Clinical Management of Sexual Disorders

second edition

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DEDICATION

To our patients and our colleagues in the SBCU from whom we have learned so much. But, most importantly, to our children: David, Laura, Magge, Eliza, and Catherine.

The Editors

Preface to the Second Edition

In the foreword to the first edition of *Clinical Management of Sexual Disorders* there was concern about a disturbing trend in work on human sexuality: a drift away from careful, considered clinical work and toward faddishness. Fortunately, at this juncture, the field appears to be maturing and the abuses, which grew out of naiveté, are in the past.

The movement, at present, is toward subspecialization in the treatment of sexual disorders. In medicine, for example, there has been progress toward a subspeciality of "sexual medicine." Subspeciality status has come by way of recognizing the vast scope of sexual disabilities—functional and organic, by way of increased sophistication in diagnostic methods, and through an additional decade's experience in the effective treatment of patients.

The Sexual Behaviors Consultation Unit (SBCU) was established at the Johns Hopkins Medical Institutions in 1971 in order to provide a clinic in which patients with the spectrum of sexual disorders could be seen, evaluated, and treated. In this book, which represents a joint effort by the faculty and staff of the SBCU and our colleagues interested in sexual medicine, more than a decade's experience is summarized. The view is toward those aspects of clinical evaluation and care which may now be applied by practitioners in medicine and the allied health professions.

Jon K. Meyer, M.D.
Chester W. Schmidt, Jr., M.D.
Thomas N. Wise, M.D.
Editors

Preface to the First Edition

This volume grew out of experience across the country in more direct, or directive, intervention in the treatment of sexual disabilities.

A reawakening of interest in sexual problems, in and of themselves, has been noticeable among the public and in medicine, psychology, and the social, experimental, and applied sciences. Sadly, among certain groups and individuals this surge of interest has led, at worst, to faddishness, hyperbole, and invective or, at best, to questionable claims of efficacy for one particular treatment, unsubstantiated cure rates, and unethical conduct. Such exploitation of recent concern is in marked contrast to the responsible clinician or investigator who wishes to make reasonable and proper use of new techniques and recent information.

This volume represents an attempt to combine between two covers the best of recent thought, minus unsubstantiated claims, regarding the approach to patients with sexual disorders, the diagnosis and classification of these disorders, the determination of significant variables in sexual conditions, and the application of selected treatment techniques.

The philosophy of this volume is that the treatment of sexual disorders is analogous to the treatment of any other major spectrum of disorders in medical practice: *i.e.*, there is not one treatment modality sufficient to cover all possible conditions; rather, the complete practitioner must have a broad range of treatment modalities at his fingertips so that the most appropriate technique may be selected according to the patient's particular symptoms, life style, interpersonal relationships, financial resources, and emotional health. Although the emphasis in *Clinical Management of Sexual Disorders* is on direct manipulation and directive techniques, the full range of appropriate modalities for treatment of sexual disorders is considered to extend from formal psychoanalysis through behavior modification and desensitization, to surgical intervention.

This volume attempts to represent an evolutionary step and not a revolutionary one. Considerable past experience in medicine, psychiatry, surgery, and psychology is applicable to sexual disorders, so that it is not appropriate to throw the baby of prior observation and understanding out with the bath

water of unnecessary past hesitance to inquire more frankly and explicitly about aspects of an individual's sexual life.

Clinical Management of Sexual Disorders is addressed to the clinician of whatever speciality, since individuals with sexual disorders are no respectors of jurisdictional lines among disciplines. The book will supplement the skills of the clinician and practitioner who is faced daily with problems of sexual dysfunction. Additionally, the authors have provided adequate documentation so that the more serious student may pursue any particular area in the original sources. This volume may also be used as a reference handbook, selected chapters being useful to broaden the capabilities of those individuals whose clinical experience and training already has encompassed one or more of the specific interventions. It is hoped over-all that it will make a contribution to the better care of those individuals suffering from a sexual disability.

Jon K. Meyer, M.D.

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Contents

Chapter 1

The Clinical Spectrum of Sexual Disorders

JON K. MEYER, M.D., Editor

1.1 Introduction

This chapter is organized to introduce the panorama of sexual complaints and to begin the process of making sense of that clinical diversity.

An underlying framework for conceptualizing sexual difficulties is the developmental model. Within this model, sexual difficulties are understood in terms of developmental precursors, physical or psychological, and the stage of life in which the sexual symptom takes its root. Through the application of this model, the treatment of sexual disorders becomes etiological, rather than merely symptomatic. The opening sections in this chapter discuss developmental issues: the following section reviews physical (largely embryological) sexual development; the next, the interface between brain and mind in the sexual sphere; and then, postnatal psychological development.

As important as it is to see the sexual disorder in its developmental context, it is also important to see it in the social and cultural milieu. Section 5 outlines the demographic variables in a sample population of individuals seeking treatment for sexual complaints. In Section 6, the way in which

social factors condition and influence the sexual symptom and treatment are briefly outlined, distilling out of the demography a more human appreciation of the patient.

Section 7 marks the transition from the basic material to the clinic. A look at clinical sexual disorders begins with terminology, reviewing the descriptive viewpoint of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition. The utility and limitations of the official nomenclature are discussed along with the terminology used in this book. A somewhat different outline of the spectrum of sexual disorders is presented in Section 8, as a transition to the discussion of diagnosis and diagnostic procedures in Chapter 2 and to treatment techniques in Chapter 3.

1.2 Sexual Aspects of Fetal Development

INTRODUCTION

This book is devoted to how the sum total of differences known as sex is acquired and expressed, focusing primarily on pathological expression. Development is emphasized because rational treatment decisions are based on understanding the anlage of current problems. Most of us, when considering the evaluation and treatment of sexual disorders, normally think of adults with problems in choice of a sexual partner, coital union, and orgasmic satisfaction. If the generation gap is not too large, we may also include adolescents. It is more rare to think about children and their literally fantastic sexual lives. I am sure that very few of us have ever considered the sexual life of the fetus.

Why worry about the fetus? For the fetus, choice of a sexual partner is premature, coital union is but a distant possibility, orgasmic satisfaction is physiologically unlikely, and preoccupying sexual compulsions await myelinization of the cortex. There is no fetal sexual activity in the usual sense, but in another sense their sexual life is dramatic: the reproductive apparatus and external genitalia are differentiating and the central nervous system (CNS) is being sexually conditioned.

This is a gigantic field to cover, so there will be unavoidable sins of omission. Problems of egg or sperm formation, fertilization, implantation, and early multiplication are omitted. Errors here are largely incompatible with life, let alone sexual activity. The sexual influences of chromosomes, gonads, hormones, internal reproductive organs, external genitalia, and the central nervous system, however, will be sketched. There will also be a look at conditions in which development has gone awry, attempting to clarify such important concepts as gender and sexual identity. [I am indebted to Baramki (1974) for his review of fetal development.]

PHYSICAL DEVELOPMENT

Genetic Factors

Humans normally have 46 chromosomes, 22 pairs of similar appearing chromosomes plus one pair of sex chromosomes. In the female, this pair is morphologically similar, but not in the male. In the female, the genetic complement is 46,XX. The role of the X and Y chromosomes is to determine the differentiation of the gonad, as the primitive gonads are bipotential and appear identical in both sexes. Under the influence of the XY karyotype, the cortex of the gonad involutes and the medulla develops; in the female (XX) the medulla regresses and the cortex differentiates.

The Gonads

Indifferent State of Gonadal Organogenesis

At about 4 weeks (when the fetus is 4–5 mm in length), the genital ridge in both sexes appears as a thickening on the primitive gut. Until late in the 6th week of embryonic life (17–20 mm in length), the gonadal ridges in the two sexes are grossly indistinguishable.

Differentiation of the Gonads

The Testis. At 5–6 weeks (15 mm fetal length), sex cords, later to become the seminiferous tubules; begin to form in the male gonad. Germ cells are incorporated in the sex cords as spermatogonia and the intervening cells becomes Sertoli cells. A testis can be recognized as such at about 6½ weeks.

Interstitial cells, which are responsible for the elaboration of male hormone, show the first signs of specialization in a 7-week embryo (31 mm). At 9 weeks (50 mm length), these cells increase in size enormously, attaining a maximum size at about 18–20 weeks. At 20–25 weeks they shrink again and remain inconspicuous until just before puberty. The testes descend into the scrotum early in the 7th month.

The Ovary. The young ovary remains undeveloped longer than the testis. The main features of ovarian development are the persistence and increase of the future cortex in which the germ cells are situated. The deeper part will become the ovarian medulla. At about 6 weeks, primitive follicles form around the germ cells, encapsulating cells become pregranulosa cells, and primitive thecal cells differentiate.

In summary, the male and female gonads differentiate from the same primitive structure under the influence of the sex chromosomes. The testis differentiates earlier than the ovary and shows signs of more secretory activity (Fig. 1.2.1).

Gonadal and Hormonal Factors in Further Differentiation

After the gonads develop, further sexual differentiation is directed by the presence or absence of specific hormone production. The critical factor is the presence or absence of testicular products. The embryonic testis appears to produce at least two functional hormones: testosterone, or a close analog, which stimulates internal and external genitalia in a masculine direction; and

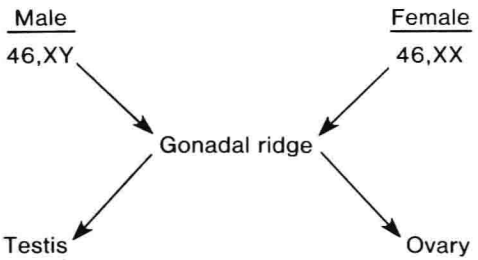

Figure 1.2.1. Chromosomal influence in the development of testis or ovary.

a polypeptide substance which suppresses the internal duct system that would otherwise develop into Fallopian tubes and uterus. This function of the polypeptide cannot be reproduced by androgen alone.

Simple but elegant experiments illustrate this point. Castration of a male rabbit fetus at the undifferentiated stage, eliminating hormone production, results in apparent female differentiation (Jost, 1947), while castration of a female rabbit fetus does not interfere with the normal differentiation of internal and external genitals. Thus, in the absence of fetal gonads and testicular products, the genital systems undergo apparent female differentiation, regardless of the genetic sex.

Furthermore, the activity of the fetal testis is spatially restricted. Unilateral castration before the critical stage leades to "female" development of the ducts on the castrated side but not on the side that has an intact testis.

The Urogenital System

For about 2 weeks, from 5 to 7 weeks fetal age, both sexes have the complete internal duct systems to form epididymis, ejaculatory ducts, seminal vesicals, Fallopian tubes, and a uterus. The ducts with the potential to form male structures are the Wolffian ducts; female structures are formed from the Mullerian ducts (Fig. 1.2.2). Normally, one of these embryonic duct systems will regress and the other will proliferate into portions of the definitive internal genitalia. Regression and proliferation are controlled by the presence or absence of testicular products. The Wolffian ducts are coded to regress without the stimulus of testosterone; the Mullerian ducts will not regress unless specifically inhibited by the testicular polypeptide.

The Wolffian (Mesonephric) Duct

Connection is established between the head part of the Wolffian duct and the seminiferous tubules. The duct next to these tubules becomes elongated and coiled, forming the epididymis, while its lower part forms the vas deferens. Each vas deferens, close to its junction with the primitive urogenital sinus, gives rise to the seminal vesicle. That part of the original Wolffian duct between this vesicle and the urethra then becomes the ejaculatory duct.

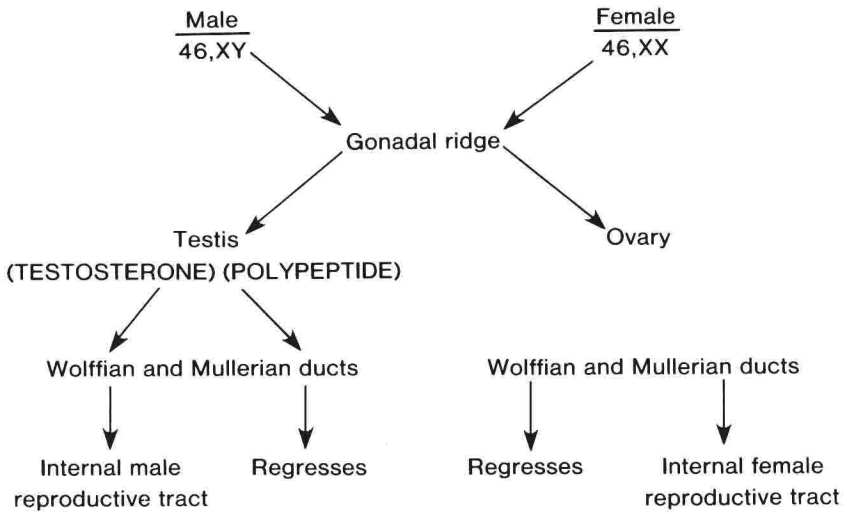

Figure 1.2.2. Influence of the fetal testis on internal ducts and duct development in the presence of a fetal ovary.

The Mullerian (Paramesonephric) Duct

The point of origin of the Mullerian ducts, the primitive body cavity, becomes the future abdominal opening of the Fallopian tubes. These ducts grow lateral to and parallel with the Wolffian duct but eventually grow toward the midline and fuse with one another. At 12 weeks (56 mm) this area of fusion forms a single cavity, the uterovaginal canal. Later in fetal life, the uterovaginal canal extends to communicate with the urogenital sinus. The hymen is the persisting remnant of the partition between the urogenital sinus and the canal.

External Genitalia

Cloaca

The external genitals begin as a cloaca, the dilated tail end of the primitive hind gut. Very early in development two lateral elevations (the genital or labioscrotal folds, which become the labia or the scrotum depending on the sex) and a midline elevation (the genital ridge which later becomes the phallus or clitoris) are raised in the cloaca.

The cloaca is subsequently divided by a septum into a primitive rectum and a primitive urogenital sinus. The septum meets the cloacal membrane at about 5½ weeks to form the primitive perineal body.

External Genitalia Proper

The external genitalia are at first indifferent. That is, the external genitalia are the same in both sexes, represented by a urogenital sinus containing a