LECTURE OBJECTIVES:

1. Describe developmental processes associated with human sexuality.
2. Discuss historical and epidemiological aspects of paraphilias and sexual dysfunction disorders.
3. Identify various types of paraphilias and sexual dysfunction disorders.
4. Discuss predisposing factors associated with the etiology of paraphilias, sexual dysfunction disorders, and gender identity disorders.
5. Describe the stages of the human sexual response cycle.
6. Formulate nursing diagnosis and goals of care for clients with sexual and gender identity disorders.
7. Identify appropriate nursing interventions for clients with sexual and gender identity disorders.
8. Identify topics for client/family education relevant to sexual disorders.
10. Describe various medical treatment modalities for clients with sexual disorders.
11. Discuss variations in sexual orientation.
12. Identify various types of sexually transmitted diseases and discuss the consequences of each.

VOCABULARY:

- anorgasmia
- dyspareunia
- exhibitionism
- fetishism
- frotteurism
- sadism
- homosexuality
- lesbianism
- masochism
- orgasm
- transsexualism
- voyeurism
- pedophilia
- premature ejaculation
- retarded ejaculation
- paraphilia
- sensate focus
- vaginismus
- transvestic fetishism
LECTURE OUTLINE:

I. Introduction

A. Sexuality - a basic human need and an innate part of the total personality.

B. Information regarding sexuality should be integrated into nursing care by focusing on preventative, therapeutic and educational interventions to assist individuals in attaining, regaining and maintaining sexual wellness.

C. Not all nurses need to be educated as sex therapists.

D. Definitions:

1. Sex - an act between two people.

2. Sexuality - a state of body and mind; an expression of self as a sexual being.

3. Sexual Health: WHO defines: “Integration of somatic, emotional, intellectual and social aspects of the human being in ways that are positively enriching and that enhances personality, communication and love.”

4. Sexual activity:
   a. Form of communication
   b. Method of self affirmation
   c. Pleasurable form of play
   d. Reflection of the individual’s value system.

5. Characteristics of a healthy sexually comfortable professional
   b. Personal resolution of sexual identity and overall sexual adjustment.
   c. Up-to-date factual knowledge.
   d. Ability to speak openly, honestly, and confidently about any aspect of human sexuality.
   e. Ability to accept the sexual preferences and activities of others without feeling personally threatened and without moralizing or being judgmental.
   f. Skill in interviewing and using oneself therapeutically - that is, being sensitive to the client’s nonverbal communications and the ability to unmask indirect cues.
   g. Knowledge of socioculture and religious tents.
   h. Ability to discuss sex with the young, middle-aged and elderly.
   i. Genuine concern for the individual and family.
j. Respect for confidentiality.

II. Development of Human Sexuality

A. Birth through 12 years

1. Gender recognition by 2 or 2½
2. Engage in heterosexual play by 4 or 5.
3. Homosexual play in late childhood and pre-adolescence.
4. Preoccupation with puberty changes and beginning romantic interests in opposite sex 10 to 12 years old.

B. Adolescence

1. Relate to sexual issues:
   a. New or more powerful sexual feelings.
   b. Whether to participate in various types of sexual behaviors.
   c. How to recognize love.
   d. How to prevent pregnancy.
   e. How to define age appropriate sex-roles.

C. Adulthood

1. Marital sex - choosing a marital partner or developing a sexual relationship with another.
2. Extramarital sex - 20-30% of all married men have extramarital sex, compared to 15-20% of females.
3. Sex and the single person - individualized due to varying attitudes. (Some seek freedom and independence and others desperately seek intimate relationships).
4. Middle years (46-65) - hormonal changes produce changes in sexual activity in both genders.

III. Sexual disorders

A. Paraphilias - identifies repetitive or preferred sexual fantasies or behaviors that involve the preference for use of a non-human object, repetitive sexual activity with humans involving real or simulated suffering or humiliation and repetitive sexual activity with non-consenting partners.

1. Historically - condemned by social and religious sanctions.
2. Epidemiological statistics - most are men and 50% develop onset of paraphilic arousal before age 18.
3. Types of paraphilias:
   a. **Exhibitionism** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving exposure of one’s genitals to an unsuspecting stranger.
   b. **Fetishism** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving the use of nonliving objects (e.g. shoes, gloves, stockings)
   c. **Frotteurism** - recurrent preoccupation with intense sexual urges or fantasies involving touching or rubbing against a non-consenting person. (crowds)
   d. **Pedophilia** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving activity with a prepubescent child.
   e. **Sexual masochism** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving the act of being humiliated, beaten, bound, or otherwise made to suffer.
   f. **Sexual sadism** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving the acts in which psychological or physical suffering of the victim is sexually exciting. Includes: humiliation.
   g. **Voyeurism** - recurrent, intense sexual urges, behaviors or sexually arousing fantasies involving the acts of observing unsuspecting people, usually strangers, who are either naked, in the process of disrobing, or engaging in sexual activity.

4. Predisposing factors to paraphilias: (Biopsychological theories)
   a. **Biological** - organic factors, i.e. abnormalities of the limbic system and temporal lobe. Also, abnormal levels of androgen.
   b. **Psychoanalytical theory** - one who has failed normal developmental process toward heterosexual adjustment, when the individual fails to resolve the Oedipal crisis and either identifies with the parent of opposite gender or selects an inappropriate object for libido cathexis (investment of energy)
   c. **Behavioral theory** - hypothesizes that paraphiliac behavior depends on the type reinforcement he receives after the behavior. Initial act may be for various reasons, i.e. mimicking sexual behavior seen in media, then choose whether to repeat or not.
   d. **Transactional model of stress/adaptation** - most likely that the etiology of paraphilias is influenced by multiple factors.

5. Treatment modalities:
   a. **Biological Rx** - focus is blocking or decreasing the level of circulating androgens.
b. Psychoanalytical therapy - client is assisted to identify unresolved conflicts and traumas from early childhood, resolving the anxiety that prevents appropriate sexual relationships.

c. Behavioral therapy - aversion techniques, such as electric shock and chemical induction of nausea and vomiting in combination with exposure to photographs depicting undesirable behavior.

6. Role of nurse:

a. May best become involved in the primary prevention process.

b. Focus - to intervene in home life or other facets of childhood in an effort to prevent problems from developing.

c. Assist in the development of adaptive coping strategies to deal with stressful life situations.

B. Sexual Dysfunction:

1. Problems in one of the phases of the Sexual Response Cycle.

a. Phase I: Desire
b. Phase II: Excitement
c. Phase III: Orgasm
d. Phase IV: Resolution

2. Historical:


b. Sexual revolution - increase in scientific research into sexual physiology and sexual dysfunctions.

c. Masters and Johnson pioneered this work with studies of the human sexual response and the treatment of sexual dysfunction.

d. Sexual literature more available in 1970's

3. Types of dysfunction:

a. Sexual Desire Disorders

1. Hypoactive sexual desire disorder - persistent or recurrent deficiency or absence of sexual fantasies and desire for sexual activity.

2. Sexual aversion disorder - persistent or recurrent extreme aversion to and avoidance of all genital sexual contact with a sex partner.
b. Sexual Arousal Disorders:

1. **Female Sexual Arousal Disorders** - failure to attain or maintain lubrication-swelling response, or failure to experience a subjective sense of excitement and pleasure during sexual activity.

2. **Male Erectile Disorder** - persistent or recurrent inability to attain, or to maintain an adequate erection until completion of the sexual activity.

c. Orgasmic Disorders:

1. **Female Orgasmic Disorder** (anorgasmia) - recurrent and persistent delay in or absence of, orgasm after a normal sexual excitement phase.

2. **Male Orgasmic Disorder** (retarded ejaculation) - persistent or recurrent delay in or absence of, orgasm after a normal sexual excitement phase during sexual activity, appropriate for person’s age with regard to focus, intensity and duration.

3. **Premature ejaculation** - persistent or recurrent ejaculation with minimal sexual stimulation, or occurring before, on, or shortly after penetration and before the person wishes it.

d. Sexual Pain Disorders:

1. **Dyspareunia** - recurrent or persist pain in either male or female that is not associated with vaginismus or with lack of lubrication, occurring before, during, and after sexual intercourse. Not R/T medical condition.

2. **Vaginismus** - involuntary constriction of the outer one third of the vagina that prevents penile insertion and intercourse.

e. Sexual Dysfunction R/T general medical condition or substance induced.

1. The sexual dysfunction is judged to be caused by the direct physiological effects of a general medical condition or use of a substance.

4. Predisposing Factors:

a. Biological factors - a relationship between serum test testosterone and hypoactive sexual desire in men and increased libido in women.

1. Medication causing hypoactive desire: sedatives, anxiolytics, hypnotics, and opioids. Also, alcohol.


3. Neurological influences: Diabetes Mellitus, Multiple Sclerosis, Spinal Cord injury
b. Psychosocial factors - religious orthodoxy, secret sexual deviations, fear of pregnancy, childhood sexual abuse, history of rape, fears, anxiety, fatigue and depression.

IV. Application of Nursing Process

A. Assessment

1. Sexual history
2. Medical and surgical conditions.
3. Infertility problems
4. STD
5. Pregnancy
6. Family planning
7. Sexual relationship (s)
8. Premarital, marital and psychiatric counseling

B. Diagnosis/outcome identification:

1. Sexual Dysfunction
2. Ineffective Sexuality patterns

C. Planning /Implementation:

1. Assisting the individual to gain or regain the aspect of his/her sexuality.
2. Being nonjudgemental and ensure that personal feelings, attitudes and values have been clarified and do not interfere with acceptance of the client.

D. Evaluation is based on outcome criteria.

1. Decrease in anxiety and fear
2. Decrease spiritual distress
3. Increased effective family coping
4. Promote comfort with personal identity
5. Promote effective role performance
6. Decreased violence: self or others
7. Decreased pain
8. Increased knowledge
9. Sex therapy (dysfunctions)

V. Treatment Modalities

A. Hypoactive sexual desire disorder

1. Testosterone
2. Cognitive therapy
3. Behavioral therapy
4. Relationship therapy
B. Sexual Aversion Disorders
   1. Systematic desensitization
   2. Antidepressant medication.

C. Female sexual arousal disorder
   1. Sensate focus exercise

D. Male Erectile Disorder
   1. Sensate focus exercises
   2. Group therapy
   3. Hypnotherapy
   4. Systematic desensitization
   5. Testosterone
   6. Sildenafil (Viagra)
   7. Penile implantation

E. Female and male orgasmic disorders
   1. Sensate focus exercise.
   2. Directed masturbation training

F. Premature ejaculation
   1. Sensate focus exercise
   2. “Squeeze” technique

G. Dyspareunia
   1. Physical and gynecological examination
   2. Systematic desensitization

H. Vaginismus
   1. Anatomy and Physiology education for both partners.
   2. Systematic desensitization and dilators of gradual size

VI. Application of Nursing Process

A. Background Assessment (symptomatology)
   1. Gender identity disorder in children
      a. Repeated statements insisting that he/she is the opposite sex.
      b. Boys cross dressing or girls wearing masculine attire.
      c. Persistent preference for cross-sex role in make-believe play or fantasies.
      d. Intense desire to participate in stereotypical games or past times of other sex
      e. Strong preference for playmates of the other sex.
2. Gender identity in adolescents and adults
   a. Stated desire to be of the opposite sex
   b. Passing for the opposite gender
   c. Desire to be treated as opposite gender
   d. Insist that feelings and reactions are typical of opposite gender.

B. Diagnosis/outcome identification
   1. Nursing Diagnosis
      a. Disturbed personal identity
      b. Impaired social interaction
      c. Low self-esteem

   2. Planning/ Implementation
      a. To enhance culturally appropriate same-sex behaviors, but not extinguishing all coexisting opposite-sex behaviors.
      b. Improvement of social interactions and enhancement of positive self-esteem

VIII. Variations in Sexual Orientation

A. Homosexuality - expression of a sexual preference for individuals of the same gender. This only seen by the psychiatric community as a problem when an individual experiences “persistent and marked distress about his/her sexual orientation.”
   1. Biological factors - possible genetic tendency (twin studies); decreased level of testosterone and increased estrogen levels (hypothetical)
   2. Psychosocial factors -
      a. possible fixation in the stage where homosexual behavior is common. (Fraud)
      b. Dysfunctional family pattern: dominant mother:: weak, hostile father
      c. Dysfunctional mother-daughter relationship, therefore unmet needs through same-gender sexual relationships.
   3. All theories are is dispute.
   4. Special concerns;
      a. STD, AIDS
      b. Discovery of their sexual orientation
      c. Fear of being rejected by parents and significant others
      d. Discrimination in society

B. Transsexualism - gender dysphoria (unhappiness with gender); self-perception of gender opposite of anatomical gender.
   1. Special concerns
      a. Extensive psychological testing prior to surgical intervention
      b. Hormonal treatment started during this phase
      c. Both men and women receive hormone treatment after surgery.
2. Bisexuality - engages in sexual activity with both genders. Neither heterosexual nor homosexual. Thought to evolve over a life time.

IX. Sexually Transmitted diseases

A. Transmission - person-to-person through heterosexual/homosexual, anal, oral, or genital contact

1. Prevention: Ideal goal; Early detection and treatment is more realistic.

2. Types of STD’s

   a. Gonorrhea
   b. Syphilis
   c. Chlamydial infection
   d. Genital herpes
   e. Genital warts
   f. Hepatitis B
   g. Acquired Immunodeficiency syndrome (AIDS)
SEXUAL RESPONSE CYCLE

<table>
<thead>
<tr>
<th>PHASES</th>
<th>MALE</th>
<th>FEMALE</th>
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<tbody>
<tr>
<td>EXCITEMENT</td>
<td>Penile erection; beginning elevation; increase in muscular tension and cardiopulmonary response.</td>
<td>Breast enlargement; nipple erection, vaginal lubrication, labial and clitoral engorgement; cardiopulmonary response.</td>
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<td>PLATEAU</td>
<td>Blood pressure and heart rate continue to rise.</td>
<td>Vagina fully expands; vagina, clitoris and labia are maximally engorged; maximal cardiopulmonary response.</td>
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<tr>
<td>ORGASMIC</td>
<td>Penile contraction and ejaculation; total body response involving muscular contractions; tightening of the rectal sphincter and cardiopulmonary response. Current literature supports the fact that ejaculation and orgasm are two separate occurrences. Orgasm is essentially a cerebral event and ejaculation is a pelvic event.</td>
<td>Simultaneous contractions involving the uterus; outer portion of the vagina and rectal sphincter accompanied by a total body response.</td>
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<tr>
<td>RESOLUTION</td>
<td>Final contraction is followed by a refractory period before erection and ejaculation can occur again.</td>
<td>Involuntary reduction of sexual tension. Unlike men, many women have the potential to be multi-orgasmic by flowing back and forth between plateau and orgasmic phases.</td>
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THE PLISSIT MODEL: LEVELS OF COUNSELING

P - Permission

L - Limited Information
I - Information

S - Specific
S - Suggestions

I - Intensive
T - Therapy
DISABILITY AND SEXUALITY

Performance

Endurance

Tolerance

Balance

Coordination