder may surface later in life

PARAPHILIAS

Ego Integrity

May express shame or guilt about behavior
May or may not act on fantasies

Neurosensory

Personality disturbances frequently accompany sexual disorder(s)

Safety

Physical injury may be seen following episodes of sadomasochistic activity

Sexuality

Recurrent, intense sexual urges and fantasies involving the exposure of one's genitals to a stranger that have been acted on, cause severe distress, and may be accompanied by masturbation (exhibitionism)
Use of nonliving object(s) to stimulate recurrent intense sexual urges and sexually arousing fantasies (e.g., female undergarments [fetishism])
Rubbing and touching against a nonconsenting person to invoke recurrent, intense sexual urges and fantasies, with the touching, not the coercive nature of the act, causing sexual excitement (frotteurism)
Sexual activity with a prepubescent child or children (pedophilia)
Participation in the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer (sexual masochism)
Participation in acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person (sexual sadism)
Cross-dressing activities (transvestic fetishism)
Observing unsuspecting person(s), usually a stranger, who is naked, in the process of disrobing or engaging in sexual activity (voyeurism)

Social Interactions

May not view self as ill; however, behavior may cause distress for the individual or may bring suffering to others
May be in conflict with partner or society because of behavior
Possible interference with interpersonal/occupational functioning

Teaching/Learning

Occurs mostly in males
Some evidence of occurrence in families of paraphiliacs and of depressed individual; high correlation between pedophiles and family history of pedophilic activity

DIAGNOSTIC STUDIES

As indicated, to rule out physical causes of sexual dysfunction.
Screening for sexually transmitted diseases (STDs) including HIV/AIDS.

NURSING PRIORITIES

1. Assist client to understand the nature of the behavior (disorder⁄dysfunction).
2. Encourage use of acceptable methods for reduction of anxiety.
3. Help to recognize the legal⁄interpersonal consequences of paraphilic behaviors.
4. Explore options for change.
5. Encourage involvement of client⁄family (significant other) in treatment regimen.

DISCHARGE GOALS

1. The nature of the problem and consequences for the individual⁄family understood.
2. Anxiety reduced⁄managed in acceptable ways.
3. Options explored and appropriate one(s) chosen.
4. Confidence in own capabilities⁄sense of self-worth expressed.
5. Participating in treatment program and using community⁄treatment resources effectively.
6. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS	SEXUAL dysfunction/SEXUALITY PATTERNS, altered
May Be Related to:	Biophysical alteration of sexuality: ineffectual or absent role models; vulnerability; misinformation; physical/sexual abuse
	Lack of significant other
	Loss of sexual desire; disruption of sexual response pattern (e.g., premature ejaculation, dyspareunia)
	Conflicts involving values; conflicts with variant preferences
	Knowledge/skill deficit about alternative responses
Possibly Evidenced by:	Reported difficulties, limitations/changes in sexual behaviors or activities
	Alterations in achieving sexual satisfaction; difficulty achieving desired satisfaction in socially acceptable ways
Desired Outcomes/Evaluation Criteria—Client Will:	Verbalize understanding of sexual anatomy/ function and individual reasons for sexual problems.
	Recognize stressors involved in lifestyle that contribute to dysfunction.
	Identify satisfying/acceptable sexual practices and some alternative ways of dealing with sexual expression.
	Demonstrate improved communication and relationship skills.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Obtain sexual history, noting when problem(s) began, degree of anxiety, presence of relationship, conflict between partners, displacement of pattern of arousal to other than the opposite sex, and client desire/need for change.	Identification of individual situation promotes appropriate goal-setting and interventions.
Determine cultural/value conflicts, preexisting problems affecting current situation.	Stress in other areas of life often affects sexual functioning. Client may feel guilt and shame or feel depressed because of sexual difficulties/deviant behavior.
Explore possible drug use.	Substance/prescription drug use may affects sexual functioning/be used to relieve anxiety of sexually deviant behavior.
Avoid making value judgments.	Does not help client deal with the situation or feel better about self.
Determine what client needs/wants to know and provide information accordingly. Review information regarding safety and/or consequences of actions.	Prevents unnecessary repetition of information or presenting information client is not willing to hear. Reviewing necessary information gives client message that it is important and serves as a reminder of own responsibility.
Encourage open discussion of concerns and expression of feelings and assist with problem-solving.	Promotes thinking about causes/results of behavior(s) and resolution of problem.
Provide sex information/education, as necessary.	Lack of knowledge may be significant to underlying problem(s).
Encourage completion of structured homework exercises dependent on behavior and individual needs (e.g., avoidance of coitus/orgasm, use of masturbation, planned progression of intimate activity, diary of feelings/perceptions).	Heightened sensory awareness and improved nonverbal communication with partner in an atmosphere free of demands for sexual performance may resolve sexual dysfunctions. **Note:** Clients without partners may benefit from assertiveness training, self-exploration, permission to fantasize, correction of misconceptions.
Collaborative	
Refer for assessment of physical conditions (e.g., presence of diabetes, vascular problems).	Between 1/3 and 1/2 of clients with sexual dysfunction have a physical condition that interferes with sexual functioning.
Monitor penile tumescence during REM sleep, as indicated.	Impotence can be assessed by noting erectile ability occurring during sleep. Physical conditions are ruled out when erection occurs.

Refer to appropriate resources as necessary (e.g., clinical specialist psychiatric nurse, professional sex therapist, family counselor).	Additional/in-depth counseling, sex therapy may help client come to terms with underlying problems that interfere with recovery. **Note:** Use of sexual surrogates for clients without partners is no longer recommended because of questions of ethics, values, psychological effects, and relevance to normal sexual relations.

NURSING DIAGNOSIS	**ANXIETY [moderate to severe]**
May Be Related to:	Unconscious conflict about sexual feelings Threat to self-concept; threat to role-functioning Unmet needs
Possibly Evidenced by:	Increased tension (sexual) Feelings of inadequacy Fear of unspecified consequences Extraneous movements (foot shuffling, hand/arm movements) Glancing about; poor eye contact; focus on self Impaired functioning; immobility
Desired Outcomes/Evaluation Criteria—Client Will:	Verbalize awareness of feelings of anxiety and report reduction to a manageable level. Demonstrate problem-solving skills and use resources effectively.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Determine degree and precipitants of anxiety.	Sexual activity is usually undertaken to reduce a state of inner tension and pressure. Fear of "failure," of being found out, and/or of disapproval also creates anxiety. Individual may have sought help because of these fears/coming to the attention of the legal system.
Identify client's perception of the threat represented by the situation.	The client may not perceive the behavior as a problem; however, it is the reaction of others and consequences that create anxiety. Circumstances that prevent the client from indulging in paraphilic behavior can lead to intense anxiety.
Assess withdrawn behavior and evaluate for substance use (alcohol, other drugs), sleep disturbances, limited/avoidance of interactions with others.	These behaviors may be used by the client to deal with anxiety/other feelings (e.g., guilt) instead of positive coping mechanisms. Substance use may be a factor in the occurrence of the dysfunction(s).
Note prodromal symptoms of irritability, restlessness, tension, and headache.	In the exhibitionist, these may be the response to abnormal discharges in the temporal lobes.

Encourage appropriate expression of feelings (e.g., crying [sadness], laughing [fear, denial], sweating [fear, anger]).	Suppression of feelings has contributed to difficulties client has in dealing with anxiety and coping appropriately with sexual desires and/or dysfunction.
Provide calm, quiet environment. Display accepting attitude.	Promotes discussion of sensitive sexual issues/concerns. Sexual performance is closely tied to individual sense of self as male or female, making self-disclosure difficult.
Confront the client's illegal behavior without judgment.	Client needs to hear that behavior, not the individual, is not acceptable.
Assist the client to recognize a helpful degree of anxiety and ways to begin to use it.	Moderate degree of anxiety heightens awareness and permits the client to focus on dealing with the problems.

Collaborative

Administer medication as indicated, e.g.:	
Antiandrogen drugs: medroxyprogesterone (Depo-Provera);	These drugs have been useful for altering sexual behavior, but their use is limited because they suppress desired as well as unwanted sexual responses.
Antidepressants: fluoxetine (Prozac), imipramine (Tofranil), lithium (Eskalith).	Research suggests that some compulsive sexual activity viewed as excessive or out of control (e.g., compulsive masturbation, obsessional fantasies about sex with children, voyeurism) may be an atypical symptom of depression. Sexual desire may be reduced and sexu al activity become more normal when antidepressants are used. **Note:** Use Prozac with caution as it may cause sexual dysfunction in some individuals.
Refer to therapy as indicated, e.g.:	
Psychotherapy;	Psychotherapy may be used to help the client recognize the problem of sadness and isolation caused by the dysfunction and deal with the emotional issues involved. May also be used to help client accept sexual nature when behavior is not damaging/dangerous (e.g., transvestism).
Marital/family therapy;	May resolve problems of communication, which may be major factor in many sexual dysfunction problems.
Behavioral therapy.	Aversion therapy, in which the unwanted sexual act/thought is linked to an unpleasant sensation such as an electric shock or nausea and/or imagining a frightening or disgusting event, is used as negative reinforcement and is designed to extinguish the desire. Desensitization to painful heterosexual coitus is used with limited long-lasting success.

NURSING DIAGNOSIS	SELF ESTEEM chronic/situational low
May Be Related to:	Emotional insecurity; lack of self-confidence Biophysical/psychosocial factors (e.g., achievement of sexual satisfaction in deviant ways; failure to perform satisfactorily) Substance use
Possibly Evidenced by:	Verbalization of fear of rejection/reaction by others; negative feelings about body; feelings of helplessness, hopelessness, or powerlessness Change in social involvement Difficulty accepting positive reinforcement Lack of follow-through Self-destructive behaviors
Desired Outcomes/Evaluation Criteria—Client Will:	Identify feelings and methods for coping with negative perception of self. Verbalize increased sense of self-esteem in relation to current situation (e.g., sees self as a worthwhile person). Demonstrate adaptation to events that have occurred by setting realistic goals and actively participating in treatment program. Report satisfactory sexual experiences.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Determine individual behaviors and situation that affect client's self-esteem, as well as client's perception of the threat to self and awareness of own responsibility for dealing with situation.	Failure to perform sexually can affect a person's sense of esteem and self-worth. When the problem is defined as paraphilic, the client may not recognize the sexual behavior as related to current problem(s). Identification of individual circumstances helps in choosing appropriate interventions.
Assess type of sexual dysfunction/problem by asking direct questions (e.g., describe the dysfunction client is experiencing, clarify relationship between partners, presence of power struggle, anger, concern regarding commitment or stability of relationship; preference for nonliving objects, dressing in clothes of the opposite sex, use of physical/mental pain as a source of sexual arousal).	Partners may have very different expectations of the relationship, and sexual disorder may serve to correct power imbalance or maintain emotional distance. Client may not see sexual deviance as a problem but may seek help for feelings of guilt and sadness. Asking directly can promote client recognition of these factors.

Provide information about sexual anatomy/physiology as needed.	Lack of information and myths/misconceptions are the basis of sexual functioning problems, and accurate knowledge may be crucial to resolution of the problems, motivation for change.
Ascertain if client has ever been arrested.	Pattern of involvement with the law can provide information about extent of the problem.
Determine client motivation for change.	When client accepts the fact that the sexual behavior is responsible for the problems that exist and makes the decision to change, therapy has more chance of being successful. If therapy is court-ordered, possibility for change is less likely but still possible.
Discuss what purpose (positive intention) the behavior serves for the client (e.g., sense of inadequacy as a male may be met by exhibitionistic behaviors) and what other options might be available to meet needs in more satisfying and socially acceptable ways.	Identification of the purpose allows opportunity for the client to examine whether the behavior meets the purpose in an adaptive or maladaptive manner.
Give positive reinforcement for progress noted.	Encouragement can support development of mature coping behaviors.
Permit client to progress at own rate.	Immaturity is believed to be involved in the development of paraphilias, and adaptation to a change in self-concept depends on the significance the individual attaches to the change, how long this behavior has been used, and necessary changes in lifestyle. Learning to see oneself as a capable, competent adult who interacts in an adult sexual manner takes a long time.
Assist client to incorporate changes accurately into self-concept.	Helps client recognize and cope with events/alterations and sense of loss of control.

Collaborative

Refer to classes (e.g., assertiveness training, positive self-image, communication).	Assists with learning skills to promote self-esteem.

NURSING DIAGNOSIS	**FAMILY PROCESSES, altered**
May Be Related to:	Situational crisis (e.g., change in roles/revelation of sexual deviance/dysfunction)
Possibly Evidenced by:	Expressions of confusion about what to do/difficulty coping with situation
	Inappropriate boundary maintenance; family does not demonstrate respect for individuality and autonomy of its members
	Family system does not meet emotional/security needs; does not adapt to change or deal with traumatic experience constructively
	Difficulty accepting/receiving help appropriately

Desired Outcomes/Evaluation Criteria— Family Will:	
	Express feelings freely and appropriately.
	Demonstrate individual involvement in problem-solving processes directed at appropriate solutions for the situation.
	Encourage and allow involved member (“identified patient”) to handle situation in own way, progressing toward independence.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Determine crisis that has occurred and individual members’ perceptions of the situation.	Dysfunction may be perceived as signaling the end of individual’s sexual activity. Sexual behavior may have resulted in arrest and be new knowledge to family members.
Identify patterns of communication in the family.	Interaction among family members provides information about family dynamics, boundaries, and role expectations and may be indicative of support client may receive.
Assess energy direction, whether efforts at resolution/problem-solving are purposeful or scattered.	Indicative of degree of disorganization family is experiencing.
Note cultural and/or religious factors.	Strong beliefs about sexual expression and deviance/dysfunction influence acceptance or rejection by individuals involved.
Assess support systems available outside the family.	May be needed to help client and family members, if disorganization is severe.
Acknowledge difficulties observed while reinforcing that some degree of conflict is to be expected and can be used to promote growth.	Acceptance of the reality of what is going on helps client and family to feel comfortable/begin to deal with situation.
Emphasize importance of continuous open dialogue between family members.	Promotes understanding of each other’s point of view and allows for clarification of misunderstandings/misconceptions.
Identify and encourage use of previously successful coping behaviors.	Family has used these in the past and may have neglected them during the stress of current situation.
Encourage use of stress-management techniques (e.g., appropriate expression of feelings; relaxation exercises, imagery).	Decreases anxiety and promotes opportunity to problem-solve in calm manner.
Collaborative	
Refer to additional resources as indicated (e.g., classes, psychologic counseling, family/multifamily group therapy).	Providing information, opportunity to share feelings/concerns with others can be helpful to positive resolution of problems.

(Also refer to CP: Gender Identity, NDs: Family Coping, ineffective: compromised, and Family Coping: potential for growth.)