Psychosexual Disorders: E resource

- Individuals with sexual disorders are likely to be encountered by clinicians in all disciplines. They may present to so called sexologists, physicians, venereologists, surgeons, psychiatrists or gynecologists.
- The name for this diagnostic class emphasizes that psychological factors are assumed to be of major etiologic significance in the development of the disorder. Disorders of sexual functioning that are caused exclusively by organic factors, even though they have are not discussed in this category of disorders according to ICD-10

Components of a Psychosexual Case history (Format enclosed)

Social, cultural, and religious factors

- Is the patient's sociocultural /ethnic background one that is stereotypically warm and expressive or aloof and stoic?
- What did he/she learn during childhood about what it means to be a man or a woman?
- What principles did he/she glean about such moral issues as monogamy or sex outside of marriage?

What attitudes and beliefs about sex were advocated by the patient's religion

- Early development
- What kinds of early messages did the patient receive about sex while growing up?
- Was his/her family environment a nurturing or a hostile one?
- Was touching acceptable and comfortable?
- Did the patient experience any touching that was "too much, too soon?"
- Body issues
- What concerns does the patient have about his/her physical appearance?
- What about his/her body does he/she like? What does he/she dislike?

How does the patient feel about his/her femininity/masculinity

- Current relationship?
- What is the nature of the patient's current relationship?

- What first drew the patient to his/her current partner? What first seemed attractive about him/her?
- When and how did things go wrong?
- If the patient were to be given a magic wand, what 3 things would he/she change about the partner?
- What does the patient foresee for the future of this relationship?

Normal Human Sexual Response Cycle

A normal human sexual response cycle can be divided into five phases.

Appetitive Phase

- This is the phase which occurs before the actual sexual response cycle. This consists of sexual fantasies and a desire to have sexual activity.

Excitement Phase

- This is the first true phase of the sexual response cycle, which starts with physical stimulation and/or by appetitive phase.
- The duration of this phase is highly variable and may last for several minutes (or longer).
- The major changes during this phase are listed below:
- Penile erection, due to vascocongestion of corpus cavernosa.
- Elevation of testes with scrotal sac.

Plateau Phase

- This is an intermediate phase just before actual orgasm, at the height of excitement. It is often difficult to differentiate the plateau phase from the excitement phase. The duration of this phase may last from *half to several* minutes. The following important changes occur during this phase:
- Sexual flush (inconsistent).
- Autonomic hyperactivity.
- Erection and engorgement of penis to full size.
- Elevation and enlargement of testes.

- Dew drops on glans penis (2-3 drops of mucoid fluid with spermatozoa).

Orgasmic Phase

- This is the phase with a peak of sexual excitement followed by a release of sexual tension, and rhythmic contractions of pelvic reproductive organs. The duration of this phase may last from *3-15 seconds*. The important changes are as follows:
- 4-10 contractions of penile urethra, prostate, vas, and seminal vesicles; at about 0.8 sec. intervals.
- Autonomic excitement becomes marked in this phase. Doubling of pulse rate and respiratory rate, and 10-40 mm. increase in systolic and diastolic BP occur.
- *Ejaculatory inevitability* precedes orgasm.
- Ejaculatory spurt (30-60 cm; decreases with age).
- Contractions of external and internal sphincters.

Resolution Phase

- This phase is characterized by the following common features in both sexes:
- A general sense of relaxation and well-being, after the slight clouding of consciousness during the orgasmic phase.
- Disappearance of sexual flush followed by fine perspiration.
- Gradual decrease in vasocongestion from sexual organs and rest of the body.
- Refractory period for further orgasm in males varies from few minutes to many hours.

Disorders according to Sexual Response Cycle

Appetite Phase

- Hypoactive Sexual Desire Disorder
- Sexual Aversion Disorder
- Female Sexual arousal disorder

Excitement Phase

- Male Erectile Disorder

Orgasmic Phase

- Inhibited female orgasms (Anorgasmia)
- Inhibited Male Orgasm (Retarded Ejaculation)
- Premature Ejaculation

Other disorders Not Related to Sexual Phase

- Sexual Pain Disorders

Vaginismus (female)

Dyspareunia (male and female)

- Others

Orgasmic anhedonia, Genital pain during masturbation,

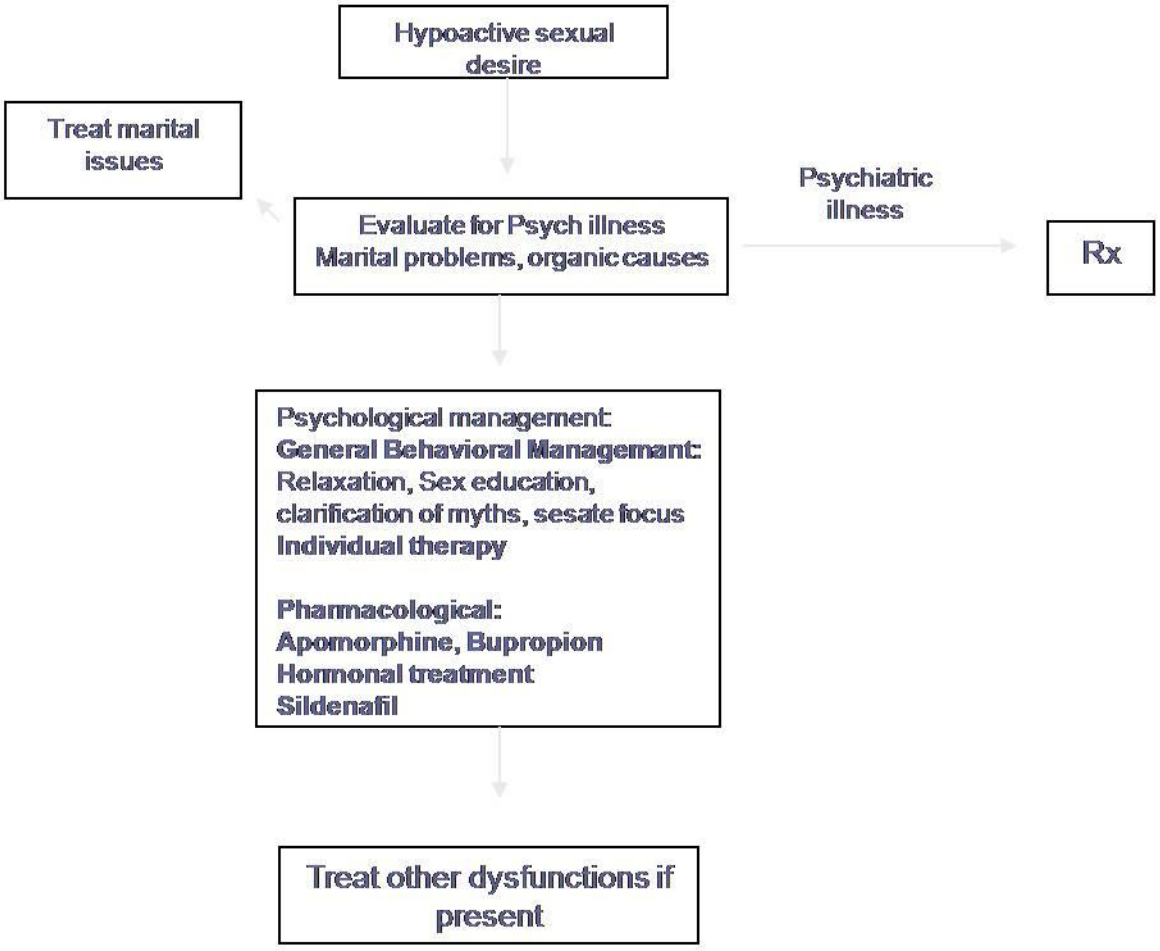
female analogue of premature ejaculation.

Psychosexual Dysfunctions and Their Management

Hypoactive Sexual Desire Disorder:

- Commonest causes are Depression, Poor Interpersonal Relationships, Adjustment Disorders.
- Hormonal Problems are less common.
- Treatment Consist of management of underlying aetiology.
- Possible causes may be Vascular, Neurogenic, Traumatic, or Psychological.
- Psychogenic ED is more common and underlying etiology is usually Depression, Relational Problems.
- Treatment for organic causes can be better understood by Physiology.

Treatment algorithm for Hypoactive sexual desire disorder



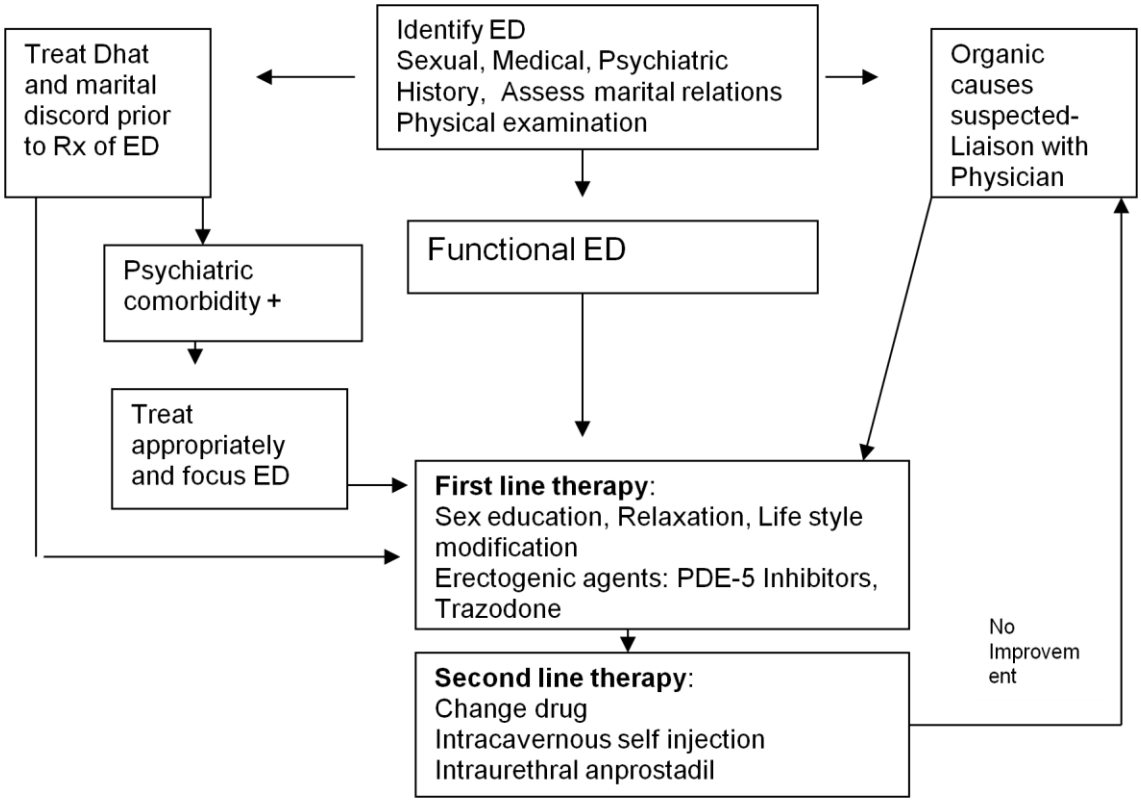
Psychogenic versus organic Erectile Dysfunction

FEATURE	*PSYCHOGENIC*	*ORGANIC*
Age	*Younger*	*Old*
Onset	*Acute*	*Gradual except Trauma, Surgery*
Circumstance	*Situational*	*Global*
Precipitants	*Psychogenic*	*Age, vascular insufficiency etc.*
Course	*Intermittent*	*Consistent/ Progressive*
Desire	*Decreased*	*Normal*
Organic risks	*Absent/ variable*	*Present*
Partner problems	*At onset*	*Secondary*
Anxiety ,fear	*Primary*	*Secondary*
Erectile response to other sex stimuli	*Usually present*	*Usually absent*
Nocturnal /morning erections	*Usually present*	*Usually absent/ intermittent loss*
Total time (min/night)	*More than 90-180*	*Less than 60*

Classification of ED

Category	Disorders	Pathophysiology
Psychogenic	Performance Anxiety Relationship problems Stress, Depression	Loss of libido, Overinhibition, Impaired NO release
Neurogenic	Stroke, Alzhimer Dis, Spinal cord/pelvic surg DM, Pelvic injury	Nerve impulse or Transmission impaired
Hormonal	Hypogonadism Hyperprolactin	Loss of libido or Inadequate NO
Vasculogenic	Atherosclerosis, HT DM,Trauma,Peyronie	Inadequate arterial flow/venoocclusion
Drug-induced	Anti-HT, Anti-Depress Antiandrogens Alcohol Smoking	Central suppression Decreased libido Alcoholic neuropathy Vascular insufficiency
Other systemic diseases or aging	DM, CRF, CAD, Oldage	Multifactorial (neural & vascular dysfunction)

Treatment options for patients with Erectile Dysfunction



Psycho-physiological Treatment

Specific Techniques

- *Sensate Focus*

Used for ED and Early Ejaculation

Aim is body areas where manipulation leads to sexual arousal

These areas are erogenic zones (Primary in males – penis/scrotum, perinium; in females- vulva, skin over pubis, perineum). Secondary in both- lips, nape of neck, inner parts of thigh). In males, visual cues and in females , physical stimulation more important.

- *Semens Stop/ Start Technique*

  Used to stop ejaculation based on assumption that there is lack of sexual sensory awareness

  Goal is to prolong neuromuscular reflexes responsible for ejaculation

  Sensation premonitory to ejaculation, extra-vaginal stimulation of penis, stimulation stopped until sensations disappear

- *Masters & Johnson Modified Squeeze Technique*

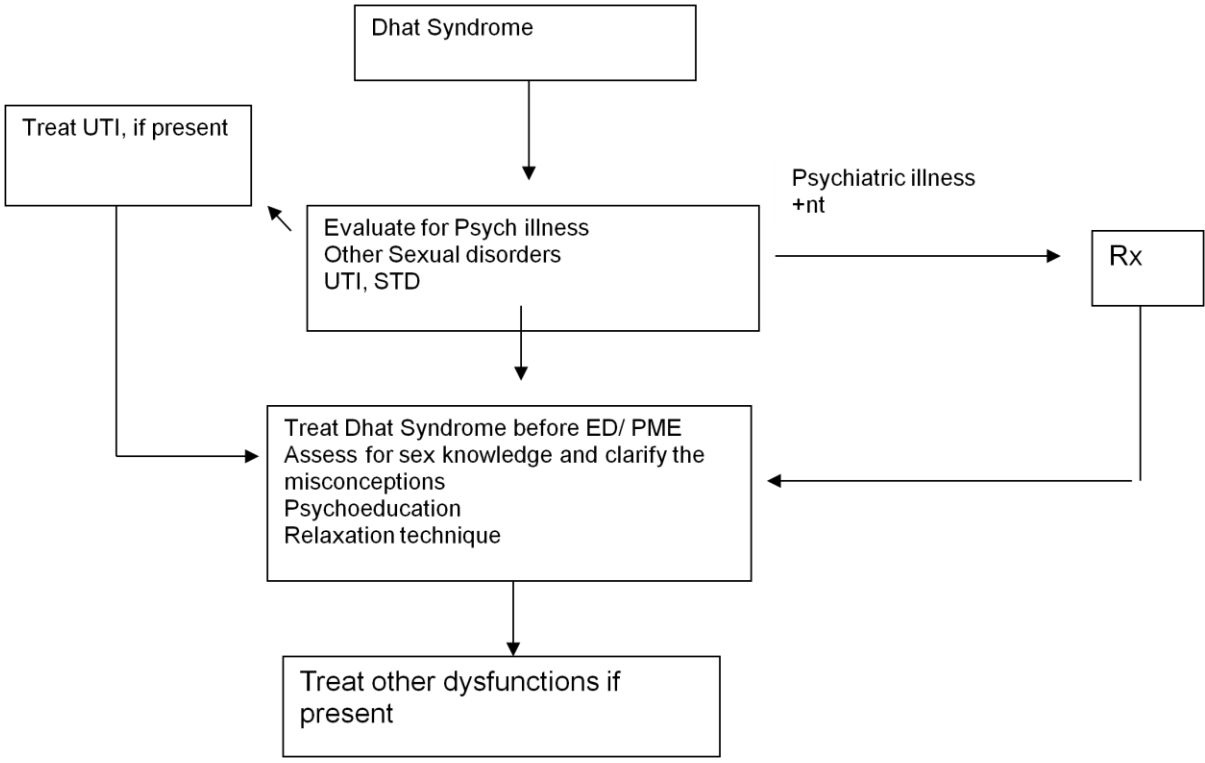
  Pressure under corona on the bottom of the penis can delay ejaculation

- *Kegels Exercises*

DHAT SYNDROME

- *It constitutes about 30 to 60 percent of patients presenting with a psychosexual problem.*
- *Clinical Picture*

  The individuals with Dhat syndrome present with vague somatic symptoms (like fatigue, weakness, anxiety, loss of appetite, etc), psychological, symptoms (like guilt, sad mood, lack of concentration and memory etc) and at times, sexual dysfunctions (impotence, premature ejaculation), which the patient attributes to the passing of semen (Dhat) in urine as a direct consequence of his excessive indulgence in masturbation or sexual intercourse.



GENDER IDENTITY DISORDERS

Psychosexual behavior can be divided into the following components.

- *Gender Identity*. It is an individual's perception and self-awareness of being male or female.
- *Gender Role.* It is the behaviour that an individual engages in that identifies him or her to others as being male or female (for example, wearing dresses/makeup)
- *Sexual Orientation.* It is the erotic attraction that an individual feels (e.g. arousal to men, women, children, nonsexual objects etc.)

Gender Dysphoria Syndrome (Transexualism)

- The essential features of this heterogenous disorder are a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex.
- Transsexuals needs differentiation from:
- *Effeminate homosexuality:* The individual displays behaviours characteristic of the opposite sex. However such individuals have no desire to be of the other anatomic sex.
- *Physical Intersex:* The presence of abnormal sexual structures rules out the diagnosis of transsexualism.
- *Other individuals with a disturbed gender identity.* They may in isolated periods of stress, wish to belong to other sex and to be rid of their own genitals.
- *Schizophrenia*
- *Transvestism*

Management

- Sexual reassignment to the opposite gender has been the most widely used and studied treatment modality for Trans-sexualism. Hormonal treatment is also available.
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PARAPHILIAS
(SEXUAL DEVIATIONS)

Recurrent, intense sexual urges and sexually arousing fantasies or acts that involve nonhuman objects or non-consenting partners. Examples are :

- *Fetishism* – Nonliving objects (e.g. female undergarments)
- *Exhibitionism* – Exposure of one's genitals to an unsuspecting stranger
- *Frotteurism* – Touching and rubbing against a non-consenting person
- *Pedophilia* – Prepubescent child or children
- *Sexual masochism* – Act of being humiliated, beaten, bound or otherwise made to suffer
- *Sexual sadism* – Acts in which the psychological or physical suffering of the victim is exciting
- *Cunnilingus & Fellatio* – The predominant use of oral manipulation & stimulation of the clitoris or penis, respectively, to produce erotic excitement & orgasm.
- *Transvestic fetishism* – Cross dressing.
- *Voyeurism* – Observing an unsuspecting person
- *Necrophilia* – Corpses.
- *Zoophilia* – Animals.
- *Coprophilia* – Faeces.
- *Mysophilia* – Filth.

- *Klismaphilia* – Enemas.
- *Urophilia* – Urine.
- *Sodomy* – Sexual excitement derived from stimulation & penetration of anal sphincter
- Epidemiology

  The exact prevalence is not known. Over 50 percent of these patients develop the onset of the paraphilic arousal prior to age 18.

- **Management**

  Antiandrogenic medications (medroxyprogesterone acetate and cyproterone acetate) have been widely used to decrease libido. Medroxyprogesterone acetate (MPA) appears to act by blocking testosterone synthesis while cyproterone acetate (CPA) acts primary by blocking central and peripheral androgen receptors. Antipsychotic medications have been used to treat deviant sexual behaviour. Sexual aggressive behaviour has been treated with lithium, propranolol, carbamazepine and clonazepam.

  Psychoanalysis and psychodynamic therapy have been used with variable results.

  A variety of behaviour therapies (aversive conditioning and convert sensitization) have been used to decrease deviant sexual behaviour.

DSM 5 Changes

- DSM-5 has sex-specific sexual dysfunctions.
- For females, sexual desire and arousal disorders are combined into female sexual interest/arousal disorder.
- Sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a duration of approximately 6 months and more exact severity criteria.
- Genito-pelvic pain/penetration disorder which combines vaginismus and dyspareunia from DSM-IV.
- Sexual aversion disorder -removed
- Specifiers for all disorders "lifelong versus acquired" and "generalized versus situational" -removed

- Sexual dysfunction due to a general medical condition" and

  " Sexual dysfunction due to psychological versus combined factors"-removed

  Paraphilic disorders

- Specifiers "in a controlled environment" and "in remission" were added to criteria for all paraphilic disorders.
- A distinction is made between paraphilic behaviors, or paraphilias, and paraphilic disorders.
- All criteria sets were changed to add the word “disorder” to all of the paraphilias, for example, pedophilic disorder is listed instead pedophilia.
- No change in the basic diagnostic structure since DSM-III-R; however, people now must meet both qualitative (criterion A) and negative consequences (criterion B) criteria to be diagnosed with a paraphilic disorder.
- Otherwise they have a paraphilia (and no diagnosis).

Case vignette

A 48 years old male patient came with the complaints of whitish discharge in urine and generalised weakness for 2 months .Patient was alright 2 months back when he started noticing whitish discharge in urine and generalised weakness and bodyache . He also had difficulty in getting erection and noticed change in consistency of semen . He also had difficulty in getting sleep . He was able to to fall asleep but was unable to maintain it.

He is married since 23 years and has one daughter .

In childhood history,developmental and social milestones were achieved well at appropriate times. His adolescent history include history of masturbation started at the age of 18 years with frequency once a week . He had history of nocturnal emissions started at the age of 22 years and subsided itself after 2-3 years.

He has spontaneous erections 1-2 times / week . The quality of erections is average with average sexual desire .

Sexual history- Heterosexual , first sexual contact at the age of 18 years with a known girl of same age frequency was once per week.

Salient points in psychosexual performa :

Pre marital –

1. Do you have premarital sexual experience – yes
2. With whom? – Known
3. Age of partner -18 years
4. Frequency – Once per week

Marital/ steady partner if unmarried –

Patient reports current sexual relationship with the spouse .

Specific questions pertaining to psychosexual stages to be asked -

1. Do you have steady sexual relationship ? – yes
2. Frequency – Once per month

Sexual response cycle (all five stages to be assessed)

Extramarital relationship – nil

Homosexual relationship – Nil

Premorbid personality – Patient reports history suggestive of occasional alcohol consumption about 250 ml country made liquor once in 2 months in the company of friends since past 5 years . He is sociable, extrovert , meticulous in doing his routine work .

Physical examination – Patient is conscious and oriented

P- 84/ min

BP- 134/83

No pallor, icterus , cyanosis , clubbing

Respirator, per abdomen, cardiovascular system, CNS nothing abnormal detected .

Mental state examination –

Patient is cooperative, help seeking , dressed appropriately maintaining average personal hygiene maintaining eye to eye contact rapport could be established No abnormal involuntary movements are noted . Speech -normal tone,volume ,rhythm, talking relevantly and coherently.

Mood-“ okay” , affect - euthymic , thought –flow- normal . Thought content – Preoccupations with passage of whitish discharge which is persisting over past 2 months .At times these thoughts are very distressing . Patient says ‘Loss of semen is contributing to his feeling lethargic and low energy.’ At night such negative thoughts lead to difficulty in initiation of sleep.

No perceptual abnormality. General information and intelligence was average .Abstract thinking intact, Judgement intact, Insight present .