Management of Psychosexual Disorders

Level VI

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Objectives of lecture

- Revise:
- Common Psychosexual disorders
- Introduce some skills that can be relevant in dealing with sexual disorders

Common dysfunctions

Include:

- Lack or loss of interest
- Sexual aversion
- Lack of sexual enjoyment
- Failure of genital response- (vaginal dryness in females, erectile failure in men)
- Orgasmic dysfunction
- Premature ejaculation
- Non organic vaginismus
- Non organic dyspareunia

Sexual Dysfunctions- DSM V

- Delayed Ejaculation
- Erectile disorder
- Female orgasmic disorder
- Female sexual interest arousal disorder
- Genital pelvic pain/penetration disorder
- Male hypoactive sexual desire disorder
- Premature- Early ejaculation
- Substance/Medication-Induced Sexual Dysfunction
- Other specified sexual dysfunction
- Non-specified sexual dysfunction

Important factors in diagnosis include:

- The disturbance causes **marked distress** or **interpersonal difficulty**
- The disturbance is **not** accounted for by a **general medical condition** or the physiological effects of a substance
- In some of the dysfunctions factors that affect sexual functioning like **age** and **context** of the person's life must be taken into account

Subtypes

- **Lifelong (primary)** or Acquired type (**secondary**)
- **Generalised** or **situational**
- Due to psychological factors or Due to combined factors

Paraphilias
Normal and abnormal?

- There is immense cultural variation in sexual behaviour across culture and times
- So what is implied by normality, abnormality, natural or unnatural, immoral sex
- How do we decide what is normal sex
- **The guidelines for determining our normality is based on what friends or relatives reveal as normal and what is depicted in the media**

Sexual diversity

- Sexual diversity can be viewed as existing in a **continuum** with the frequency that individuals engage in different types of sexual practices ranging from never to always
- Under this understanding of sex there is no normal or abnormal
- One can then talk about an individuals behaviour being **more or less typical** or **atypical** of the group average to which he/she belongs

Definition

- Paraphilias are frequent, intense, sexually arousing fantasies or behaviors that involve **inanimate objects, children or nonconsenting adults, or suffering or humiliation of oneself or the partner.**

DSM V Classification

- Most people with atypical sexual interests do not have a mental disorder
- DSM V differentiates between paraphilias and Paraphillic disorders

Criteria for Diagnosis of a paraphilic disorder

- includes a feeling of personal distress about the interest, not merely distress resulting from society's disapproval

OR

- have a sexual desire or behavior that involves another person's psychological distress, injury, or death

Or

- A desire for sexual behaviors involving unwilling persons or persons unable to give legal consent

Types of Paraphilias

- The criminal and noncriminal.

Criminal Paraphilic Disorders

Acting on these sexual urges constitutes a crime in many countries

- Exhibitionistic,
- Frotteuristic,
- Pedophilic,
- Voyeuristic Disorders

all require a nonconsenting person

Noncriminal Paraphilic Disorders

Acting on these sexual urges would not constitute a crime necessarily in many countries

- Fetishistic
- Sexual Masochism su
- Sexual Sadism do
- Transvestic Disorders clo

usually involve a consenting partner

Treatment of paraphilias

- Most paraphilias are very resistant to treatment
- Rarely do people suffering from paraphilias seek treatment voluntarily- usually being forced to seek treatment after being arrested
- Treatment includes:
  Psychotherapy, support groups, and antidepressants particularly the selective serotonin reuptake inhibitors (SSRIs).
- Other forms of treatment include- drugs that alter the sex drive and reduce testosterone levels in males.
- All with questionable outcomes and usefulness
- The diagnosis of a mental disorder shoudl have a clinical utility a usefulness- This makes the diagnosis of these conditions questionable

Management of Psychosexual dysfunctions

- Sex therapy (Psychosexual therapy)- Refers to the psychological treatment of non organic sexual dysfunctions
- Often closely related to relationship couple therapy

Historical development

- Interest in sexuality in modern times- Freud Psychosexual development and the psychoanalysis
- Alfred Kinsey: Sexual behaviour in the Human Male (1948); Sexual behaviour in the Human Female (1953)
- Masters and Johnson- Human sexual response (1966)

Sexual Response Cycle

The stages of the sexual response cycle in males and females by Masters and Johnson

1. Desire
2. Excitement- characterised by physiological changes in the genitals
3. Plateau- inc HR, BP, RR, Muscle tension
4. Orgasm- single or multiple- rhythmic muscular contractions and ejaculation in males
5. Resolution

- Read more on this- Getting the most out of psychosexual therapy- understanding the sexual response (PDF)-Written by ROSE WHITELEY for the Porterbrook Clinic, Sheffield
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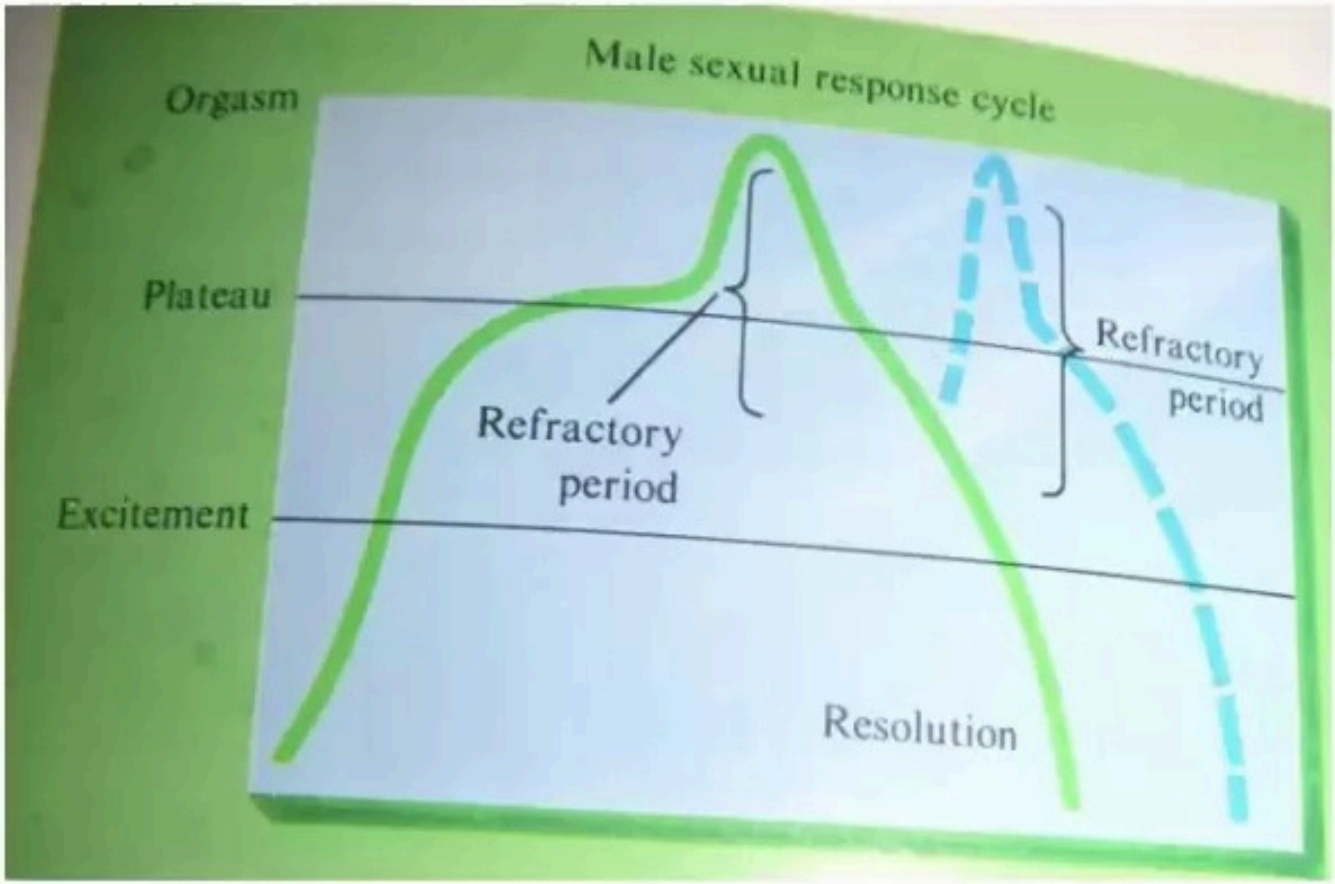
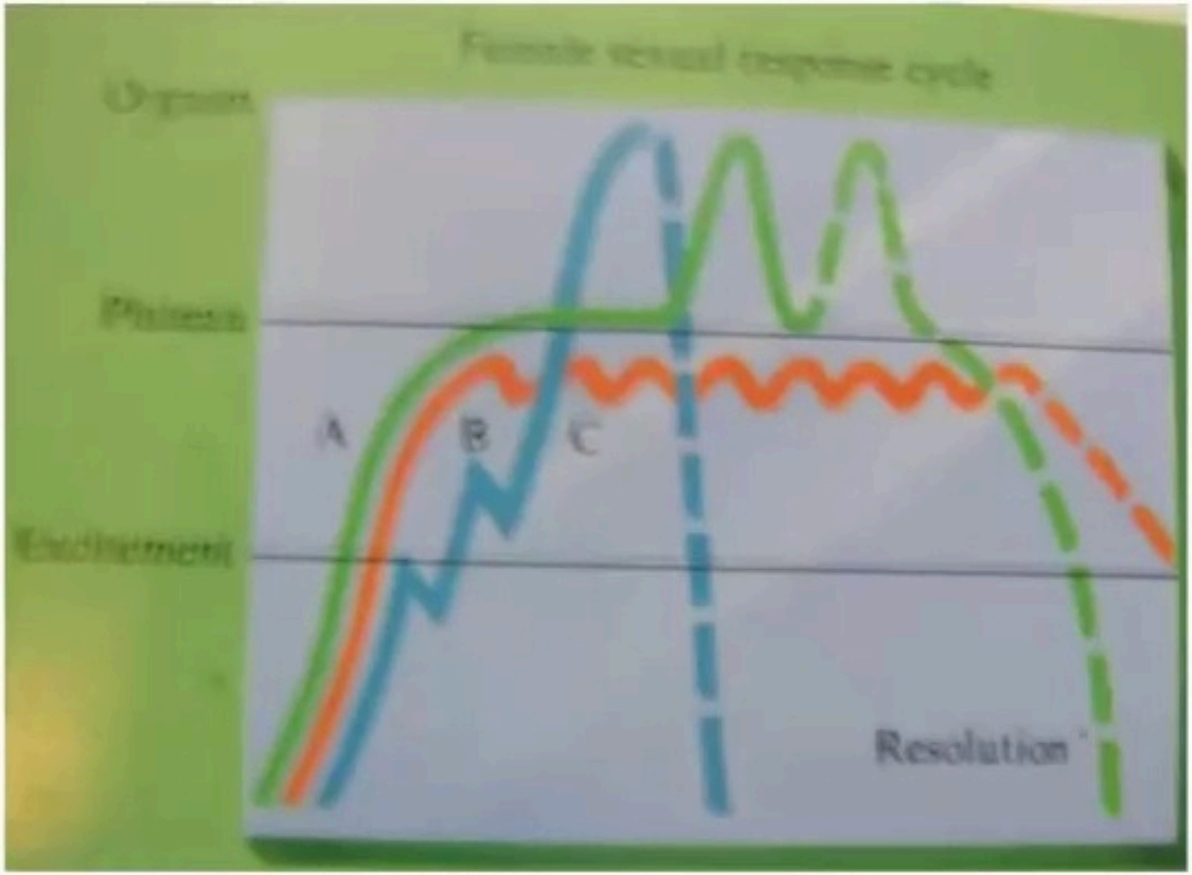
Male sexual response cycle



Female sexual response cycle



Levels of psychosexual intervention

The PLISSIT model

- P: permission- acknowledging human sexuality and possible dysfunctions
- LI: limited information- basic information/ Psychoeducation
- SS: specific suggestions- making specific suggestions, excercises and strategies
- IT- intensive therapy- requires referral to a psychosexual therapist

Therapist's attributes

- Feeling comfortable talking about sex
- Being conversant with the local language of sex
- Being conversant with cultural aspects related to sexuality- beliefs, myths, attitudes, practices
- Having the basic knowledge about sex and sexuality to give education
- Attitude- ability to listen, empathy, non-judgmental, non moralistic

Initial session

A comprehensive Medical and psychiatry history and a MSE

1. Important in all cases to rule out organic conditions
2. Detect other related psychiatric disorders or co-morbidity
3. Embarrassment about talking about sex and admitting to a sexual problem are big hindrances and therefore asking about sexual history is important even if this is not part of the presenting complaints- particularly in medical and psychiatric conditions where sexual dysfunctions are suspected
4. Decision should be made whether to include partner in therapy

With or without partner

- With Partner

1. Allows observation of couple interaction and communication
2. Partner as informant
3. Avoids stress and anxiety when patient comes home with new strategies or behaviour after therapy
4. Reduction of potential threat and conflict in the relationship and increases support of the afflicted partner
5. Enhances sexual satisfaction

Without Partner

Treatment of individuals without partners follows a different approach that takes into account the reasons for lack of partner.

Important stages in therapy

- Determining whether the problem is primary or secondary- has the problem always been there or has it developed over time
- Is the problem total or situational
- What are the related psychosocial factors- ie., relationship, tiredness, lack of privacy, fear of pregnancy or infections.

Some forms of therapy

- Basic psychoeducation and reassurance
- Behavioural therapy
- Combined

Specific Suggestions/strategies

- Behaviour therapy-
- Self Exploration and directed masturbation
- Sensate focus for couples
- Kegel's Pelvic floor exercises
- Sexual fantasies
- Lubricants

Therapy of some common conditions- Failure

of genital response in women

- Investigate factors that may inhibit arousal- Partner Arousal tecniques, Lack of privacy, tiredness, beliefs and cultural practices (FGM)
- Psychoeducation- female sexual and physiological anatomy, the female sexual response cycle, the use of lubricants
- Use of erotic material

Therapy of some common conditions- Failure

of genital response in men

- Erectile failure
- Investigate- childhood- socialisation religious moralistic sexual attitude- punishment for sexual play,
- Adolescence sexual experiences
- Performance anxiety may be related to premature ejaclution
- Psychosexual education-
- Self and partner stimulation
- Use of erotic material-
- The use of viagra- cause a relaxation of penile blood vessels and increasing blood flow
- Other forms of physical treatment- penile prosthesis, prostaglandin E1 injection

Orgasmic dysfunction in women

- Treatment- rule out other sexual disorders
- Psycho-education- female sexual response cycle
- Behaviour therapy- Exercises- directed masturbation
- Sensate focus for couples
- Kegel's Pelvic floor exercises
- Sexual fantasies

Sensate focus for couples

- Sensate focus for couples- partner exploration. Starts with non genital caressing progresses to genital and eventually sexual intercourse
- Concentration should be on pleasurable feelings rather than striving for erections and and orgasms

Kegel's pelvic floor exercises

- Repeated contraction, holding and relaxation of the pelvic muscles
- Strengthens the pelvic floor muscles and increase womens' ability to recognise sensations in this area

Fantasy

- Permission giving in the use of sexual fantasies
- Use of erotic literature and media material

Premature ejaculation

- inability to control ejaculation adequately for both partners to enjoy sexual interaction- ejaculation before or just after penetration
- usually primary- men who never learnt how to control ejaculation
- May be a history of rapid frequent masturbation associated to guilt
- Reaction – anger, frustration, accusations/ condemnations which make condition worse
- Happens to all men sometimes and is normal.
- Can also be secondary in times of stress, anxiety or long periods of abstinence

Premature ejaculation- therapy

- Psycho-education- myths and beliefs- issues that contribute to performance anxiety
- Specific exercises

1. Seman's technique- stop start technique (arousal and pauses) with graded approach starting with sensate focus – genital stimulation & eventually penetration
2. The squeeze technique- can be started at failure of above squeeze the head of penis- 10-20 seconds until the urge to ejaculate goes down
3. Sensate couple focus

Non orgasmic vaginismus

- Penetration is impossible or painful because of a spasmic contraction of the vaginal muscles- pelvic floor muscles:
- Casues: fear of penetration and anticipation of pain
- Previous sexual trauma
- Religious and cultural beliefs-causing fear or guilt
- Childhood punishment for masturbation
- Fear of pregnancy or painful labour
- In Vagimismus- penetration causes pain- vicious cycle or complete abstinence

Vaginismus- Therapy

- Psychosexual education-
- Treatment of underlying psychological disorders and dispelling myths
- Giving permission- to enjoy sex
- Relaxation technique- progressive muscle relaxation- reduces generealised muscular tension
- Kegel's excercise- to teach control of the pelvic muscles

Teaching specific Strategies

- Gradual progression from self exploration to sexual penetration
- Self exploration
- Insertion of graded trainers
- Sensate couple focus
- Graded penetration from object to penile
- Sexual position- position in which woman can control penetration

Non organic dyspareunia

- In men usually related to physical causes- common in men infections, scarring tight foreskin
- In women may also be related to physical conditions or poor arousal response
- Psychoeducation on arousal- important
- Modification of intercourse positions- use positions with less penetration