PSYCHOLOGY

Done by : **Volunteer**

Reviewed by :

Sexual and gender issues

❖Healthy normal sexual response :

Variety of expressions of human sexuality across time, among cultures, and for individuals,As with many human behaviors, sexual activity varies among persons during their life span.,Is influenced by social, political, religious, and cultural factors, which vary over time.**Healthy sexual functioning** is a part of overall wellness and as such should be assessed as part of every comprehensive medical examination.

❖Stages of sexual response :

Phase I: Desire

 begins with a primarily mental component in which there is a desire for and fantasies about engaging in sexual activity, It is at this stage that an individual s personality, motives, and drives influence the sexual response

Phase II: Excitement

 This stage includes the transition from subjective to objective arousal. The subjective fantasy or actual focus of sexual desire and/or physical stimulation lead to physiologic responses identified as sexual arousal. This phase can last for minutes to hours for both sexes.

 Physical arousal can include not only the genitals but also the skin, breasts, cardiac and respiratory systems , and a variety of muscles.

 The characteristic features of this stage are penile tumescence, resulting in erection in men, and vaginal lubrication in women. The majority of women experience nipple erection, as do some men. The woman s labia minora and clitoris become engorged with blood. Excitement can last seconds to hours. The duration for the height of excitement is seconds to minutes.

Phase III: Orgasm

Both men and women. For men and women, orgasm occurs when sexual excitement reaches its peak and there is a release of the building tension, marked by loss of voluntary muscle control and rhythmic contractions of muscles in the genitalia and of the internal and external anal sphincter. Blood pressure and heart rate both increase.

Men. Typically men experience a subjective indication of pending ejaculation followed by four to five rhythmic spasms of the prostate, seminal vesicles, vas, and urethra, causing the emission of semen.

Women. Women experience a series of three to 15 contractions of the labia minor and vagina. The origin of female emission of fluidduring orgasm is controversial and debated regarding not only its content but also it being a female counterpart to the emission of male semen.

Phase IV: Resolution

Both men and women. For both men and women, this stage is characterized by a disgorgement of the genitalia. With orgasm, this usually takes 10 to 15 minutes, but without orgasm, it can last one-half to a full day. The mental facet of this stage is described as a relaxing and positive feeling.

Men. The penis returns to its flaccid state. The refractory period begins, during which the penis cannot become erect for several minutes to several hours.

Women. The labia and breasts return to their pre-excitement size. Vaginal blood pooling subsides and contractions cease. Women do not experience a refractory period and can immediately achieve another orgasm followed by a theoretically endless quantity of orgasms.

Normal sexual function and gender identity development

- **"Normal"** can be defined as

that which the majority of persons engage in and as such is statistically normal or mathematically average.

what a given culture, religion, political entity, etc., perceive as acceptable during a given point in time.

What is practiced by the majority varies both over time and across settings.

healthy, non-abusive, consensual, and developmentally typical rather than what is linked to a particular sample of the population.

- **Sexual identity** refers to an individual's biologic composition including chromosome configuration, genitalia, hormone levels, and, after puberty, secondary sex characteristics.
- **Gender identity** is a person's self-identification as male or female, which usually occurs by the age of 2 or 3 years. This is typically influenced by biologic characteristics and social interactions.
- Gender role is the external manifestation of being masculine, feminine, or androgynous in a social context. It represents what society expects of each sex and thus to some extent is fluid across time and among cultures.
- **Sexual orientation** refers to the object of an individual's sexual desire:

heterosexual, which is attraction to only the opposite sex;

homosexual, which is attraction to only the same sex;

bisexual, which is attraction to both sexes;

asexuality, which is a lack of sexual attraction to either men or women, has been reported.

- **Sexual behavior** describes all the activities employed in the expression of sexual desire, It is a combination of both psychological and physiologic components driven by internal and external stimuli, including fantasy and physical interaction with self and others.
- Although everyone has a sexual drive, its strength and manifestation vary among people and across time and situations for each person. In addition, the sex drive is shaped and influenced by life experiences, especially during puberty, and life stage.

1- Sexual Dysfunctions

Conditions in which the sexual response cycle is disturbed, or there is pain during coitus

Hypoactive sexual desire disorder	*Persistent or recurrent deficiency or lack of sexual fantasies and desire *To receive this diagnosis: 1.There must be marked distress or interpersonal difficulties from the condition 2.Should not be from medical condition 3.Should not be due to substance use
Sexual aversion disorder	Characterized by persisting or recurring aversion, leading to avoidance of almost all or all genital sexual contact with others
Female sexual arousal disorder	Diagnosed when there is inability to initiate or sustain sexual excitement, characterized by lubrication and swelling sufficient to complete sexual activity
Male erectile disorder	Recurrent or persistent inability to sustain a penile erection sufficient to complete sexual activity
Female orgasmic disorder	□Recurrent or persistent delayed or lack of orgasm after sexual excitement □Results in distress or interpersonal relationship problems
Male orgasmic disorder	
Premature ejaculation	Persistent or recurring pattern of ejaculation with minimal stimulation before, during or within a short time after penetration; ejaculation occurs before desired, and there is marked distress and interpersonal relationship problems
Dyspareunia	Persistent or recurrent genital pain during sexual intercourse, either in men or in women
vaginismus	*Recurrent or persistent involuntary muscle spasm of the outer third of the vagina that disrupts vaginal intercourse and causes distress and interpersonal relationship problems *The previously stated disorders can be further classified into subtypes: □Lifelong type (starting when sexual activity started) □Acquired type (begins after a period of normal sexual activity) □Generalized type (occurs during all types of sexual activity and is not limited to specific types of stimulation, specific situations or specific partners) □Due to psychological factors □Due to combined factors (psychological + medical + substance use)
General dysfunction caused by a general medical condition	□Characterized by marked distress and problems in interpersonal relationship and is caused by the effects of a medical condition □Diagnosis does not apply if the symptoms are more accurately accounted for by a psychiatric disorder
Substance – induced sexual dyfunction	□Characterized by marked distress and interpersonal relationship problems caused by substance use, and the symptoms began no more than one month after substance intoxication, or a medication is known to cause the sexual symptoms. □Not diagnosed if accounted for by another psychiatric disorder

2-Paraphilias

- Characterized by recurring, intense, and sexually arousing fantasies, sexual urges, or behaviors that involve non-human objects or the suffering or humiliation of either oneself or someone else or children or other non-consenting persons.
- Symptoms must exist over a period of at least 6 months, but can be episodic
- Exhibitionism, frotteurism, pedophilia and voyeurism can be diagnosed if the urges have lead to paraphilic behaviours or if they cause marked distress and interpersonal relationship problems without actual behaviors
- Sexual sadism can be diagnosed if urges led to behavior with non-consenting persons, or if it caused marked distress and problems in interpersonal relationship without actual behaviour
- The remaining paraphilias are diagnosed if the urges, fantasies or behaviours cause marked distress or interpersonal relationship problems

Exhibition	Characterized by exposure of one's genitals to an unsuspecting stranger
Fetishism	*Characterized by arousal from non-living items, such as female undergarments *Diagnosis does not apply if the use of female undergarments is more appropriately a criterion of transvestic fetishism, or if the use is of items specifically designed for sexual arousal
Frotteurism	Characterized by touching or rubbing against a non-consenting person
Pedophilia	*Characterized by arousal to a pre-pubescent child or children *The pedophile must be at least 16 years of age and at least 5 years older than the child *Diagnosis does not apply to late adolescence-aged persons involved in an on-going sexual relationship with someone who is 12 or 13 years of age *When making the diagnosis, the following should be specified: 1.Attraction to females, males or both 2.Limited to incest 3.Exclusive or non-exclusive type (pre-pubescent and pubescent)
Sexual masochism	Characterized by the person experiencing real acts (not stimulations) of humiliation, beating, being bound or suffering in some other way
Sexual sadism	Characterized by a person being sexually aroused by real (not stimulated) acts, in which another person suffers physically or psychologically
Transvestic fitishism	Applies only to heterosexual men Characterized by cross-dressing If the person has persisting conflict with his gender role or identity, the phrase: with gender dysphoria is specified
Voyeurism	Characterized by observing an un-suspecting person naked, undressing or engaged in sexual activity
Paraphilia not otherwise specified	*Used for paraphilias other than those listed *There are hundreds in literature *Here are some: Coprophilia(arousal from feces) Klismaphilia(arousal from enemas) Necrophilia (arousal from corpses) Partialism(arousal restricted to a specific body part) Telephone scatologia (arousal from making obscene phone calls) Urophilia(arousal from urine)

	□Zoophilia(arousal from animals)

3-Gender identity disorder

- Characterized by persisting identification with the other gender (cross-gender), not just for what is viewed as a culturally manifested gain by being the other gender; being uncomfortable with one's current sex, or a belief that one's current gender role is incorrect, and lack of a physical manifestation of intersex, which together cause marked distress or impairment in social, employment or other major aspects of life
- Diagnosis in children requires presence of at least 4 of the following:

1.Recurring statements of wanting to be or being the other sex

2.Dressing in clothing or appearance of clothing stereotypically worn by the other sex

3.Persisting fantasies of being the other sex or taking stereotypical role of the other sex during play

4.Pursuit of stereotypical activities of the other sex

5.Preferring playmates of the other sex

- Symptoms in adolescents and adults:

1.Verbalizing wanting to be the other sex

2.Portrayal as the other sex

3.Wanting to live or be treated as the other sex

4.Describing having the feelings and beliefs as someone of the other sex

- When diagnosing persons who have completed puberty, the sexual attraction should be specified as one of the following:

1.Males 2.Females 3.Both 4.Neither

Diagnosis of sexual dysfunction and sexual disorder

- **The sexual complaint**

□Time of onset □Duration □Frequency

□Context □Relieving factors □Aggravating factors

□Associated symptoms □Impact on functioning □Previous history

- **Sexual history**

□Relationship status

□Biologic sex (male, female, intersex or transgender)

□Gender identity

□Sexual orientation (autosexual, asexual, bisexual, heterosexual, homosexual)

□Age when sex education was provided (if provided) and by whom. What was provided; reaction to experience

□Onset age of puberty

□Age at first sexual fantasies, reaction and current frequency

□Sexual activity. Age at first time. Age and sex of first time partner

□Current frequency of sexual activity and desired frequency

□Total number of consensual sex partners; number of each sex

□Duration of longest sexual relationship

□Current marital and relationship status

□If ever unfaithful, and the number of partners

□History of STD’s and treatment

□Pain during sexual activity

□Satisfaction with current sexual functioning

□Sexual dysfunction related to underlying medical condition or substance use

□Sexual dysfunction medications

□Sexual behavior resulting in difficulties socially, legally, in work or in relationships

□Engagement in paraphilic fantasies or behaviour

□Involvement in consensual or non-consensual violence

□Experience of sexual abuse or non-consensual sexual activity

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Differential diagnoses

Medications

1.Adrenergic antagonists

Prevent erection, reduce ejaculation volume, cause retrograde ejaculation and reduce libido for both sexes

Beneficial in premature ejaculation

2.Anticholinergics(such as benztropine) :Vaginal dryness and penile erection dysfunction

3.Antihistamines : Can be sexually inhibiting because of their hypnotice side effect

4.Anti-anxiety (such as benziodiazepines)

5.Anti-psychotic medications

Have anti-adrenergic and anti-cholinergic side effects. Second generation are less likely to produce such effects

Some may cause priapism

6.Lithium(erectile dysfunction)

7.Monoamine oxidase inhibitors : ED, retrograde ejaculation, delayed ejaculation, vaginal dryness and anorgasmy

8.Psychostimulants : Decreased libido and erection with long-term use

9.SSRI's : Decrease libido and delay orgasm for both sexes

10.TCA's :ED and delayed ejaculation due to anticholinergic side effects

Substance of abuse

1.Alcohol

Has depressant effect on CNS; thus, impairing penile erection. With long-term use, estrogen metabolism is decreased, leading to male feminization

In small quantities, it can increase testosterone quantities in women, leading to increased libido

2.Barbiturates

3.Benzodiazepines

4.Cannabis :Can cause increased sexual pleasure for some; however, long-term use leads to decreased testosterone levels

5.Hallucinogens

6.Opiods :Cause impotence and decreased libido for some

General medical conditions

Accounts for 50-80% of male sexual dysfunction

For males, conditions causing erectile dysfunction include: mumps, atherosclerotic disease, cardiac failure, chronic renal failure, cirrhosis, respiratory failure, Klinefelter syndrome, malnutrition, vitamin deficiencies, diabetes, hyperthyroidism, MS, Parkinson disease, temporal lobe epilepsy, peripheral neuropathy, lead poisoning and prostatectomy

Women's sexual functioning is affected by: surgeries, major illness, hypothyroidism, DM, primary hyperprolactinemia, hysterectomy and mastectomy

Psychiatric disorders

mood disorders Anxiety disorders Personality disorders Schizophrenia

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Treatment

Sexual dysfunction

- **Evaluation** is the first, most critical step in devising a treatment plan. A complete physical examination and, if appropriate, urologic or gynecologic examinations are indicated. Substance abuse and psychiatric screening examinations are the next steps in the evaluation.
- **Education** may be among the most effective available treatments for general sexual dysfunctions. The clinician should gently assess the patient's knowledge of sexual function and beliefs about sex. Interventions should be tailored to the information deficits identified.

(1) Patients may need to learn the stages of sexual arousal to solve misinterpretation problems.

(2) A couple may need to be taught details of sexual activity to eliminate the cause of their sexual "dysfunction."

(3) Teaching each partner about the sexual responses of both sexes often is a major step in helping couples deal with sexual dysfunction.

(4) Desensitizing the discussion of sexual issues for individuals and couples by teaching language for discussing sex is a useful communication tool for sexual partners or for the therapist and patient.

(5) Specific physiologic and anatomic education may be helpful for some patients. For example, some patients may not know that most women cannot have an orgasm without some clitoral stimulation. These patients can be taught that in some women, sexual positions that promote satisfaction. Often, this type of simple suggestion solves much of a patient's or couple's sexual dysfunction.

- **Communication training** of the couple to enable them to talk about sex and about their own wishes and needs can lead to greater intimacy. Getting both partners to agree to tell the other what they enjoy and what they find unpleasant is a critical step in working with the couple (if they can agree to express needs and wishes in a nonthreatening manner and learn to accept feedback non-defensively).
- Steps to better communication include the following:

(1) Exploration of cultural and religious beliefs

(2) Examination of the "goals" of sex, which can lead to a productive renegotiation of these goals

(3) Teaching the couple to talk during sex, which is often a major step in resolving minor difficulties

- **Behavioral therapy** is another effective group of techniques for "simple" sexual dysfunctions. Behavioral interventions usually involve education and a behavioral technique designed to address a specific problem.

(1) Relaxation training may be helpful for both men and women whose dysfunction is related to anxiety.

(2) Sensate focus (male). Couples are instructed to explore non-coital caressing, focusing on the discovery and enjoyment of sensual feelings. These exercises should have a pleasuring quality rather than a demanding quality. This allows rediscovery of sensual feelings, which may have been suppressed by the sexual problem.

(3)Sensate focus (female). Exercises initially are used for the woman to explore her own sensuality. The activities are designed to progress at the patient's own rate and to be undemanding.

(a) The woman is then encouraged to explore her sensations by touching herself to know her pace.

(b) Anxiety management. Prohibiting orgasm during sensate focus exercises reduces performance anxiety. Relaxation techniques, hypnosis, and, occasionally, antianxiety agents may be used.

(c) Strengthening the pub-coccygeal muscles

(d) Experiencing orgasm with a partner. The woman is encouraged to educate her partner about activities that she finds stimulating.

□Couple therapy

□Group therapy

Medication

(1) Alprostadil contains prostaglandin E, which is a vasodilator that relaxes penile vasculature, thus improving blood flow and in turn erection. Alprostadil is injected directly into the penis when an erection is planned.

(2) Dopaminergic medications such as L-dopa, bromocriptine, bupropion, and selegilinecan increase libido.

(3) Estrogen replacement decreases the onset of vaginal atrophy and aids vaginal lubrication.

(4) Gonadotrophin-releasing hormone (GnRH) such as **luteinizing hormone–releasing hormone (LHRH)** causes an increase in testosterone production, which can benefit either sex when testosterone levels are low.

(5) Testosterone is used with postmenopausal women and women with otherwise low testosterone levels. The effect of testosterone supplementation for women and men with low levels is typically an increase in libido.

□For men there is a risk of hypertension and prostate hypertrophy.

□for women there is a risk of irreversible virilization.

□For both, hepatotoxicity is possible.

(6) Yohimbine, an $^{p}2$ antagonist, has been found to dilate the penile artery and aid erections.

Gender identity disorder

□**Psychotherapy.** Pervasive identity problems can sometimes cause confusion and doubt about sexual and gender roles.

□**Behavioral therapies for children with primary gender identity disorder**

□**Psychodynamic and psychoanalytic approaches for children with gender identity disorder** are no longer considered the preferred interventions.

□**Medication treatment** for adults with protracted gender dysphoriahas not proven to be effective, and in some cases reassignment surgery is an appropriate option. An evaluation by a gender identity clinic and a Real Life Test of 1 to 2 years are considered requirements before such surgery is given consideration.

Paraphilias

- Treatment success varies with the intensity of the behavior, effort of the patient to engage in treatment, and treatment modalities employed.

- **Psychodynamic and psychoanalytic approaches** do not seem to provide significant results in patients with paraphilias.

- **Behavioral therapies** consisting of aversive conditioning (i.e., pairing a noxious odor with a deviant stimulus), satiation therapy (i.e., overstimulation of deviant stimuli until exhaustion), and covert sensitization (i.e., matching early cues with severe consequences) are the predominant methods.

- **Cognitive therapies** focus on changing thought processes and patterns that lead to paraphilic behavior.

- **The Relapse Prevention Model** and similar approaches have resulted in effective therapy and lowered recidivism rates. There has been considerable debate as to the effectiveness of this method.

- **The Good Lives Model** is an approach that is more comprehensive in scope by including the assessment and subsequent treatment of coterminous personal deficits (i.e., socialization skills, intimacy deficits, decision-making skills, excellence in work and play).

➢ **Pharmacologic treatments** currently employed include antiandrogens, antigonadotropics, and SSRIs.

(1) Antiandrogens decrease androgen levels at their target sites and block the action of androgens. The effects are a reduction to complete cessation of sexual fantasies and decreased sperm synthesis, ejaculate, and penile erections. Pure antiandrogens include cyproterone and flutamide, and major antigonadotropics include cyproterone acetate (CPA) and medroxy progesterone acetate (MPA). CPA is not available in the United States. MPA, a synthetic progestin, increases testosterone-A- reductase activity and in turn decreases testosterone blood levels.

(2) GnRH agonists such as **LHRH agonists** are also employed. LHRH ethylamide, which interferes with the hypothalamic–pituitary axis by blocking secretion of gonadotropins, decreases sexual desire and in turn sexual intercourse. Leuprolide acetate, a synthetic analog of LHRH used to treat prostate cancer, decreases pituitary–gonadal function and testicular steroidogenesis, thus lowering testosterone level.

(3) SSRIs have also been used to treat paraphilic behavior, but with less success and significantly less supporting scientific literature. Efficacy has been difficult to determine from published studies because of heterogeneous samples, small sample sizes, and varied outcome measures. SSRIs have been recommended for use with compulsive sexual behaviors and suggested to be avoided in cases of sexual sadism and pedophilia. The data supporting SSRI use for treatment of paraphilias are retrospective and minimal.

➢ **Multimodal treatment** currently is the treatment of choice for patients with paraphilias.

(1) The Standards of Care as established by the Association for the Treatment of Sexual Abusers is considered the most effective approach for the treatment of paraphilic behaviors.

(2) There are services available for persons with paraphilias who have not offended or been arrested through organizations that support primary prevention strategies, defined as treatment and support before an offense occurs.

(3) Treatment should be multimodal and address comorbid psychiatric diagnoses and lack of social skills and provide empathy training, cognitive restructuring, and supportive group therapies.

(4) Treatment outcomes are difficult to assess because data collected for recidivism often have only a single source (i.e., documented criminal reoffending) and there are differing definitions of recidivism depending on the study.

(5) Although there is overlap, the treatment for adolescents differs considerably from treatment for adults and is beyond the scope of this chapter.