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## **"Psychosexual Disorders"**

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**PeachTree Professional Education, Inc.  
Richard K. Nongard, LMFT/CCH  
15560 N. Frank L. Wright Blvd, #B4-118  
Scottsdale, AZ 85260**

**Voice: (800) 390-9536  
Fax: (888) 877-6020  
[www.FastCEUs.com](http://www.FastCEUs.com)**

# PSYCHOSEXUAL DISORDERS

## 6 CEU Credit Hours

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### **Course Description:**

Where is the line between 'normal' and 'abnormal' sexual behaviors? This course tackles numerous paraphilias and psychosexual disorders beyond pedophilia, (B/D S/M, frotteurism, ED, more) and discusses each individual DSM-IV category's diagnostic criteria, and offers great insight into treatment and intervention strategies.

### **Course Objectives:**

At the conclusion of this course, the professional will be able to:

- 1) Describe the essential diagnostic features of each of the psychosexual disorders and paraphilias listed in the DSM-IV.
- 2) Understand some of the possible rule-outs that may appear to be manifestations of psychosexual disorder, including conditions which are actually social rather than psychiatric in nature.
- 4) Assess client condition in context of the disorder or paraphilia as outlined in the DSM-IV.
- 5) Define Psychosexual Disorders Not Otherwise Specified and site specific examples from clinical experience.

### **Purpose of this course:**

The purpose of the course is to assist mental health counseling professionals in assessing clients in all settings, (in-patient, outpatient and criminal justice) who may be affected by a psychosexual disorder or dysfunction.

### **Course Outline:**

Part 1: Read this entire course text file.

Part 2: Read the DSM-IV's Sexual and Gender Disorders section.

Part 3: Complete and submit the required course Evaluation Quiz documentation.

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**6 Clock Hours / CE Credits**



Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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# Psycho Sexual Disorders

## Introduction

When Bob Dole retired from the U.S. Senate and began a new career in the advertising business as a pitchman for a variety of different products, psychosexual disorders suddenly came out of the closet. When he admitted in television commercials running across network T.V. on a nightly basis that he had E.D., an erectile dysfunction, and intimated that he couldn't 'get it up', Viagra sales soared through the roof.

It is important to note that while Viagra has become a popular recreational drug, it was designed to treat a specific medical condition. As a pharmaceutical product, it treats those with physical problems related to impeded sexual performance, and works essentially by increasing blood flow to the penis.

The erectile dysfunction Bob Dole manifests is not caused by a psychological difficulty, but instead stems from a medical condition created by his injuries during World War II. Consequentially, Bob Dole very well may have sexual difficulties or sexual problems resulting from these war injuries, but he does not have a 'psychosexual disorder'.

Psychosexual disorders emerge as a result of *psychological* difficulties rather than social or situational difficulties, medical conditions or side effects from medications. Many of the sexual problems we will discuss in this course affect thousands of people in our country on a daily basis. Although we will talk some about medical conditions related to sexual performance, sexual disorders and sexual satisfaction, this course focuses on those who have dysfunction due to specific psychological factors underlying their sexual development, attitudes and behaviors. We will seek to understand the various manifestations of sexual disorders from a psychological perspective, and will offer ideas for the clinician working with couples and individuals in the context of counseling and psychotherapy.

Whenever I present a clinical workshop on psychosexual disorders, the participants usually arrive believing that we will primarily focus on pedophilia, cross-dressing and other “Geraldoish” manifestations of paraphilia. Instead, as in this CEU course, we cover much more, taking a holistic tour of numerous and varied manifestations of psychosexual disorders, which seem to primarily fall into two categories in the DSM-IV.

The first category is what I call the ‘normal’ psychosexual disorders. These include arousal disorders, orgasmic disorders and difficulty in deriving satisfaction through sexual performance. The second category is the paraphilias, or what I call the ‘abnormal’ psychosexual disorders.

It is important for us to realize that defining “normal” truly is a difficult task. This course will attempt to define sexual normalcy not from a moral perspective, nor even from a behavioral perspective, but simply from a psychological perspective.

We’ll follow these three basic ideas:

- 1.) While some sexual behaviors might be considered ‘different’, they are still ‘normal’.
- 2.) Just because they are ‘normal’ does not mean they are ‘good’ or ‘right’.
- 3.) A lot of ‘normal’ sexual behaviors are self-defeating or unhealthy.

This course is designed to assist the clinician working with individuals and families in resolving presenting problems related to psychosexual disorders. It includes a broad discussion of many subjects, and should be useful to all mental health professionals.

Those who specifically practice sex therapy or work with a sex-offender population will certainly want to absorb this text, but should also receive further in-depth education on specific relevant conditions or disorders, in an effort to maximize your ability to create the most effective interventions for your specific client base.

## SECTION ONE

### Defining Normalcy

When we think about what is normal and/or abnormal from a sexual perspective, we must first consider our own sexual behaviors. Everyone reading this text believes that their own frame of reference - and their own sexual behavior - is the most normal of all. This is to be expected; as humans, we generally define the 'normalcy' of anything and everything from our own frame of reference. We often label those behaviors we choose not to engage in as 'abnormal'. When we define normalcy from a moral perspective, we say 'this is a right behavior' or a 'wrong behavior'. A great number of people believe that certain behaviors are morally wrong, and yet they engage in them anyway because they find it pleasurable. They then believe that since they are acting immorally, they must be functioning abnormally.

This text will not discount the importance of moral understandings of human behavior. A moral frame of reference is essential to develop a sound counseling philosophy that allows us to assist in the resolution of client difficulties, and we will talk in great length near the end about moral issues in regards to client behaviors. However, our first task is to define what is normal from a *clinical* perspective.

The DSM-IV states:

“Sexual dysfunctions are characterized by disturbance in sexual desire and in psycho-physiological changes that characterize the sexual response cycle and *cause marked distress and interpersonal difficulty.*”

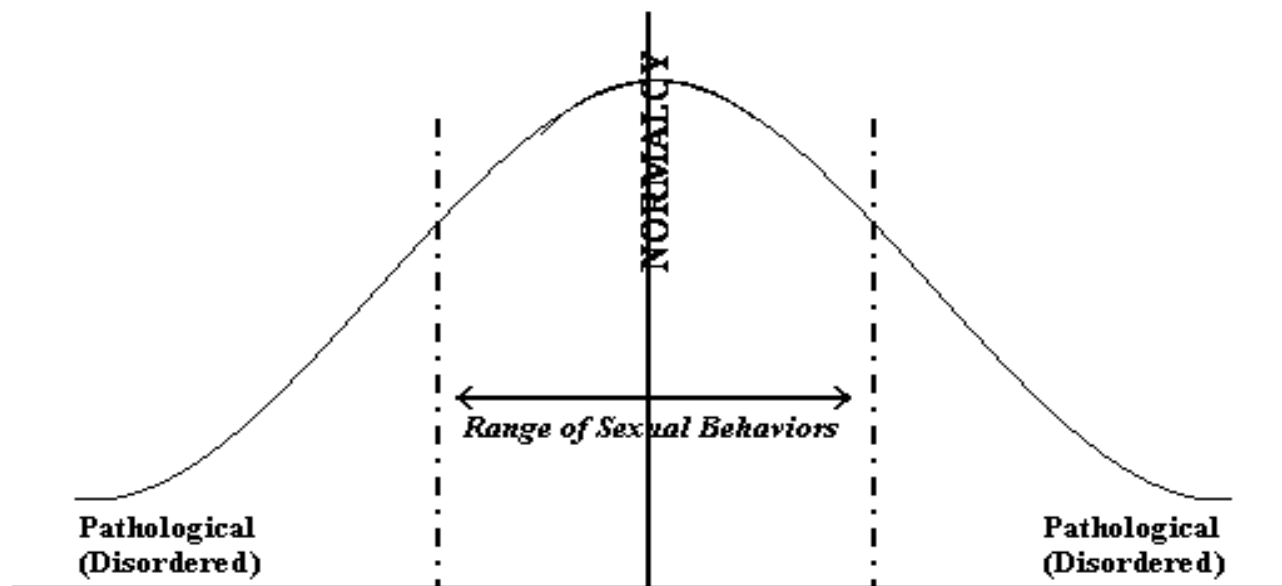
Also according to the DSM-IV, the paraphilias are:

“Characterized by recurrent and intense sexual urges, fantasies or behaviors that involve unusual objects, activities or situations, and that *cause clinically significant distress or impairment* to the social, occupational or other important areas of functioning.”

Therefore, for our purposes, we will define psychological normalcy as those sexual behaviors that do not cause impairment, distress or problems.

For example, other people surely engage in some behaviors that you might not find pleasurable. But, as long as those behaviors are not causing that individual any interpersonal distress, difficulty in their important relationships or occupational and social impairment, no matter how we feel personally about that behavior, we will still label that behavior as normal. Clearly, this definition of psychological normalcy is much different than a moral one, but from a clinical perspective, this definition is what we need to use.

In Statistics 101, we learned about the Bell Curve and the Standard Deviation from the Norm. In understanding what is and is not pathological, picturing a Bell Curve can be useful.



Inside the standard deviation falls a wide range of behaviors which various individuals choose to engage in - without legal, social other important consequences - and are therefore labeled as 'normal'.

Those who engage in specific behaviors that do cause marked interpersonal distress or impair their ability to function in the world around them will fall outside the Bell Curve, and will be considered 'abnormal'. For example, pedophiles who victimize others and suffer the legal consequences of their behavior are found on the outside of the standard deviation.

Using this definition of normalcy clearly places some of the psychosexual disorders discussed in the DSM-IV outside of the normal range at all times. Pedophilia is a perfect example. Pedophilia, from our cultural perspective, is always outside of the standard deviation because the pedophile is unable to function within our society's standards and always suffers consequences in their life because of their behaviors. Additionally, the pedophile's behaviors have consequences that impair *other people's* ability to function in a normal manner. The victims of the pedophile are often devastated by their experiences and can suffer not just physical or sexual difficulties for years following the abuse, but may also suffer profound spiritual distress, social impairment and psychological difficulty.

That all said, at first glance it may seem easy to determine which behaviors fall inside the standard deviation or outside, but it's really quite complex.

## The Man With the Panty Fetish - Case #1:

Let's take the case of the man with the panty fetish. I'm going to give three examples of a man with a panty fetish and we're going to try and figure out which is inside of and which is outside of the Bell Curve. In the first example, one fetishist, who we'll refer to as Bob, finds that he is sexually aroused and emotionally comforted by the scent, touch and feel of women's used undergarments (used means previously worn by the woman and not laundered).

As an aside, some of you may wonder how many people are actually into this kind of thing. Well, surprising as it may be, not so long ago, people on EBay, the popular internet auction website, were selling between 300 and 500 used panties on its auction site - *each and every day*. (This form of auction was discontinued for 'health reasons' in the year 2001). But those sales statistics alone should make it clear that while the reader of this course may not be aroused by the touch, feel and scent of someone's used undergarments, a large number of people on this planet apparently are.

Bob is one of these individuals. He travels regularly on business. He is married to wonderful lady we'll call Shelly. Bob finds Shelly attractive. He enjoys the sexual experiences they share together. He likes taking her to Victoria's Secret and helping her pick out the undergarments that she feels comfortable wearing and that he enjoys seeing his lovely wife wear. Frequently Bob will begin foreplay with Shelly by caressing her intimately while she is wearing her panties. He is aroused by the emotional and tactile feelings associated with this behavior. Shelly thinks that his behavior is a little naughty, but she enjoys the way Bob looks at her lustfully and lovingly, even after 12 years of marriage.

One day Bob is getting ready to go on a business trip and he thinks to himself, "I will be out of town for five days, all alone in a hotel room. I sure would love to have a token of last night's lovemaking so that I will be able to fantasize about Shelly and touch her

panties as if she were next to me.” He thinks that the scent of her used panties would be an erotic turn-on, even when he’s alone. So, after making love to his wonderful wife in the morning, he says to her, “Honey, I would love to take something with me to remember our experience. Those beautiful panties you were wearing have been saturated with your excitement and I would like to take them with me - no, not so that I can wear them - but just so that I can sleep with them under my pillow and feel like I am touching you and smelling you and tasting you again, even while I am alone.” Shelly blushes, thinking to herself that this is a little odd, but she finds it kind of cute and loving, and since she knows he masturbates, she tells him, “Sure, go ahead take them with you, and I’ll have another pair waiting when you get home.”

In this example, Bob clearly uses a non-living object in his masturbatory play to help experience sexual fantasies while on his business trip. Now, bringing your spouse’s used panties or boxer briefs on your next business trip might not be on *your* list of things to do. Unlike Bob’s wife, you might not find it amusingly erotic; you might even find it a bit creepy. But in this example, is Bob’s behavior inside or outside of the Bell Curve? Bob may be doing something that only a small percentage of the population does - but he suffers no impairment, and causes no harm to others. In fact, not only does he not experience impairment, he finds sexual pleasure and satisfaction. And his wife, who at first found the request a little odd, discovers that she feels at peace with him out of town knowing he will be fantasizing about her, rather than fantasizing about the strippers that business men usually meet on their trips out of town.

While Bob’s behavior may be odd to some, his sexual behavior in this example fails to impair, and instead actually enhances his own sexual satisfaction and the relationship he has with his wife.

## The Man With the Panty Fetish - Case #2:

In this scenario, let's suppose Bob's wife was not so amusingly aroused by Bob's request. Let's say she found the request odd, eccentric and weird, and so she said to Bob, "Hell no, I won't give you my used panties to take on a business trip with you. That's creepy! End of discussion."

Bob now feels humiliated. Bob feels as if he took an emotional risk and that the risk was not only unrewarded, but also just flat out denied. And even though Bob is tired of traveling and spending night after night in hotel rooms by himself, fidelity is a value that is important to him, and he is simply not going to slut around town looking for an easy lay.

Bob enjoys sexual fantasy and masturbation and so since his wife has turned down his request, he goes to the Internet and logs on to the website Ebanned.com (which, by the way, sells everything that EBay used to sell). On Ebanned.com, he finds that there are many people selling used panties. The descriptions all have a picture of the panties, usually being worn by a young, sexy female posed in an erotic position. The ad promises that the panties will be shipped in a zip-sealed baggy to ensure the preservation of the fresh scent and taste of the used undergarments. Bob would have preferred to have his own wife's panties, and Bob plans on fantasizing about his wife and the experiences he has had with her while removing her panties as a prelude to sex. But Bob cannot get his wife's Victoria's Secret panties, and so he buys some used panties on the Internet and has them shipped discreetly to his business PO box.

On his next business trip, Bob takes the plastic baggy with the used panties, opens it, carefully removes the panties, and places them under his pillow, as if his wife had left them there for him. Later that night, he crawls in bed, reaches under the pillow, and carefully pulls out the panties. He clutches them with one hand, brings them to his face, and inhales deeply to discover that the ad was honest and they were in fact a well-worn pair of panties. He immediately creates a visual image in his mind of his last

sexual experience with his wife and thinks about the way she tastes and smells, and as he occasionally brushes them across his face and chest, he masturbates to the point of climax.

Bob feels a little guilty about his behavior, but the pleasure of sexual fantasy while alone on a business trip outweighs this small feeling of guilt. When he returns home he immediately kisses his wife passionately and leads her back to their bedroom for an afternoon of mind-blowing sex.

In this second example you may believe at first glance that Bob's behaviors are outside of the Bell Curve because there appears to be an extreme behavior of purchasing used panties on the Internet. But, from a psychological perspective (although this may be different from a moral perspective), there is no impairment. Like in the first example, Bob has met his short-term sexual needs. His wife has not been lied to; she has just been kept oblivious to Bob's personal sexual fantasies. And although the behavior is perhaps more extreme than the average business traveler typically engages in (but likely not), it seems to both enhance his individual sexual experience and preserves his marital relationship by avoiding a power struggle over whether he should have been able to take her panties with him in the first place.

From a therapeutic perspective, an issue that should probably be addressed is whether Bob felt unable to perform sexually without the aid of used panties. But in the broad scheme of Bob's life, the behavior - although perhaps strange to others - appears to be innocuous at the worst, and beneficial at best.

### **The Man With the Panty Fetish - Case #3:**

In this example, Bob finds himself aroused by women's undergarments and when his wife says, "No, I will not let you take my used panties," instead of going to a legal auction site and purchasing an inanimate object for his own sexual gratification, he decides that the lady who lives three doors down 'sure is sexy'. He then breaks into her house while she is at work and steals her previously worn panties from her laundry basket.

Now we have a person who clearly falls outside of the Bell Curve, and for two reasons. First is the strong potential for legal consequence. The news media has reported on more than one occasion that burglars caught in the act were stealing nothing more than women's underwear. Even though the theft of underwear is not great from a financial perspective, the act induces fear in the victims and creates a sense of insecurity and feelings of personal violation. So, even if the law does not catch Bob, in this last example we clearly have implied impairment from a legal perspective, as well as the potential for incredible ramifications for both the perpetrator and the victim.

Secondly, there is further impairment because although Bob may find intense sexual arousal from his ability to touch, feel, smell and taste used panties, he is apparently unable to function sexually apart from experiencing fulfillment of his paraphilia fantasy. This indicates a psychosexual maladaptation that does not allow him to function in a way that brings him pleasure or climax without another specific behavior occurring. This psychological distress leads to obsessive and compulsive behaviors, feelings of guilt, antisocial behaviors and the potential for self-destruction and bringing harm to others.

In this third example, there is no question about whether or not the behavior is inside or outside of the standard deviation; this is clearly a pathological sexual behavior.

In this next example you will see that a number of different issues come into play when we try to define what is inside and what is outside of the Bell Curve and how our own personal bias, moral beliefs and sexual behaviors can cause us difficulty in defining what is inside or outside of that standard deviation.

### **The Case of The Gay Old Man**

While driving back from a book signing a few years ago, I was listening to the local Tulsa news radio station. They said the Tulsa Police Department had posted a new website of sex offenders registered within the city limits. I lived in a pretty nice neighborhood so I didn't think any sex offenders would be living in my area, but out of curiosity, I decided to check out the website just to see what all it had to offer. It said you could search by zip code, so I entered mine, just for grins.

Wow! I was shocked to see that the first address that popped up was on *my street*. I couldn't believe my eyes when a picture of my neighbor appeared with an angry scowl on his face and the words, "Indecent Exposure" written underneath.

My neighbor had been arrested for indecent exposure and was now a registered sex offender with his picture on the Internet. This was a complete shock to me. I knew this neighbor well - or so I thought. In fact, he was one of the few neighbors I really liked. I had asked him for his help on several occasions. He was an older man with years of business success. He and I had a couple of things in common, and we would often stand on our front lawns and talk.

Now, although I am a clinician, the minute I saw his picture and the words Indecent Exposure I immediately retreated from clinical or curiosity mode to Dad Mode. I had four kids and three dogs at my house. Just what does Indecent Exposure mean? I thought to myself, "Does that mean he went down to a baseball game, had too much beer to drink, and whipped out his pecker in front of 10,000 people and took a leak?" That would certainly get you arrested for Indecent Exposure. But as a father and pet

owner, it would not be something I would worry too much about.

Then I thought, “Does Indecent Exposure mean he went down to the neighborhood park and perhaps took out the one eyed snake and showed the young children in the sandbox how it’s charmed?” If he were arrested for that, it would most definitely concern me.

Then I thought, “Perhaps he just got caught with his fly down in public, because that could probably get someone a ticket for Indecent Exposure as well.” And then, “Well, you know, he’s an older guy, and maybe things at home just aren’t the way he wished they could be. Perhaps he rented a date down on 11<sup>th</sup> Street and got busted by the police for engaging in a sex act in his car.” Although I certainly wouldn’t endorse renting a date, I really wouldn’t be too worried about it affecting my family.

I was in a tizzy. The problem was that “Indecent Exposure” could mean any number of things. Some of those things I would be worried about, and some of those things I would not personally be concerned about at all. So, I called a police detective friend of mine and said, “My neighbor got busted for Indecent Exposure and his picture is on the Internet. Can you find out what he did?”

A little while later, my friend faxed over a copy of the police report. As the story goes, my neighbor allegedly invited an undercover male Police Officer into the men’s restroom at a city municipal park and then unleashed and stroked his own penis back and forth, until it became semi-erect. At that point, he did not get the response he wanted from the undercover officer and scampered out of the men’s room towards his car. According to the police report, the local Vice Squad then subdued him, and a 22-caliber Jennings pistol was recovered from the scene (which only helped support my theory that most criminals have poor taste in weapons). He was written a citation for Indecent Exposure, but taken downtown for processing based on his prior sexual convictions.

Now I thought, “I sure am glad his crime had nothing to do with children or pets!” I also

thought, “It appears as if my neighbor is simply a gay man born at the wrong time. He’s older and doesn’t know that these days, if you want to get some ‘strange’ from a member of the same sex, you just head down to any of the many gay nightclubs and meet a date.”

But the fact that he had a prior conviction history interested me. Maybe *those* incidents involved children or animals. So, I called my friend at the police department again and asked, “What are his prior convictions?”

I then received a pile of faxes. The most recent arrest before the park incident had occurred in a shopping mall where my neighbor was apparently first detained by mall security and then arrested by the police after engaging in a lewd act with another male in the men’s room of a department store. There were a number of other arrests dating back through the years, all involving men over the age of majority in public places, and sometimes including small caliber cheap weapons, probably used by my neighbor for self-protection.

When I finished reading my neighbor’s arrest history, I tried to keep an open mind. I again thought, “Poor John, he really appears to be a gay man born at the wrong time who just doesn’t know that you can pick up guys on the Internet or at the local gay bar without getting arrested.” I then happily thought, “Whew! This really doesn’t seem like anything I need to worry about, since all of his offenses have involved men over the age of majority, in consensual sexual behaviors.”

Even though I would not personally engage in the behaviors that my neighbor engaged in, I decided I would classify him as “Inside the Bell Curve”. Why? Well, because although I’m sure it caused him difficulty with his wife, and he certainly had some legal difficulties with the local police, I decided that the heart of the issue was that he just was born at the wrong time to come out of the closet.

I'm a dad, but I'm also still a therapist. I wanted to believe this theory I'd conjured, but something about the situation kept nagging at me. Something just wasn't quite right. So, I called a friend of mine in Texas who is also therapist. But she's not just any therapist; she is an openly lesbian social worker who works with Texas Department of Criminal Justice in a sex offender treatment program. She has worked with pedophiles, rapists, bestiality, fetishes and every psychosexual disorder specified and not otherwise specified in the DSM-IV. I guess I called her for peace of mind. I wanted her to tell me that my assessment was correct: my neighbor was simply a gay man born at the wrong time, and therefore I didn't have anything to worry about.

When I explained the story to her, she said to me, "Richard, you definitely *do* have something to worry about."

I interrupted her with, "Hey, I'm only worried about kids or dogs - I can take care of myself."

She said, "You just don't get it, do you?"

I said, "Get what?"

She said, "You're still thinking like a dad and not like a clinician. You're trying to justify reasons not to fear this neighbor, when in fact you know there *is* something to fear."

I asked, "What, exactly, should I fear?"

She said "Richard, there is a big difference between homosexuality and perversion."

She continued by stating that based on the police history I provided, her professional assessment was that my neighbor was not gay or straight, and that his sexual orientation had little to do with his sexual behavior. She went on to explain that all of

his arrests involve anonymous high-risk encounters in public places with cheap weapons, and this meant that my neighbor was not simply aroused by another man engaging in sexual activity with him - but rather by the danger associated with these sexual encounters.

My social worker friend further explained her belief that homosexuality had nothing to do with what turned my neighbor on. He was aroused by danger and excitement, and antisocial and lawless behaviors. This kind of situation was, in fact, a bigger turn on to him than who might be stroking his penis.

And so, she said, I definitely did have something to worry about. When the law stops him on multiple more occasions from engaging in this behavior in public places, and when that further impedes his relationship with his adult children and his spouse, and when the legal consequences of his behavior begin to negatively impact his business, he will look for targets that have lower public risk.

And, she reminded me, there is the continuum of behavior factor to consider - the progression of lower to higher risk situations - from those who were consenting, to eventually engaging in behaviors with the un-consenting (including children and animals). This was a likely manifestation of his further sexual deviance.

She concluded by pointing out that my neighbor not only belonged *outside* of the Bell Curve, but he was clearly a dangerous predator - living in my neighborhood.

(As a side note for those who are curious about the rest of the story: My neighbor mysteriously passed away less than a week after showing up on the local police's Internet sex offender site. I was never able to hear the real details on how or why he died.)

For the clinician working with sexually impaired individuals, being able to keep our own moral or behavioral understandings of what is normal or abnormal out of our

assessments is essential. This may be a difficult task, but it is vital in order for us to provide the correct interventions.

In the case of the 'gay old man', we would have treated him entirely differently if we viewed him only as a gay man born at the wrong time rather than as a dangerous perverted predator.

In the case of the panty fetishist from example one, if we treated Bob as a pathological freak, we would have caused him (and also his wife) much unnecessary psychological distress.

In the third panty example, if we had treated Bob merely as an individual who engaged in odd or eccentric behavior rather than the criminal he was, we would have provided the wrong interventions, and possibly accelerated the risk to his victims.

## SECTION TWO

### Areas of Sexual Dysfunction

The DSM-IV defines seven areas of sexual dysfunction in its section on psychosexual disorders. Chances are good that anyone reading this text has at one time or another experienced any one or more problems associated with these disorders. But it's important to note that just because someone may experience a sexual problem at one point in their life does not instantly define them as mentally ill or as psychosexually disordered. Impairment in important areas of functioning defines psychosexual disorder. A single or brief sexually distressing performance situation in a particular relationship, in the grand scheme of life, is not sufficient to diagnosis psychosexual disorder.

As we discuss what I call the normal and abnormal sexual dysfunctions, it's also important to recognize that in order to be defined as a psychosexual disorder, the manifestation of these problems must be caused by a psychological difficulty rather than a medical or social difficulty.

For example, Female Sexual Arousal Disorder can be caused by the onset of a new medical condition, or as the result of a medical condition developed over time as a person ages. This would not be a 'psychosexual disorder' per se, even though the inability to achieve arousal appears to match the diagnostic criteria for Female Sexual Arousal Disorder.

A female may be un-aroused simply because her lover may be no good at it. This would be a situational or social cause of the dysfunction described in the DSM-IV, and although it may be difficult for an individual (and her partner) to deal with emotionally, physically or socially, it is still far different than a true psychosexual disorder.

The diagnosis of a psychosexual disorder is not based merely on the presence of a symptom or set of symptoms, but also on the presumption that the symptoms manifest

in light of all other things being normal in an individual's life. In other words, Female Sexual Arousal Disorder is diagnosed when she is in physically good condition and is able to manifest the normal stages of sexual excitement and her lover is a satisfactory partner, yet despite all of these strengths being present, she continues to be unable to experience sexual arousal. Only in this scenario do we now have the diagnosis of a psychosexual disorder.

In the following subdivisions, the seven areas of sexual dysfunction described in the DSM-IV are briefly outlined.

## **SEXUAL DESIRE DISORDERS**

### *1) Hypoactive Sexual Desire Disorder*

The DSM-IV describes two sexual desire disorders. The first is the Hypoactive Sexual Desire Disorder. This is much different than the more famous hyperactive "nymphomaniac". The hypoactive sexual desire disorder is characterized by an absence of sexual fantasies and an absence of desire for sexual activity.

One study I saw recently indicated that men think about sex an average of seven times a day. Mathematically that's over 2,500 mental sexual encounters each and every year.

It's normal to have sexual fantasies, and it's considered abnormal to be void of sexual fantasies, sexual thoughts or sexual desires, because 1/7th of who we are is sexual.

Think back to 5<sup>th</sup> grade science. We learned that there were 7 systems within the body. The Circulatory System, the Skeletal System, the Epidermal System, the Endocrine System, the Nervous System, the Respiratory System and the Reproductive System. Study of the Reproductive System includes, of course, male and female genitalia, male and female hormones, and male and female reproductive functions, i.e.: sex.

While it may be normal in some circumstances for a person to choose to abstain from sexual relationships, and while it may be normal, healthy and even desirable for a

person not to take action on their sexual fantasies, it is an abnormal condition to be devoid of sexual fantasies or to have no desire for sexual activity.

Those working in the context of couples counseling where one partner has a Hypoactive Sexual Desire Disorder will often find that the consequences to the relationship can be devastating.

For those working with individuals, we may see a presenting problem such as social inhibition or the ability to maintain and build important interpersonal relationships. The Hypoactive Sexual Desire Disorder can sometimes exacerbate this kind of presenting problem. Clearly, we don't have sex with most of the people we meet on the street or live with, but since 1/7 of who we are is sexual, we naturally relate sexually in our interpersonal relationships with individuals who are important to us. A person who is unable to experience sexual fantasies or sexual desires does not relate to the world in the same way the rest of the population does, and as a result, this condition can sometimes manifest tremendous interpersonal difficulties.

## ***2) Sexual Aversion Disorder***

The second sexual desire disorder discussed in the DSM-IV, is the Sexual Aversion Disorder. This is essentially genitalia phobia, penis phobia, vagina phobia, manifesting in the aversion to or specifically, the avoidance of sexual genital contact with another partner.

I have treated several individuals who have been able to masturbate, and who have been aroused sexually by other individuals, but when it came time to perform a sexual activity with a partner, this specific sexual aversion disorder kept them from being able to function in a normal way.

One couple that I worked with in counseling was particularly religious. They had sexual desires and fantasies about each other preceding their marriage, but because of their

moral beliefs, neither one of them had ever engaged in sexual behaviors with other individuals. On their wedding night, which is naturally a nervous yet exciting scenario for virgins, he was unable to perform satisfactorily. This was specifically due to his aversion to her genitals. He was overanxious about the cleanliness factor, about potentially physically harming her, about pregnancy, and of course, about whether or not he was doing it right.

Being unable to perform on one's wedding night is a sexual stressor that does not start one's relationship off with a bang. And unfortunately, this was not just a case of wedding night jitters. After a year and a half of marriage, they found that their happily-ever-after plans were now at risk, all due to his apparent inability to become comfortable with her genitalia and enjoy physical sexual contact with her.

## **SEXUAL AROUSAL DISORDERS**

The second category of sexual dysfunction listed in the DSM-IV is Sexual Arousal Disorders, which includes both male and female problems.

It's important to remember that many people have manifested a lack of sexual arousal at one time or another. This can be due to simple factors such as fatigue, daily stressors, lack of emotional intimacy, age, menopause, substance abuse or any number of other causes. The inability to become aroused does not define psychosexual disorder. Again, what defines psychosexual disorder is when, despite all other things being normal, the person is unable to perform, and as a result, this lack of sexual performance impairs their ability to function in personal relationships or in other aspects of their life.

### ***1) Female Sexual Arousal Disorder***

The first sexual arousal disorder listed is the Female Sexual Arousal Disorder. This is a recurrent and persistent (the key words here are *recurrent* and *persistent*) inability to

attain an adequate lubrication and swelling response to sexual excitement throughout the act of intercourse.

It is common, particularly for a female as she ages, to become less 'wet' during sexual activities. The use of personal lubrication products (i.e. KY liquid) can alleviate many of the difficulties that couples experience because of physical changes within the body.

What this disorder entails is the inability to achieve orgasm, not because the lover is no good or did not meet her needs or touch her in the right places, but because due to psychological factors there is an incongruence between the behaviors and their outcome.

## **2) Male Erectile Disorder**

The second arousal disorder is the Male Erectile Disorder, as Bob Dole has popularized. Erectile Dysfunction, or ED, is defined by the DSM-IV as a persistent or recurrent (the key words again are *persistent* and *recurrent*), inability to attain or maintain an adequate erection until completion of the sexual activity.

Like women, as men age, their sexual performance decreases. Their penis becomes less hard, for less time, more frequently. As unwilling as many are to accept it, this is normal.

The persistent and recurrent inability - not due to medical conditions, war injuries or whiskey dick (substance abuse), but rather due to psychological factors - is what defines Erectile Disorder.

For many men, mood disorders such as anxiety can complicate sexual performance. For those with concomitant mood disorders like depression or anxiety, Erectile Disorder is an even more common phenomenon, and it may often cause significant distress, and bullying or avoidance behavior. Within the context of a marriage, this can cause tremendous social difficulty and negative impact within the family system.

At first glance, Bob Dole's Viagra may seem to be The Cure. But remember, Viagra and its new counterparts are medications designed to treat physical conditions - not psychological ones. Many, many men (and women) who believed Viagra would fix their Erectile Disorder sadly discovered that the magic potion was not so magic for them.

Men, historically, have been resistant to attend counseling. I would imagine they are even more resistant to seek counseling related to their sexual performance, or lack thereof. Rarely has anyone come to my office with Erectile Dysfunction as the presenting problem. Usually they call seeking treatment for anxiety or depression, and then the sexual dysfunction is eventually disclosed when their wife brings it to my attention, because they (perhaps wisely) believe the anxiety or depression is contributing to their husband's Erectile Dysfunction.

## **ORGASMIC DISORDERS**

### ***1) Female Orgasmic Disorder***

The first Orgasmic Disorder discussed is the Female Orgasmic Disorder, formally known as Inhibited Female Orgasm. This is a *persistent or recurrent* delay and absence of orgasm following a normal sexual excitement phase. The key here is a 'normal sexual excitement' phase.

Many individuals do not have the Big O. Most frequently, this is because their lover was not attentive to their physical and emotional needs. This situation is not Female Orgasmic Disorder; this is bad sex.

It may be an old barb or joke, but it's true...

Question: *When is a female most likely to masturbate?*

Answer: *Immediately following sex.*

Why? Most likely because her partner failed to bring her to orgasm. He probably

climaxed first, and then he was 'done', leaving her sexually (and likely emotionally) unsatisfied.

Pop magazines like Playboy and Cosmo frequently release lists of women's complaints about men's sexual behaviors. One of the most common complaints, other than smoking immediately after sex, is that once they are personally satisfied, men roll over and go to sleep. This complaint stems not only from women wanting tender caressing and hugging following the sexual experience, but because for many of these women, he is asleep and she is simply not anywhere near done yet.

This is not Female Orgasmic Disorder. This is having a lazy lover.

The Female Orgasmic Disorder defined in the DSM-IV presumes that there is a normal sexual excitement phase and that the inability to experience orgasm is not due to a medical condition or a social condition like a bad lover, but to a psychological block that keeps the woman from experiencing satisfactory orgasmic states.

As an aside, just in case you didn't know, research indicates that it takes a minimum of 20 minutes (yes, twenty full minutes) of proper stimulation (emotional and physical) for a woman's body to reach the arousal state necessary to physically achieve orgasm. (Keep this in mind later, when you read how long the average sexual encounter is for married couples.)

Furthermore, ninety percent of women who masturbate to orgasm do so by stimulating their clitoris. Only ten percent of women stimulate their vagina while masturbating, and even they usually stimulate their clitoris at the same time.

## ***2) Male Orgasmic Disorder***

Male Orgasmic Disorder, formally called Impotent Male Orgasm, is a persistent and recurrent delay in or absence of orgasm for the man following a normal sexual

excitement phase.

While much has been written in pop literature about the female's inability to experience orgasm, many men also find it difficult to experience orgasm during sexual intercourse. When we rule out medical and health related conditions and social conditions such as an inattentive lover, we find that men who are able to experience arousal may still have tremendous difficulty reaching the peak level of sexual satisfaction. This undoubtedly can cause major problems with interpersonal functioning.

I had a client not too long ago who was referred by his employer for work related difficulties - anger in the workplace. We began to talk about some of his interactions with his colleagues at work that lead him to me, and eventually we discussed some of the difficulties he was experiencing in his home life.

He was insightful, and honest. He identified that one of the major reasons he manifested a short fuse was intentionally and specifically to keep people at a distance. This protected him emotionally and physically from intimacy not only with his coworkers, but also with his spouse. But this emergency coping strategy had gotten out of control, as most do. In fact, his wife was ready to call it quits.

Through the therapeutic process, we discovered that most of his current interpersonal difficulties were directly related to his humiliation, embarrassment and low self-esteem resulting from his inability to manifest and experience orgasm.

He loved his wife dearly, but she figured that since he wasn't performing adequately, he must have been having an affair. This presumption was not true, but her suspicion only added to the turmoil within the relationship.

As he stressed over his sexual difficulties, she stressed over her suspicions, which only caused him more stress, and the destructive cycle continued, as it always does without effective communication or therapeutic intervention.

Because of the general tense climate at home, he began to avoid sexual situations with his wife, in order to avoid further failure of climax-less sex. Instead, he chose to engage her in angry interactions. Desperate to evade intimacy, he would deliberately pick fights at bedtime or put up hostile fronts whenever she alluded to sexual activity. Eventually, as it always does, this pattern of behavior extended to his other important relationships, including his co-workers, and eventually affected his vocational performance.

### **3) Premature Ejaculation**

The DSM-IV says that Premature Ejaculation is the persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The key words here are *persistent* and *recurrent* - but the key phrase is *before the person wishes it*.

Every now and then, men find that they are over-excited with a new lover, or they might be in a deeply passionate state in a situation they find specifically or intensely erotically stimulating, or maybe it's just been a really long time between sexual encounters - and they climax 'too soon'. This is normal.

But when men orgasm and ejaculate before they desire it - or before their partner desires it - in a persistent and recurrent manner, this can cause tremendous embarrassment and interpersonal difficulty, and may eventually lead to other performance problems.

## **SEXUAL PAIN DISORDERS**

### **1) Dyspareunia**

The DSM-IV says the essential feature of Dyspareunia is genital pain associated with sexual intercourse. Although it is most commonly experienced during coitus, it may also

occur before or after intercourse. It can occur in both males and females. In females, the pain may be described as superficial during intromission or as deep during penile thrusting. The intensity of the symptoms may range from mild discomfort to sharp pain. The disturbance must cause marked distress or interpersonal difficulties, and is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another disorder, and is not due exclusively to the direct physiological effects of a medication or drug of abuse, or a general medical condition.

The repeated experience of genital pain during sex may result in the avoidance of sexual experiences, disrupting existing sexual relationships or limiting the development of new ones.

## **2) *Vaginismus***

The essential feature of Vaginismus is the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with a penis, finger, tampon or speculum is attempted. The disturbance must cause marked distress or interpersonal difficulties, The disturbance is not better accounted for by another disorder and is not due exclusively to the direct physiological effects of a general medical condition. In some females, even the anticipation of vaginal insertion may result in muscle spasm. The contraction may range from mild, inducing some tightness and discomfort, to severe, preventing penetration. Sexual responses (desire, pleasure, orgasmic capacity) may not be impaired unless actual penetration is attempted or anticipated. The physical obstruction due to muscle contraction usually prevents coitus. The condition, therefore, can limit the development of sexual relationships and disrupt existing relationships. Cases of unconsummated marriages and infertility have been found to be associated with this condition.

The diagnosis is often made during routine gynecological examinations when response to the pelvic examination results in the readily observed contraction of the vaginal outlet. However, Vaginismus occurs in some women during sexual activity but not

during a gynecological exam. The disorder is more often found in younger women than in older females, in females with negative attitudes towards sex, and in females who have a history of being sexually abused or traumatized.

## **Sexual Dysfunction Due to a Medical Condition**

This is in the DSM-IV because, as mentioned repeatedly throughout these pages, sexual difficulties can have their roots in a medical condition, perhaps as a side effect of a specific illness or injury, or even due to the inability to meet the basic needs of physical health.

Without enough sleep, satisfactory sexual performance for both men and women can become extremely difficult. Without proper nutrition or exercise, obesity and poor health can contribute to sexual difficulty. Probably one of the most overlooked areas or causes of sexual dysfunction due to a medical condition is cigarette smoking. When natural oxygen flow is impeded throughout a person's body as it is with smokers, this can result in sexual dysfunction, impairing their ability to perform.

It is important to note that while the DSM-IV discusses 'sexual dysfunction due to a medical condition', this is a Rule Out from the psychological factors, which ultimately must be present to cause a diagnosis of psychosexual disorder.

## **Substance Abuse Sexual Dysfunction**

The next major sexual dysfunction identified by the DSM-IV is Substance Abuse Sexual Dysfunction. This dysfunction can come in a number of different forms.

Alcohol abuse can significantly contribute to decreased sexual performance. In the addiction treatment centers where I have worked, many addicts listed sexual difficulties at the top of their list of issues they needed to address in therapy. Time after time, I heard stories from cocaine or designer drug users about how at first the

drug made sex so fantastic, but then it became a curse to their sexual performance.

Other substance induced sexual dysfunctions may come from the prescription medications people receive for a variety of common psychiatric conditions. It's been established that several of the more popular antidepressants can decrease a person's libido or cause difficulty in sexual performance.

Some medications are simply inappropriate for certain clients. For example, Desyrel, which was once a trendy antidepressant, has since proved to have potential catastrophic sexual consequences for young men. The obvious consequence is that if you are a depressed young man to begin with, and your medication makes you unable to perform sexually during the prime of your sexual life, this will probably only serve to increase your level of depression.

### **Sexual Dysfunction Not Otherwise Specified**

The last area of sexual dysfunction specified in the DSM-IV is Sexual Dysfunctions Not Otherwise Specified. This, of course, is a 'catch all' category for the less common sexual dysfunctions people experience, or even those experiences unique to your particular client.

Walter was a psychiatrist I worked with years ago. He was an older gentleman, nearing retirement. He and I worked at an adolescence residential treatment facility where those who had been defined as sex offenders were referred for treatment. One day, the psychiatrist and I spent about two hours with a new admission named David.

David was 17-year old male who was compulsively masturbating 5 to 10 times a day. Now, if you find yourself masturbating 5, 7 or even 10 times a day, there will be consequences. If you devote that much time to masturbation, you'll have to be jacking-off just about everywhere you go, and that's what was happening with David. He was repeatedly caught masturbating in the boy's room at school and in other public places,

which is what ultimately led to his referral to our facility.

After the intake assessment was over, I turned to Walter the psychiatrist and I asked, “Is it really *possible* to masturbate 5 to 7 times or more a day - every day?”

Walter turned toward me. His gray bearded face was serious; his eyes glowed hard and sharp through his bifocals. “*Not at my age!*” he grumbled.

The case of David identifies one of the psychosexual disorders or compulsive sexual behaviors that might not specifically be addressed in the DSM-IV. Common enough for its own category or not, it certainly brought catastrophic consequences for this kid, not only in terms of behavior referral, but social alienation and the inability to complete the normal tasks of the day.

## SECTION THREE

### PARAPHILIAS

As mentioned earlier, whenever I do a workshop or staff-training on the subject of psychosexual disorders, many of the participants attend specifically seeking more information about treating and working with the sex offender, and primarily the pedophile.

Pedophilia is but one of the psychosexual disorders listed in the DSM-IV. There are numerous other paraphilias as well; including some that can potentially cause as many problems for both the perpetrator and the victim as pedophilia. Understanding the DSM-IV classification of paraphilias in its entirety, not simply focusing on pedophilia, is essential for the clinician.

When individuals manifest a specific paraphilia, it's frequently a unique behavior, which meets specific psychological, social and physical needs for that person. And, those who manifest one form of paraphilia may manifest other forms of paraphilia as well. For example, the transvestite fetishist and the sexual masochist are frequently seen co-existing in patient populations.

In our understanding of psychosexual disorders, we must realize that the DSM-IV categories are only guides. We must also remember that sometimes people just don't seem to fall within the neat little boxes characterizing their diagnostic criteria. We may have an individual who manifests predominantly the characteristic of one paraphilia, and at the same time, also incorporates the behaviors of another paraphilia.

#### ***What characterizes paraphilias?***

Paraphilias are characterized by recurrent and intense sexually arousing fantasies, sexual urges or behaviors that occur over a period of least six months, generally

involving:

- A) Non-human objects
- B) The suffering or humiliation of one's self or one's partner
- C) Children or other non-consenting persons

Before we go on, it's important to remember that we are looking at the subject of paraphilias from a psychological perspective. It is also important to note that our psychological and our legal definitions sometime differ. As we talk about pedophilia and other paraphilias, we will discuss cultural definitions and how they may differ from legal, moral and psychological definitions of a specific disorder.

The occurrence of an isolated behavior cannot define pathology. For a definition of pathology, the behavior must have occurred over a period of at least six months. The behavior may be illegal, it may be immoral, it may be odd, strange, bizarre or eccentric - *but it cannot be defined as paraphilia unless it is manifested behaviorally over a period of least six months.*

For the majority of clients diagnosed with a specific paraphilia, we find that it actually seems to be part of their personality. And, for most clients, it's a life-long constant. It's true that periods of stress in an individual's life may exacerbate specific fantasies or specific urges. However, it is important for us to recognize that the individual engaging in the specific paraphilia may not manifest the set of pathological behaviors every time they have a sexual encounter.

The behavior that we are labeling as a paraphilia predominates their sexual encounters, thoughts, attitudes, interpersonal expressions and behaviors. When we are dealing with a sexual sadist or a pedophile, we see that the imagery is often acted out with a non-consenting partner. In the case of the pedophile, the non-consenting partner is a minor. In the case of the sexual sadist, an unsuspecting partner may have been duped into a sexual encounter with them.

We are most likely to encounter the voyeur and the pedophile in criminal justice

settings. Not all of the paraphilias have legal consequences, however many do. It is always illegal for a person over the age of majority to engage in sex with a non-consenting person under the age of majority. Therefore, pedophilia, as a behavior, is always outside of our standard deviation on the Bell Curve because it always injures other people and always carries consequences for the perpetrator.

However, some other paraphilias are difficult to place inside or outside the standard deviation on the Bell Curve. For example, if a sexual masochist finds a sexual sadist and engages in a consenting relationship with that individual and it does not cause either one of them impairment in their ability to function, it may be strange behavior, it may be obsessive behavior, it may even be self-deprecating behavior, but there is certainly no legal consequence.

On the Internet, just about every single night, you can find hundreds of groups in cities all over America who are devoted to BDSM (Bondage, Domination, Sadism and Masochism). These are, for the most part, participants desiring sexual contact with other individuals. They meet not to engage in their sexual preferences with non-consenting individuals, but with those who have similar or related desires.

Through the proliferation of the Internet, we have seen a tremendous rise in not only recreational swinging behavior (or 'wife-swapping'), but also in role-playing, fantasy fulfillment, true bondage and domination, and sadomasochism.

## The Case of the Bank Executive and His Wife

Dale is a mortgage lender working for a large urban bank. He and his first and only wife, Belinda, have two children and a golden retriever. Dale does not drink and he does not smoke. He's 42 years old and works out several times a week at the local gym. On Saturday afternoons, he cuts his lawn. On Sunday mornings, his family goes to church.

Throughout his life, Dale has always preferred to play the passive role in sexual encounters. Belinda, who has a dominant personality, has always encouraged Dale's sexual passivity. As she stated in therapy, it's okay with her because her favorite position is "riding him into the night."

As their sexual relationship evolved over the years, they have become intuitively aware of what brings each other pleasure. Dale really enjoys two specific sexual activities with his wife. One is when Belinda plays with his anus using sex toys (vibrators, dildos, etc) as he lies submissively on the bed. She teases him with the toys by placing them inside herself and then making him beg to have them inserted into him. He becomes extremely aroused when she plays rough with the toys, inserting them deeply and quickly and then withdrawing them and holding out until he begs for more.

The second activity that Dale enjoys in this passive role is when Belinda sits on top of him and urinates. Dale said, "It's like all of her warmth covers my body at the same time."

Dale clearly manifests many of the behaviors common to the sexual masochist. Belinda, in a dominant role from at least a psychological perspective, appears to be quite comfortable in the sadist role.

By all accounts, Dale and his wife are the normal next-door neighbors. Perhaps some of you reading this text believe this example to be far fetched, but these and similar scenes are acted out in many homes in many neighborhoods across the country, on a

nightly basis.

You might find the above story repulsive. You may consider it extreme, odd, strange, humorous or even normal. But as strange or creepy as these behaviors may seem to others, Dale and Belinda appear to have developed a psychologically thrilling sexual relationship that meets both of their needs. Their actions bring them pleasure rather than misery or problems.

So, as we go through the list of paraphilias outlined in the DSM-IV, it is important to remember that just because an individual engages in a specific behavior does not necessarily mean there is a diagnosis of psychosexual disorder, because the diagnosis of psychosexual disorder is always predicated on impairment or inability to function.

Let's look at the case again. Let's say Dale still has the same sexual desires and fantasies, but Belinda is unwilling to play the dominant role or to do the things he likes. If Dale were to seek out anonymous homosexual experiences or anonymous experiences with prostitutes in order to fulfill his desires, he could easily experience impairment through potential health related problems, family problems, legal problems and social problems.

But he has not done this. His wife is a willing and eager partner acting out his desires. Therefore, Dale and Belinda, in spite the fact that their behaviors are similar to those of 'disordered' individuals, are still inside of the Bell Curve.

## ***Exhibitionism***

In the DSM-IV, Exhibitionism is defined as exposing one's genitals to a stranger. In order to diagnose an individual as an exhibitionist, there must be a sexual quality (sexual urge, desire, arousal) attached to the exposure.

Lets say we go to a strip club (or, if you prefer, a Gentleman's Club or Adult Cabaret) and we sit down at a table and watch the dancers take turns on stage. As they collect their tip money, some of them, in exchange for a larger tip, might expose their genitals to the stranger tipping them. In the erotic dancer business, the slogan is "the bigger the tip - the better the show."

When the dancer exposes his or her genitals to a stranger, can we diagnose that dancer as an exhibitionist? The answer is no. Not because he or she is not engaging in the behavior defined in the DSM-IV, but because there is no sexual quality to the dancer's actions. In fact, the stranger may even repulse the individuals giving up a dollar in exchange for a peek at their privates.

Why do they expose their genitals to a stranger? The simple answer is cash. They want the tip. They need to pay the electric bill to keep the lights on at home. Nude or topless dancers are often single mothers with little or no education and the inability to find full-time work above minimum wage. When she collects tip money, her thought is not sexual, but rather, "Wow, if I can get another 40 people to do this before the night is over, I'll have enough money to pay my bills tomorrow."

We must remember that a strictly behavioral definition cannot define the presence of paraphilias or psychosexual disorder. The person who actually meets the criteria for the diagnosis of exhibitionism is a person who exposes their genitals to a stranger because they derive personal sexual pleasure from it.

We must always consider motivation.

The 'dirty old man' wearing a trench coat on a sunny day exposing his genitals in a public parking lot and obtaining a sexual thrill from the shock of the individuals he is

exposing himself to, is an exhibitionist. He may then go home to masturbate while thinking about the all the reactions he received throughout the day.

### ***Fetishism***

Fetishists use non-living objects, frequently women's wearing apparel, including underpants, bras, stockings, shoes or boots - not for cross-dressing - but to enhance their sexual pleasure, often as part of sexual activity with a partner or during masturbation. The focus of their sexual pleasure is generally on the texture, the scent or the feel of those apparel items.

The fetish item is usually required for sexual excitement, and without it, males may experience erectile dysfunction.

Inanimate items specifically designed for sexual pleasure such as vibrators are not considered fetish items. There are individuals who manifest fetishism with jewelry, pictures, certain sheets, specific candle scents, and so on, which for some personal reason may be associated with prior sexual experiences, fantasies, or general sexual pleasure. However, the majority of fetishists are in to women's wearing apparel.

At the beginning of this course, there were three examples of a man with a panty fetish. Those examples serve well to outline the presence of fetishism and the potential difficulty in finding a specific behavior inside or outside of the Bell Curve.

### ***Frotteurism***

Frotteurism involves a person rubbing their genitals against another person, or touching another person's genitals, usually in crowded public places where they can escape quickly if detected. Busy elevators, shopping malls and mass-transit cars are popular due to the access of unsuspecting people and the ability to get away.

The target persons are non-consenting. As the frotteurist rubs and touches, he or she usually fantasizes about an exclusive and caring relationship with that person, which may bring themselves to the point of sexual ecstasy.

A fascinating characteristic about the frotteurist is that they derive their sexual pleasure not when they are discovered like the exhibitionist, but when they can keep their sexual fantasies and behaviors hidden from the person they are victimizing. The intensity of their sexual urges or fantasies seems to intensify, as the victim remains unaware of what the perpetrator is doing.

Have you ever been to an amusement park in the summer? Maybe Six Flags, or Great America, or Coney Island? Most all theme parks have some sort of a log ride, and in July and August, this is one of the most popular attractions because in the hot summer sun, people enjoy cooling off by being splashed with water. Unfortunately, this often translates into a 90-minute wait in line for the three-minute ride. Interestingly, it seems that just about every summer when I take my children to the amusement park, we usually wait in line for an hour or more, and when we finally get near the gate, we see somebody in line a few places ahead of us suddenly decide to leave. I often wondered why would these people wait in line for an hour or an hour and a half and then get out of line at the last minute. Recently it occurred to me that these are the frotteurists. They never intended to get on the log ride; they had their ride while waiting in line.

### ***Pedophilia***

Pedophilia is always outside of the standard deviation. Even when the pedophile gets away with their behavior from a legal perspective, their behavior always harms others individuals. Pedophilia is the paraphilia most commonly talked about probably the most frequently seen in criminal justice settings.

Working with the pedophile is usually an extremely difficult professional challenge. The damage done to the victims is particularly catastrophic, and the recidivism rate is

tremendously high. What some would label as denial and defensiveness is quite excessive with this patient population.

The pedophile defines pedophilia behaviorally - based on others' behaviors and excluding their own. In a group session with several pedophiles, each one thinks that he or she is the exception; he or she is the one who does not belong in the group because his or her behavior was not like the behavior of the other group members. I have heard many pedophiles say, "I don't know why I have to be in this group, I did not penetrate - or, I did not engage in oral sex - or, I did not do this or that..."

The definition of **pedophilia** from a psychological perspective as stated in the DSM-IV involves sexual activity or sexual contact with pre-pubescent children age 13 years or younger. The perpetrator must be at least 16 years of age, and there must be at least five years age difference between the victim and the perpetrator.

It is important for us to note that pedophilia always involves sexual activity with a pre-pubescent child. If a person over the age of majority has sexual contact with and a person under the age of majority but past puberty, we actually have a different condition know as **Hebophilia**.

The DSM-IV talks about the exclusive type of pedophile who only engages in sexual activities with children, and the non-exclusive type who also seems able to maintain, on at least at one level or another, some age appropriate sexual relationships.

In reality, aside from the vileness of their own behavior and their high level of defensiveness, difficulty in treating the pedophile often comes from our society's differing definitions of pedophilia. The psychological definition we use comes from the DSM-IV. However, there are also legal and cultural definitions of pedophilia, which may differ, sometimes substantially, from the psychological definition, depending on the culture of the community. The difficulty for clinicians is when someone meets the legal

criteria for pedophilia but not the psychological criteria, and yet we must provide services to them within the same setting as we provide services to those who do meet the psychological criteria.

Consider the following news story:

### **OU Says Student Sex Offender Can Stay in His Dorm**

*2004-04-05*

A 19-year-old Akron man will be allowed to continue living in Ohio University's Wilson Hall, despite his status as a registered low-level sex offender.

Nicolette Dioguardi, OU's associate director of legal affairs, said last week that the freshman, who applied for enrollment and dorm residence in January 2003, is not causing problems in the dorm, and OU officials see no reason to throw him out.

She noted that OU Police have investigated details of the July 2003 criminal conviction that earned the man his status as a sexually oriented offender, Ohio's least serious category of sex offender.

The case apparently involved the man's having had consensual sex with a 13-year-old girl. Contacted by The Athens NEWS last week, the man claimed the girl told him she was older. Dioguardi said that given the circumstances, it does not appear that the student poses any serious risk to other dorm dwellers in the co-ed residence hall, but that the university may tighten up the questionnaire filled out by dorm applicants, to catch cases like his.

"Everyone was very forthright and forthcoming about the case," the attorney said. She added that based on documents in the man's case, the girl apparently came forward and told authorities that she had wanted the sexual relationship with the 18-year-old man.

OU currently asks dorm applicants to disclose any felony convictions,

but at the time the man applied, he had not yet been convicted. Dioguardi said the university may begin requiring dorm residents to reveal felony convictions both before and after they move in.

OU only found out about the man's presence after the Athens Messenger found his name on a list of county registered sex offenders, and began asking questions. In the future, Dioguardi said, as a precaution an OU Police officer will make regular checks with the county for any registered offenders in the 45701 area code.

She pointed out that under Ohio law and OU policy, no one fouled up. The man did not have to reveal his conviction after he was accepted into the dorm, and county authorities were under no obligation to inform the university of his presence, given the low level of his offender status.

The man, meanwhile suggested last week that he hopes other Wilson Hall residents will realize that his legal status doesn't mean he's predatory or dangerous.

"People could look up the definition of (sexually oriented offender)," he said. "It could be (based on) many things."

**In this case, we find that while the defendant met the legal criteria for pedophilia and must now register as a sex offender for the rest of his life, he does not meet the psychological criteria. Sadly, cases like this happen all the time.**

It is tremendously difficult to provide services, especially in the context of a residential facility or a group therapy setting, when those who meet a legal definition of pedophilia but fail to meet a psychological definition are treated with a one-size-fits-all approach.

Another difficulty in understanding and treating pedophilia arises from cultural differences. This is probably one of the most controversial sections of the course, but we need to be aware that adolescence is an American cultural phenomenon - it's something that we created in our country because of wealth. It's true that over time

and to an extent we have exported adolescence to Asia, Europe and other parts of the industrialized world, but in reality, the majority of the world still does not have adolescence.

In the majority of the world and in our own country up until about 60 years ago, a girl became a woman as soon as she menstruated and a boy became a man as soon as he hit puberty, his muscles developed, and he became big enough to do physical labor. Think about your grandparents or your great grandparents and how old they were when they got married. Many reading this know that back just a generation or two, your grandparents or even your parents were married by the time they were 13 or 14, and were having children by the time they were 14 or 15. My grandmother, now in her 90's, was not married until she was almost 20. For her generation, she was an 'old spinster' and was lucky to be wed at all at that 'old' age.

The point is that occasionally there are cases where our cultural values and the client's cultural experiences or values will differ. When we fail to understand the cultural definitions of paraphilia and apply our legal or psychological definitions to these cases, we can find that we have tremendous difficulty in providing services to clients.

Yes, it would be undeniably wrong for a man my age to go down to the local high school and troll the parking lots for some freshmen girls to date. But in many parts of the world, those 14 or 15-year-old girls are actually considered women in the prime of their childbearing years. They make ideal partners for not only a sexual relationship but a marital family relationship as well.

A case in point occurred a few years ago in Texas and made the national news. It had been reported that a 25-year-old-or-so pedophile was traveling around doing migrant farm work with what appeared to be a pregnant 10-year-old girl. The authorities tracked the couple through north Texas, through central Texas, and finally apprehended him in Houston. They then discovered that the pregnant girl was not 10 years old but 14. The country was still outraged though. What is this 20-something-

year-old sicko doing getting a 14-year-old girl pregnant? Pedophile! they cried, at least until the public discovered they were not Americans, nor were they Texans.

They were not Univision's *Sabado Gigante* Mexicans from Mexico City, nor were they Matamoros or Juarez middle-class dollar-using Mexicans. They were agricultural Indians from the heart of old Mexico. When interviewed, we discovered that these illegal aliens were doing work in our country and saving up money because the soon-to-be father wanted to be able to provide for his fiancé and her new baby when they returned to Mexico.

In this case, from both legal and DSM-IV psychological perspectives, a 25-year-old man with a 14-year-old girl clearly meets the criteria for pedophilia. However, taking the cultural factors into consideration, awareness of the unique nature of this particular case must lead the clinician to deal with these specific individuals differently than we would deal with 99.9 % of the other cases defined as pedophilia that come our way.

But these cultural differences are an exception rather than the rule. Convicted sex offender Tom Green from Utah tried to claim that his sexual behavior with a 13-year-old was normal based on his religious values and experiences (Mormonism, The Church of Jesus Christ of Latter Day Saints). But when we look at the Tom Green case in its entirety, we find that his claim to be practicing his faith was rejected not only by his own church (who rejected polygamy over 120 years ago) but also by his five wives that he was convicted of being married to at the same time. Tom Green was a shrewd perpetrator of sexual crimes - for a time at least - believing he would be able to get away with his behavior by playing on the cultural definitions of pedophilia rather than the legal or psychological definitions of pedophilia.

## ***Sexual Masochism***

The sexual masochist seeks out real acts from which they derive their sexual pleasure by being humiliated, beaten, bound or otherwise made to suffer. This may include a cadre of behaviors such as fantasies of being raped, bound, spanked, blindfolded, whipped, electrical shock, cutting, urination, defecation and being forced to crawl and bark like a dog.

Many people want to spice up their sex life by introducing a little sex play, especially after years of 'straight-laced' sex or a monogamous relationship. The couple that visits the local sex shop and purchases Velcro collars or leg restraints may be acting out a mild fantasy of sadomasochism. The true sexual masochist, however, derives their sexual pleasure not from fantasy role-playing with their partner on a Friday night, or by dressing up for a theme party at a swingers club, but from truly being humiliated.

In the previous case of Dale the Banker, his masochism involved both experiencing the rough physical pain associated with the large sex toys that his wife would use on him and the 'golden showers' she would give him. These are real acts of masochism where sexual pleasure is derived from the humiliation and/or pain involving bondage, or by simply being under the total control of another person.

It is important to remember the Bell Curve at the beginning of the course and that many people may engage in behaviors different than those you would choose to engage in. *Masochism is considered a paraphilia, but is not automatically considered a psychosexual disorder.*

Again, what defines a psychosexual disorder is not how odd or freaky a behavior is, or even how unusual or how rarely it occurs. Once more, the question is: does a person suffer impairment in their ability to function in important areas of life because of their behavior? Dale and his wife engaged in what some would call freaky sex, but without any noticeable impairment to either one's ability to function.

The sexual masochist who meets the criteria for a psychosexual disorder is generally unable to derive any sexual pleasure apart from being in the masochist role. If their partner is unwilling to dominate them or play the sadist role to their satisfaction, they will likely begin to seek out unhealthy relationships. This often occurs in the form of anonymous sexual contact with 'strange' partners, which not only puts their health at risk, but also perhaps even their life in jeopardy. More than one news story has told of someone who became the unfortunate victim of an anonymous BD or SM encounter that went too far, and they were found dead, bound and gagged or beaten and mutilated.

### ***Sexual Sadism***

Sexual Sadists engage in real acts, not simulated or role played, where they derive their sexual excitement from the complete psychological or physical suffering of their victim. They desire complete control of a terrified victim and receive their sexual excitement, not from the specific sex acts performed, but from the power and control gained in the context of the sexual encounter.

Dale's wife, who manifested a dominant personality, enjoyed being the sadist for a voluntary masochist. This may seem odd, eccentric, or creepy to those outside their world. Yet if a person over the age of majority is in a consensual relationship with another person over the age of majority, and they have agreed on a repertoire of behaviors, even if we might find their behaviors repugnant or offensive, they probably do not meet the criteria for sexual sadism as a psychosexual disorder.

The criteria for sexual sadism as a disorder is met when a person derives his or her psychological thrill from power and control in relationships that are often non-consenting, or relationships that begin consensually, but where limits are not respected and the masochist has now become a truly terrified victim.

Serial killers are subjects outside the scope of this text, but many serial killers have also been Sexual Sadists, deriving their sexual satisfaction from the complete control of a terrified victim to the point of inducing death. The Central Park case of autoerotic-

asphyxiation that made the headlines in the 1980's may be an example of sadism coupled with the autoerotic-asphyxiation fetish that resulted in the death of a young socialite. The Eyeball Killer, the only serial killer ever arrested in the city limits of Dallas, Texas, was also a Sexual Sadist. He surgically removed the eyes from his terrified victims and performed sex acts using the eye sockets to derive sexual pleasure.

Sexual Sadism is different than domination. However, the dominatrix (female) or the dominator (male) is certainly at risk for crossing the standard deviation line in playing the master/servant role, even during consensual situations.

### ***Transvestic Fetishism***

Transvestic Fetishism is different than Gender Identity Disorder, which is found in a separate section in the DSM-IV. Transvestic Fetishism is cross-dressing for the purpose of sexual stimulation. The person may be wearing one hidden item, or they might be in full drag, out in public.

It's interesting to note that the Transvestic Fetishist is usually a *heterosexual* male. However, their histories may reveal numerous homosexual encounters.

Why do heterosexual Transvestic Fetishists often have a history of homosexual encounters? Opportunity. Let's just say that I am a Transvestic Fetishist and I enjoy wearing full drag on occasion, but I live in the buckle of the Bible Belt; a place where people still listen to country music on a regular basis and have shotguns hanging in the back window of their pickup trucks. If one evening I decided to go out on the town wearing some women's apparel items, I very well may be putting my life in jeopardy. Chances are good that as I'm seen driving around with a mustache dressed as a women, or walking from one country bar to another, I'm likely to attract the attention of several cowboys who will take it upon themselves to rid the world of "one more queer", and I am probably going to get my ass kicked.

Since I cannot walk around dressed in drag without putting my life in jeopardy, what am I going to do? I have a sexual urge to wear these clothing items and to go out in public and be seen by others while feeling the texture of those sexy panties and silk stockings against my body. The answer is to go where I am welcome, or at least where I won't be criticized. Whether in Tulsa, Memphis, New York, San Francisco, Chicago, Kansas City or Dallas, I can wear my full female regalia and go to any gay bar in the country for the Sunday night drag shows, whether I am actually gay or not.

If I am a heterosexual Transvestic Fetishist, about the only place I have an opportunity to feel free to express my sexual turn-ons is that gay bar. And now that I have spent the evening dancing and parading around in my lace demi-cup and my silk hose, I am aroused. As the alcohol kicks in and the night wears on, I become more and more urgently in need of sexual relief. But since I am at a gay bar, whom do I have the opportunity to interact with sexually? The answer is, of course, other men.

Consequently, many heterosexual Transvestic Fetishist's may find themselves with a history of 'unintentional' homosexual encounters. The contact may be brief or shallow, such as fondling or maybe a single kiss, or it may involve significantly greater sexual interaction.

Either way, these encounters may cause significant emotional distress. Remember, the Transvestic Fetishist does not want to be a member of the opposite sex, but rather they find that wearing certain items of apparel that may have belonged to a lover or can be associated with their sexual fantasies essentially turns them on.

It is important for the counselor to recognize the client's cognitive dissonance between their sexual orientation and their fantasies. Emotional responses to their own behavior may cause their marriage, peer interactions or even vocational success to suffer. In a nutshell, they are often impaired because of their fetishism.

## ***Voyeurism***

Voyeurism is the last of the paraphilias specifically identified in the DSM-IV. This involves observing an unsuspecting individual, usually a stranger, in the act of disrobing, engaging in sexual activity or in other compromising situations that the voyeur associates with eroticism. These are the Peeping Tom's. They usually desire no sexual activity with the observed person, but instead prefer to masturbate to the mental images later, often while fantasizing about an exclusive relationship with the individual or remembering the observed act.

Occasionally, the voyeur is in fact masturbating while watching the unsuspecting victims, but due to their need to keep from being discovered, their orgasm more frequently occurs at a later time and place.

Some regard the voyeur as a harmless freak. In reality though, the voyeur is probably one of the more dangerous psychosexually disordered individuals. Their behavior is always outside of the Bell Curve because not only does it have the potential for legal consequences, but it also victimizes the unsuspecting target.

In order to avoid discovery, the voyeur may harm the victim or others. The predatory nature of the voyeur's patterns shows that this individual - like the frotteurist or the 'gay old man' discussed earlier - derives their sexual excitement from high-risk situations. Therefore, when caught and found responsible for their behavior, in the future they will often cross the line into other predatory behaviors with victims they see as potentially easier to target, such as children, the elderly or isolated individuals.

## ***Paraphilias Not Otherwise Specified***

The DSM-IV provides this section for coding Paraphilias that do not meet the criteria for any of the specific categories mentioned above. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Again, we must consider the Bell Curve and the risk for or presence of impairment when evaluating even these Paraphilias.

**Telephone Scatologia** involves making phone calls, often to strangers at randomly chosen numbers, and experiencing sexual gratification while talking about sexual things. Having consensual “phone sex,” no matter how raunchy or vulgar the content of the call, is not the same as perpetrating telephone scatologia. And, though perhaps equally illegal, a teenager making a sexually rude prank call is not the same thing either. Exploring the motivation behind the act is always important.

Some people derive sexual satisfaction from receiving an **enema**, whether they give it to themselves or someone else does the deed. Along these same lines, some seem to experience sexual stimulation during the physical act of **defecation** or by the smell of **feces**. Provided health precautions are taken and all parties are in consensual agreement, so far as we know, these behaviors are legal. And for most people, so long as everything is done in private, they generally cause no impairment. When a party is non-consenting, things are done in public, health concerns arise, or an individual becomes unable to experience sexual pleasure without an enema or the act or smell of defecation, we find impairment.

Others enjoy watching someone else **urinate**, urinating on others, or being urinated on. Provided the activity is consensual by all parties involved, this act is legal, and there is generally little or no impairment for most people. If lines of consent are crossed, sexual

satisfaction declines without the presence of urination, or laws are broken, we find impairment.

**Partialism** involves an individual finding sexual gratification from the thought of, touching or receiving the touch of, or the smell of a very specific part of the body. This could be any part of the body, from the eyes, the nose, the toes, the knees, shoulder, belly button, etc. Again, if lines of consent are crossed, sexual satisfaction declines without the ability to focus on this body part or a law is broken, we find impairment.

Sexual acts involving animals or corpses are generally considered illegal, and thus are generally considered to be outside the Bell Curve.

## SECTION FOUR

### SEX EDUCATION

#### *Educating People About Good Sex*

One of the most effective interventions in the counseling process is patient education. Reframing, thought-stopping techniques, relaxation training, insight-oriented approaches and so on have efficacy with certain clients or in certain stages of the counseling process, but with all of our clients, change is often predicated on education. Our clients come to us not the way they could be, should be, or ought to be, but simply the way they are, and many are quite unaware of the severity of their own condition.

Many clients also come to us believing things about themselves or their situation that simply are not true. For example, the pedophile that has never actually penetrated a victim believes something to be true that is not: that it's only sex if it's intercourse.

Our clients also need to be taught specific skills.

Whether in individual counseling or couples counseling, whether the presented problem is sexual dysfunction, or the sexual dysfunction is discovered after the presenting problem is explored, educating clients about sex is an essential intervention. It is interesting to discover just how little people actually know about sex.

There are five things that I teach almost all of my clients. None of these things will make a pedophile an un-pedophile. None will make the Transvestic Fetishist lose interest in becoming aroused by the tactile feel of an expensive pair of panties. But in the context of couples counseling or working with individuals who have sexual difficulties, imparting paramount truths can change behaviors and minimize problems such as achieving orgasm or creating a healthy repertoire of sexual activities with a loving partner.

Interventions outlined in this section are likely of particular value to the first group of psychosexual disorders outlined in the DSM-IV and of less value to the paraphilias. However, for some of these clients, like the voyeur, the fetishist or the exhibitionist functioning at a high level, these ideas may sometimes be effective at decreasing the severity of their condition and the consequences of their behavior.

## **5 Truths About Sex Everyone Should Know**

### **1. Sexual satisfaction ultimately comes from a relationship, and a relationship only comes from intimacy.**

Many people have had a one-night stand or have engaged in sexual activity with a partner on a first date. This is common in today's society. From a purely physical perspective, sex feels good whether it occurs in a long-term monogamous relationship or with a new partner who we just met. 'Fantastic' and 'amazing' sex, however, does not come only from physical pleasure; it comes from physical pleasure combined with shared spiritual values, social comfort and psychological commitment. Many of our clients do not know that truly good sex does not come simply from an intense orgasm, but rather from a relationship predicated on emotional, social, psychological and physical intimacy.

Many people who have been promiscuous or engaged in one-night stands report that the physical pleasure in certain relationships was high, but following the physical pleasure, feelings of emotional, psychological and spiritual pain usually emerged at one level or another. These claims hold true for both men and women, and both adolescents and adults.

### **2. It is okay to talk about sex.**

People need to know that it's okay to talk about sex, and they need to learn *how* to talk about sex. I remember when I presented my first workshop to a professional audience on the subject of sex. It was in Abilene, Texas, and a group of about 20 Marriage and Family Therapists came to hear me speak on the subject of 'Sex and

Money', in the context of couples counseling. Although I had talked to clients about sex and to people in my personal world about sex, I had never addressed a group of professionals about sex. I knew a few of the people in the room, but the majority were strangers to me. As I introduced the topic and then began to cover the course objectives, I remember saying the word masturbation and becoming embarrassed.

At that moment I thought, if I am a licensed mental health professional speaking to other licensed mental health professionals and I am having a hard time talking about sex, how much more difficult must it be for our clients to talk to their partners about sex? Dr. Ruth and the Sunday Night Sex Show lady on the Oxygen network don't seem to have any trouble talking about sex in front of millions of people, but the majority of us are not Dr. Ruth or the Sunday Night Sex Show lady, and neither are our clients.

In order to help my clients begin talking about sex with their partners in a non-threatening way, I take them back to second grade. In second grade, we learned that there are 5 senses: sight, sound, touch, feel and taste. I ask my clients to complete a simple assignment: come up with a list of adjectives that describe sex as it relates to each of those 5 senses. While presenting live workshops, I will sometimes break the participants up into smaller groups and have them complete this same assignment.

Initially, there is always giggling, whether I give this assignment to a professional group or to a couple in couples counseling. As people begin to write down the adjectives that they may have thought about but never actually discussed, things like salty for taste, fishy for smell, dark for sight, expletives for the sound of sex, all top the list.

When partners begin talking about sex in a non-threatening way with their lover, they can begin for the first time to explore some of the difficulties surrounding their sexual experiences. I remember giving this assignment to one couple where Sexual Aversion Disorder was present. When coming up with adjectives to describe sex, the man used some rather unflattering terms. This gave us an opportunity to explore these thoughts

and to reconcile his perceptions with reality, which proved to be an effective intervention for resolving this couple's sexual disorder.

### **3. Technique.**

I am surprised by how many people just don't know how to do "it". When *Maxim* magazine first began publishing, I received a complimentary copy in the mail. *Maxim* is essentially the men's version of *Cosmo* magazine. The plotline on every cover says "Beer, Sex, Toys, and Gadgets." I remember leafing through that magazine and discovering an article on "How To Finger-Fuck Your Lover." I remember the article gave a couple of rather humorous hints, including don't dig around her vagina as if you were digging for a quarter lost deep inside your pocket. Another article on the subject of performing oral sex reminded that men need to come up for air frequently, and to also seize that time as an opportunity to remember that there are other parts of a women's body which also need some attention.

While the humor of these articles helped take the edge off, and while they gave generally good advice, I do not recommend that people turn to the pages of popular magazines to learn sexual technique. Nor do I recommend that people watch pornography to learn sexual technique. My best advice to couples I work with is to learn sexual technique from your partner.

Ask, listen, tell, show, and of course, practice.

## ***The Case of the Catholic Couple***

She was a Catholic schoolteacher and he was an insurance salesman. The presenting problem was not sexual difficulty. However, within a session or two, it became apparent that sexual frustrations topped their list of things they wanted to talk about.

Their story was interesting, as they truly were childhood sweethearts. They were both devout Catholics and had met when they were in Catholic elementary school. They began dating in the 7<sup>th</sup> or 8<sup>th</sup> grade. They continued this relationship when he attended the private Catholic high school for boys and she attended the one for girls. After high school graduation, they went off to a Catholic university together and after completing their educations, they got married. We'll call them Joe and Mary.

Joe and Mary had been married for 12 years and had one child, age 5, before they came to my office. So apparently, they had had sex at least once, although at this point in their marriage they were not having sex. They were committed to each other and they loved each other, but Mary did not find sex pleasurable.

As I was sitting in the counseling chair listening to them, I was perhaps not attending fully. Don't get me wrong; I heard what they were saying, but at the same time, it was near the end of the day and I was thinking about those tasks at home that needed to be done, and so while I was listening, I was perhaps not giving them my full, undivided attention.

They were going on about sexual frustrations and began to talk specifically about oral sex. Mary reported that she just did not enjoy that activity. Perhaps it was because I was not attending fully, or perhaps it was my shock that she did not enjoy oral sex, but whatever the reason, I suddenly lost all professionalism and spoke before I thought. I turned to Joe and said, "That's because you're no good at it."

At this point, I thought he might hit me. Then, when Joe's eyes met mine, the instant anger on his face suddenly melted into a sly smile. I set back in my chair, silently

watching his reaction in light of my insult. He now looked, well, thankful and eager, in a state of happy desperation.

I realized that I had just set him up to finally discuss what he has always wanted to discuss. He took a deep breath, rearranged himself in his chair, and confessed, “Well Richard, maybe you are right. Maybe I am no good at it.”

I leaned forward. (At this point, I was paying very close attention to my clients.)

Joe continued, “And I have an idea. You know we are both very religious and neither of us has had a sexual encounter with anyone else. Neither one of us have ever even seen anyone else have sex. Neither one of us has even talked to anyone other than you about sex. But I have an idea. Maybe,” he paused looking at his wife, “Maybe - and I want to make it clear here that this request is not for prurient reasons but only to help us as a couple - but, maybe we should learn how to have sex by watching some porno films together.”

I looked over at his wife who was now the angry one. She was fuming. Joe stammered, “Really, not because I’m not happy with Mary or want to see other women, but because we could, as a couple, watch and see what they are doing and then we could maybe do it ourselves. You know what I mean?”

I hated to cut down his idea after I had already insulted him, but this was a bad idea. So, I told him, “No, you cannot watch porn together for the purpose of learning how to have sex.”

He said, “But why not? Other people do that. Don’t they?”

I explained that those who watch porn to learn how to have sex were often the people who ended up in my office for sexual counseling. I told him, “There is only one reason to watch porn and it’s not for any educational value. It’s because you are turned on and

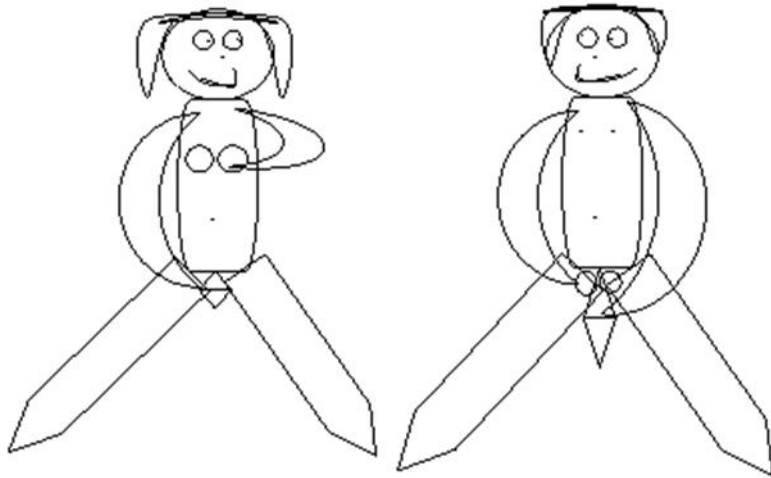
aroused by watching other people have sex.” I asked him if he knew anything about the porn business and of course, he said no. So, I educated him.

The actors and actresses in porn films are not union actors, they are not members of the Screen Actor’s Guild and unlike the actors and actresses you see on television shows and the big screen, the typical porn star on a DVD movie was paid maybe \$300 ‘per fuck’. Most of the people who appear in porn films are desperate to have next month’s rent money, to keep their utilities on, or to finance their drug habit. They are getting paid to get laid.

I must confess that I, like many readers of this course, have seen some porn films. In my opinion, no one appears very happy in these films. The women always seem to fake their orgasms, and the men often look as if they have a difficult time getting off. The actors regularly give the impression of being bored or not enjoying it, and sometimes they even appear to be in pain.

I do not want my clients to learn sexual technique from somebody who got paid \$300 to ‘fuck for the camera’. I told Joe and Mary that the only real way to learn sexual technique is not by watching somebody who is unhappily making enough money to pay their rent at the end of the month, but instead to learn from each other how to make love.

Then, I went to my marker board and drew a picture.



When I drew this picture on my marker board, their faces were white with shock. After a bit of silence, Mary spoke up. “What are they doing?”

I nodded, “Yes, they are masturbating.”

She choked. “Together?”

I said, “Yes. Specifically, what they are doing is he is showing her what makes him happy and she is showing him what makes her happy. You both know what brings you pleasure - or at least you should. How do you liked to be touched? Some people like to be touched in one way, and other people like to be touched in another way, and some don't like to be touched in that way at all, and only you know what it is that turns you on. So, in order for the two of you to learn sexual techniques that will be pleasing to yourself and your partner, you are going to need to show your partner what it is that you like.”

She looked indignant for a moment, or maybe it was horrified. Finally, she asked, “You want him to... masturbate... in front of me?”

I told her of the statistic on masturbation, that 95% of all men masturbate and the other 5% lie. I explained to her the reality that the majority of women masturbate on a

regular basis, most frequently after sex.

Joe grinned and broke the ice. “So that’s why you take the long baths after we make love, huh?”

The couple went home that night, tried the assignment, and discovered that you can enhance your sexual satisfaction by learning - and teaching - sexual technique with the partner who you love.

#### **4. People need to know that today’s relationship is not the same as yesterday’s relationship.**

I have worked with many people in counseling who have been physically, sexually and emotionally abused in prior relationships. The trauma of these past experiences can certainly affect a person’s outlook and viewpoint and can shape their current experiences in regards to sex and sexuality. But the fact remains that while these prior experiences may have been difficult, today’s relationship is often different.

Sue and Ron had been married over ten years. Overall, they had an excellent relationship, but when it came to sex, issues related to Sue’s emotional reality continued to cause them difficulty. Ron liked performing oral sex on Sue, and she enjoyed receiving it. Sue knew that her husband also wanted to experience receiving oral sex on occasion, and she expressed that this was something she desired to do for him. However, because of her experiences in a prior relationship, Sue found that every time she tried to pleasure her husband this way, she would end up losing interest or just quitting. This prior relationship was in high school, and the boyfriend, who was apparently abusive to her particularly when she was performing oral sex, was her only other sexual partner in life.

I am not a believer that every relationship must have reciprocal oral sex in order for it

to be satisfactory. Different people find that different things pleasure them, at different times. In fact, I have found that blowjobs are over-rated. I say this because many of the men who I talk to claim that while oral sex does feel good, it often just doesn't give them the intense stimulation necessary to bring about the enhanced physical pleasure required for orgasm. Many even report that they actually feel guilty about being unable to come when their partner is kind enough to perform this sexual act.

But remember that Sue and Ron wanted to develop sexual compatibility. Sue had stated that she really wanted to be able to do this for her husband, and Ron really wanted her to do it. They told me that over the years they had engaged in a variety of techniques to try and make it more exciting or different than her prior experiences. They tried the whole gamut ranging from using honey, chocolate, barbeque sauce and ketchup in an attempt to make the experience more pleasurable for her, but no matter what they tried, she was unable to maintain any interest and even became irritated by the recollections of her prior life experiences.

I listened. Finally, I turned to Sue and said, "I am not a believer that you have to do this in order for your husband to be happy, but you say it is something you want to do, and you say you love your husband. You have also told me that your husband has been a faithful, kind and gentle person who has treated you well and respected you throughout your relationship with him. Why then do you continue to punish him by correlating your current sexual activities with Ron to your prior life experiences? Do you not realize that your loving husband of 10 years is not your abusive boyfriend from way back in high school?"

Sue was clearly shocked. After a moment she responded by saying, "I never really thought of it that way. Yes, he is different. Very different." A cute little smile came across her face. She leaned over, hugged her husband, and said, "Ron is not my abusive boyfriend. He is my loving snuggle bunny."

All it took to change the dynamic of this couple's sexual frustration was for somebody to point out that today's relationship is not necessarily the same as yesterday's relationship. Until she was confronted with that factual reality, it had not become an emotional reality for her. Once she was confronted with the truth and accepted it, she was able to move forward and experience sexual pleasure with her husband in a way that the two of them had never experienced it before.

## **5. People need to be taught that sex does not begin when Jay Leno finishes his monologue.**

A few years back, I was cruising through a Baptist bookstore and I saw a book titled *Sex Begins in The Kitchen*. I must confess I never read the book, but I loved the title. My guess is that as a way for promoting sexual intimacy in the context of marriage, the book focuses on the relationship rather than simply on the act of sex.

Research says that the average duration of the typical sexual experience in most marriages is 14 ½ minutes - from foreplay through clean up.

That tells me that most people wait for Leno to finish his monologue then say, "Hey, honey, wanna do it?" For most couples, after several years of marriage, this becomes their sexual norm.

Sex does not begin when Leno finishes his monologue. As I stated at the beginning of this section, good sex is predicated on a relationship and the development of intimacy. That means that good sex starts in the kitchen at 7:15 in the morning as the couple shares Pop Tarts or one helps the other get their stuff organized for the workday. Good sex is an extension of shared experiences and respect throughout the day, and begins when the sun rises in the morning. Every morning.

Since we are talking about mornings, let's talk about sex in the morning. From a practical aspect, our bodies are primed for sex in the morning. Evolutionary psychologists would tell us this is to preserve the seed in case the hunter-gatherer does not return from his foraging trip. I don't know if the evolutionary scientists are correct or not, but I do know that many people report that they are the most aroused when they wake up. However, most couples I talk to reserve sex for the end of the day, when they are, unfortunately, the most fatigued and least likely to respond physically to the sexual pleasures of shared intimacy with their partner.

How does this tie in with sexual disorders and paraphilias? Simple: Some find that fatigue and the timing of sex impedes their partner's interest level, and so they compensate for this by focusing on specific erotic acts or attributes to better facilitate the sexual process. Therefore, by simply teaching couples that sex should not always only occur when Leno is finished with his monologue, but sometimes when the morning show cuts to a commercial break, we can sometimes bring renewed interest to our clients' sex lives and change the dynamics of their relationship forever.

## SECTION FIVE

### SEXUAL PROBLEMS AND POTENTIAL SOLUTIONS

This section will provide an overview of potential solutions and interventions that may be effective with a client manifesting psychosexual disorders. The majority of these interventions are probably most effective with the areas of sexual dysfunction as outlined in the DSM-IV. In dealing with the paraphilias, specific interventions will be offered. However, the clinician should remember that effective intervention with paraphilias is much more limited than in the areas of sexual dysfunction.

In fact, some of the more effective interventions with the paraphilias are those that do not induce change in the perpetrator, but instead are designed to protect innocent victims. Overall recidivism rates in regards to sex offenders are extremely high. In some states, an 83% recidivism rate (yes, 83% going out and doing it again) is considered successful.

I am not implying that there can be no advocacy with the paraphilia, but it should be understood by the clinician that 'change' should not be the only goal in working with these individuals. Sometimes monitoring for recidivism and creating interventions that protect the victims of the perpetrators is most effective.

**Pedophilia literature in the past has defined two types of pedophiles:  
the fixated and the regressive sex offender.**

The fixated pedophile is an individual who has sexual fantasies, urges and actions fixated on a prepubescent body type, and often of a particular age. The fixated sex offender usually has a history of many victims, because as their victims mature in age they become, well, for lack of a better word: 'useless'. The offenders will then seek

out new experiences with ‘useful’ victims, the kind of person that they are most drawn toward by age and physical appearance.

It’s as if their sexual orientation is geared specifically towards 5-year-olds, 8-year-olds, or 11-year-olds, and although ‘sexual orientation’ is not exactly the right term to describe the state of the fixated sex offender, used in this context the concept demonstrates the rigidity in their mind regarding the age or appearance of their victims.

The regressive sex offender is someone who throughout their life span has predominately been interested in age-appropriate sexual relationships. If they are 50, they maintain sexual relationships with other 50-year-olds. If they are 30, they maintain relationships with other 30-year-olds. But, for some reason at some time or other in their life, opportunity and desire have translated into sexual encounters with the prepubescent child. Even though they have been interested in age-appropriate sexual relationships throughout their life, they ‘regress’ (in age) and victimize children.

The regressive sex offender, because they are involved in age appropriate relationships, usually has a history of less victimization. While the fixated sex offender is more likely to perpetrate their crimes against neighbor children and strangers, the regressive sex offender is probably more likely to engage in incestuous relationships. This behavior often occurs while the perpetrator maintains a marriage, steady relationships or other age-appropriate sexual relationships.

Assessment of specifics is the key to developing interventions with any client. As we seek out interventions that are helpful to those who manifest psychosexual disorders, we want to be able to allocate resources to those who are most able to benefit.

Using the terms fixated and regressive sex offender is a controversial concept in the field of counseling. Those who have advocated for victims rights say it does not really matter if they are fixated or regressive sex offenders, we simply need to lock them up and throw away the key.

But the fact is that while the behavior of both is vile and illegal in our culture, counseling techniques have demonstrated some advocacy to reverse pedophilia behaviors. The regressive sex offender is most likely to benefit from intervention focusing on change, while the fixated pedophile is least likely to benefit from psychological or psychiatric intervention.

However, a number of common intervention strategies will have no impact on this paraphilia and are probably more suited for traditional couples counseling in resolving issues such as Sexual Aversion Disorder or Orgasmic Disorder in otherwise healthy patient populations.

There is not a magic psychotropic medication nor a specific modality of therapy such as Cognitive Behavioral Therapy or Aversion Therapy that is always useful to all those with psychosexual disorders. A mix of interventions is provided here as an overview or a starting point for understanding and to lay a foundation. These interventions draw from a multi-theoretical approach, designed to target specific client needs in the context of in-patient or outpatient therapy. These ideas should be expanded on by anyone providing full-time counseling services to those manifesting psychosexual disorders.

### ***Interventions For Physical Problems***

Again, in order to meet the criteria for a psychosexual disorder in the DSM-IV, the core of the dysfunction cannot be due specifically to a medical or pharmacological cause. In other words, Bob Dole, as we discussed at the beginning of this text, does not meet the criteria for a psychosexual disorder because his inability to maintain an erection is due to a physical injury rather than to a psychological stressor.

However, it should be recognized that our physical health does play a role in our emotional and mental health, and psychosexual disorders can certainly be exacerbated by physical conditions and the general status of one's health.

Clients manifesting problems in the areas of sexual dysfunction outlined in the first section of this course should be referred to and screened by their primary care physician for problems related to blood pressure, menopause, and physical damage, or evaluated for side effects to their medications. Clients with sexual pain due to a physical problem may require surgery, medication or other physical treatment. Individuals who suffer from impeded blood flow to their sexual organs by injury or illness may very well benefit from current medications such as Viagra, to treat these conditions. These are all obvious physical interventions.

When physical and pharmacological causes of a client's disorder have been ruled out or found to encompass only a small portion of the difficulties they are experiencing, the clinician must evaluate other areas of physical health, which may be controlled by a client. Some simple things from a physical perspective can make a big difference in sexual performance. It has been said, "You are what you eat." When dealing with couples and difficulties related to sexual performance, the taste or smell of a person's skin and even sexual fluids can be influenced by the individual's diet. Couples with difficulty in performing oral sex because of "the way it tastes" may find that a simple adjustment to the diet and the cessation of cigarette smoking can often dramatically change how they feel about certain sexual activities.

Diet not only affects the way a person tastes or smells, but also how a person performs. Providing continuing education training workshops causes me to travel extensively. Subsequently, I eat a lot of unhealthy drive-through-window food, like cheeseburgers, French fries, apple pies, and even snack cakes from truck stops. When I travel and eat like this, my body does not get the nutrition necessary for maximum performance, and after a day or so, I begin notice the negative effects in all aspects of my health, including my emotional and sexual health. Addressing basic nutritional needs is an intervention that can be highly effective at reducing the severity of sexual distress.

Other physical problems can be easily addressed with patient education services. The

amount of sleep we get each night affects our sexual performance, particularly as a person ages. I have worked with many couples whose main complaint is they are simply 'too tired to do it'. Incomplete sleep cycles, irregular sleep cycles and sleep disorders can be contributing factors to the decline of sexual performance. Teaching our clients basic sleeping skills such as to sleep in 90-minute increments to help insure complete sleep cycles can have a powerful impact on their overall health. (This means to actually sleep for approximately 6, 7.5 or 9 hours at a time.)

In addition to sleep and nutrition, moderate exercise also benefits sexual functioning. Clients do not need to become Olympic athletes in order to have good sex, but toning back and abdomen muscles, maximizing oxygen flow to the muscles and maintaining general physical wellness is of paramount importance to sexual satisfaction.

Clients who smoke 2 to 3 packs of cigarettes a day or have troubles breathing due to obesity are going to have sexual difficulties, particularly as they age and oxygen flow becomes even more necessary to achieve sexual orgasm.

Evaluation of a client's overall physical health is part of responsible counseling. Just as physical wellness can positively impact depression, it can also have tremendous impact for those experiencing difficulty in the areas of sexual dysfunction.

### ***Social Skills Training***

Many people manifesting psychosexual disorders find that not only do they have a difficult time relating to individuals sexually, but they have a difficult time relating to people around them - period. If you cannot maintain an age-appropriate relationship from a social perspective, it should be understood that it would be even more difficult to develop an age-appropriate sexual relationship.

This is not to say that pedophilia is caused simply by a lack of social skills. However, we find that populations of frutterists, pedophiles, voyeurists and many other paraphilias may manifest a broad range of interpersonal defects, including social skills.

Often the pedophile, from a social perspective, is functioning at a level of social maturity comparable with the ages of their victims. Teaching social skills ranging from assertiveness training to advanced interpersonal communication skills and age appropriate dress, leisure activities and emotional expression are all tasks to accomplish in counseling.

Furthermore, those manifesting difficulty in the areas of sexual dysfunction may also benefit from social skills training. It can be a tremendous boost in their ability to interact comfortably with their sexual partners and gives them resolution strategies for dealing with difficult times.

When I think of the quintessential socially retarded individual, I personally always conjure up a mental picture of Michael Jackson. Now in his 40s, he maintains a childish way of dressing. He appears to have an inability to articulate and communicate adult issues in adult language. His leisure activities seem to be at a pre-adolescent level of functioning rather than at an adult level of functioning.

Training the socially retarded individual in social skills will not make the pedophile a non-pedophile. However, it is one intervention strategy that when used with others, may help to reduce the severity of client condition. With some of our psychosexually disordered clients, it may actually help promote wellness and normal functioning.

### ***Addressing Issues of Anxiety, Anger and Depression***

Interventions borrowed from anger management, anxiety treatment and depression resolution can be highly affective with the psychosexually disordered client. I am convinced that anger is an underlying emotion for many of our perpetrators of sex crimes.

The reason chemical castration (Depo-Provera), or physical castration is not the panacea for curing pedophilia is that the behavior is not all sexual; in many cases, it is a manifestation of rage and anger. The acts are primarily violent rather than sexual,

and if we remove a person's genitals or render them useless but do not treat their anger, we will still have a violent person. They may be unable to penetrate their victim, but they certainly have the capacity to continue victimizing.

The same idea holds true for the sexual sadist. Bringing about the complete psychological suffering of their victim is often about manifesting their anger and rage towards a specific individual, people in general, or society as a whole, and anger work may be quite helpful with these kinds of clients.

On the other hand, I have become frustrated working with criminal justice systems because the latest one-size-fits-all approach to dealing with offenders is to send them to anger management classes. While I think the principle is a good idea in general, in many institutional cases the classes are poorly run and ultimately fail to address the other important emotions underlying the anger, such as fear, shame, guilt and confusion.

I am also not a believer that one magic intervention can impact all of our clients. I believe that an intervention with advocacy must be coupled with other interventions of advocacy to truly achieve results with our impaired clients. So, the basic tenets of anger management including anger reduction and the development of behavioral options are useful strategies, but like social skills training, they must be combined with other interventions.

Many of our clients manifest aggressive or violent anger behaviorally because they have come from family situations where they have learned this behavioral response. If grandpa manifested his anger through violence and sexual acting out, and his son was sexually violent in his own family system, the grandson (our client), when angry, will likely manifest violence in sexually aggressive ways as well.

***People only know how to do what they have learned how to do.***

If Grandpa throws a chair through the window every time he gets angry, and Father

throws a chair every time he gets angry, the son will likely also throw a chair through a window every time he gets angry.

When I work with angry clients who manifest their anger in violent ways, I ask them what they could do other than *blank* (throw a chair through a window, sexual aggression, physical fights, etc). In response, they usually give me a blank stare. In their entire life, they have never thought about options or what else they could do.

The clinicians reading this course all have a repertoire of coping strategies for dealing with anger. Some are unhealthy. Some are innocuous or even pointless and others are certainly healthy. I could do 20 different things when I am angry other than throw a chair through a window, and so could you. But for many of the clients on our caseload there is only one option: doing what they know how to do.

It's our job to teach them how to do something different.

Assessing for and treating depression can be a significant step in reducing psychosexual dysfunction. If a person has become hopeless they will act in hopeless ways, often in sexually self-defeating ways. Depression is a very physical condition. The criteria for the diagnosis of major depression include not only symptoms related to sleep, weight and eating, but also a markedly diminished interest or pleasure in activities, which in many individuals includes a significant reduction from previous levels of sexual interest or desire.

Arousal Disorders, Orgasmic Disorders and Aversion Disorders can all have roots in depression. Treating major depression with psychotropic medications along with cognitive behavioral modalities can often help end self-defeating sexual behaviors. Additionally, those already on certain medications should be evaluated to be sure that the medication itself is not a contributing factor to a diminished libido.

Emotional responses to the behaviors that clients engage in while manifesting their

paraphilias may also contribute to the severity of clinical depression. For example, the fetishist, the transvestic fetishist and the frotterist may feel shame because of their behaviors, which can contribute to the severity of depressive episodes.

I have worked with many pedophiles who believe there is nothing wrong with their behavior. Some, however, have felt tremendous guilt over their inability to control their urges and have felt genuine remorse for their actions and the hurt they have caused others. Some of them may feel hopeless. And if you believe that life is truly hopeless, how will you act? You will act hopeless. For the person without hope, continuing a lifestyle of harmful behaviors is the norm rather than exception. Clinicians treating those with psychosexual disorders can borrow heavily from the treatment of anxiety. Many problems such as premature ejaculation have a root in our client's inability to manage anxiety. Interventions such as paradoxical intentions, which force the client to experience the symptom in an artificial or predetermined environment, can sometimes have tremendous advocacy on specific problems.

Teaching clients skills related to anxiety management and techniques for therapeutic relaxation can go along way towards addressing both paraphilias and areas of sexual dysfunction that we have discussed. During periods of stress or fear, clients are more likely to manifest their paraphilias and other sexual problems. Stress itself does not cause fetishism, but when the fetishist is under extreme stress, they are more likely to fixate specifically on what is familiar or comfortable to them, or that which brings 'escape pleasure', which is often the manifestation of their fetish during the course of their sexual actions.

## THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE

To receive continuing education credit for this course, you must have read this entire text file and the required DSM readings.

You must also complete and return the Evaluation of Learning Quiz and pay the CEU fee. (Instructions are on the next page.)



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Richard K. Nongard, LMFT, CCH, CPFT  
Executive Director

# “Psychosexual Disorders”

## 6 Continuing Education Clock Hours

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# EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

\*\*\*\* OR \*\*\*\*

You may complete and submit this information **ONLINE** by following this link:

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## EVALUATION OF LEARNING QUIZ - PAGE 2 of 4

### **Course Title: "PSYCHOSEXUAL DISORDERS"** **6 Hours of Approved Continuing Education Credit**

*The purpose of the following Evaluation of Learning questions is to:*

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

#### **➔ ANSWER THE FOLLOWING EVALUATION QUESTIONS – TRUE OR FALSE.**

- T F** 1. I have read the required .pdf text file for this course.
- T F** 2. Psychosexual disorders emerge as a result of psychological difficulties rather than social or situational difficulties, medical conditions or side effects from medications.
- T F** 3. As humans, we generally define the 'normalcy' of anything and everything from our own frame of reference.
- T F** 4. The DSM-IV defines two areas of sexual dysfunction in its section on psychosexual disorders.
- T F** 5. Men think about sex an average of seven times a day.
- T F** 6. The inability to become aroused does not define psychosexual disorder.
- T F** 7. The Female Orgasmic Disorder defined in the DSM-IV presumes that there is a normal sexual excitement phase and that the inability to experience orgasm is not due to a medical condition or a social condition like a bad lover.
- T F** 8. The essential feature of Dyspareunia is genital pain associated with sexual intercourse.
- T F** 9. Alcohol abuse can significantly enhance sexual performance.
- T F** 10. Desyrel has potential catastrophic sexual consequences for young men.
- T F** 11. Our psychological and our legal definitions of disorder sometimes differ.
- T F** 12. The occurrence of an isolated behavior cannot define pathology.
- T F** 13. Some paraphilias are difficult to place inside or outside the standard deviation on the Bell Curve.

***(The Evaluation Quiz continues on the next page )***

## EVALUATION OF LEARNING QUIZ - PAGE 3 of 4

### Course Title: "PSYCHOSEXUAL DISORDERS"

6 Hours of Approved Continuing Education Credit

- T F** 14. In the DSM-IV, Exhibitionism is defined as exposing one's genitals to a stranger.
- T F** 15. Fetishists use non-living objects, frequently wearing women's apparel, including underpants, bras, stockings, shoes or boots -- for cross-dressing purposes.
- T F** 16. Frotteurism involves a person rubbing their genitals against another person, or touching another person's genitals, usually in crowded public places.
- T F** 17. Pedophilia is always outside of the standard deviation.
- T F** 18. The sexual sadist seeks out real acts from which they derive their sexual pleasure by being humiliated, beaten, bound or otherwise made to suffer.
- T F** 19. Having consensual "phone sex," especially when raunchy or vulgar, is the same as perpetrating telephone scatologia.
- T F** 20. People need to know that it's okay to talk about sex, and they need to learn how to talk about sex.

## **GRADE THIS ONLINE COURSE! – Page 4**

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### **Participant Assessment of Home Study CEU Course**

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**Please Rate the Following Statements from 1-5**

***(1 being the Lowest, 5 being the Highest.)***

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- \_\_\_\_\_ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

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