Faculty of Medicine

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Men’s and Women’s sexual health and dysfunction among students population.
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**Summary:** The subject is contributing to discuss the knowledge about safety sexual behaviour and different points of view regarding this topics in LUHS (Lithuanian University of health sciences) students from different countries and ages. Students from different countries, religions and ages can have different points of view about this topic. The most important task is know the behaviour from students regarding sex and their knowledge about contraceptive methods to prevent pregnancy and STD. A questionnaire was perfom to LUHS students from different ages, nationalities and religions.

Mostly all the results that were obtained from the test were similar and there was not big differences than can make a huge changes in the statitics, but regarding the results, all the students that were participating know how to practice sex in a healthy and safety way.
Conflicts of interest: The author reports no conflict of interest.
Clearance issued by Ethics Committee:

- **Title:** Men's and Women's sexual health and dysfunction among students population
- **Date of issue:** 2014-10-16
- **Number:** BEC-MF-58
Abreviations:

- STD: Sexual trasmitted disease.
- ICD: International classifcation of diseases.
- CBC: Cell blood count.
- HSDD: Hypoactive sexual desire disorder.
- ISD: Inhibited sexual desire.
- ED: Erectile dysfunction.
- PSA: Prostate specific antigen.
- FSH: Folicule-stimulating hormone.
- LH: Lutenizing hormone.
- SAD: Sexual aversion disorder.
**Introduction:** The subject is contributing to discuss the knowledge about safety sexual behaviour and different points of view regarding this topics in LUHS students from different countries and ages. Students from different countries religions and ages can have different points of view about this topic. The most important task is know the behaviour from students regarding sex and their knowledge about contraceptive methods to prevent pregnancy and STD. A questionnaire was perform to LUHS students from different ages, nationalities and religions.
Aim and objectives:

1. **Abstract of the thesis:** Perform a test to different students and make statistics about results
2. **Aim:** To evaluate sexual health and dysfunction prevalence among the students.
3. **Objectives:**
   
   I. To evaluate sexual habits among students from different countries.
   II. To compare the sexual habits between religious students and non-religious students.
   III. To compare the sexual habits in relation to age.
LITERATURE REVIEW:

Definition of Normal human sexuality: Is the process by which people experience and express themselves as sexual beings, sexuality has been a consistent focus of curiosity interest and analysis of humankind. Sexuality is determined by anatomy, physiology, the culture in which a person lives, relationships with others and developmental experiences throughout the life cycle, it includes the perception of being male or female and private thoughts and fantasies as well as behaviour.

Normal sexual behaviour brings pleasure to oneself and one partner, involves the stimulation of the primary sex organs including coitus.

Normal sexuality is devoid of inappropriate feeling of guilt or anxiety and is not compulsive. The main aspects of sexual behaviour are anatomical, physiological, psychological, sociological and philosophical.

ICD classification of sexual disorders:

- ICD-9-CM code 302 Sexual and gender identity disorder
- ICD-10-CM code F66 sexual masturbation disorder, increased libido disorder, sexual relationship disorder
- ICD-10-CM code F52.0 Hypoactive sexual desire disorder (lack of sexual desire, decrease libido, situational hypoactive)
- ICD-10-CM code F52.1 sexual aversion disorder (a disorder characterise by recurrent or persistent extreme aversion to, and avoidance of all genital contacts, with sexual partner)
- ICD-10-CM code F52.22 Female sexual arousal disorder (a disorder characterise by a recurrent or persistent inability to attain or maintain until completion of sexual activity, an adequate physical response of sexual excitement, consisting in vasocongestion in the pelvis, vaginal lubrication and expansion and swelling of the external genitalia)
- ICD-10-CM code F65.52 sexual sadism (a disorder characterise by a recurrent sexual urges, fantasies, or behaviours involving acts in which the psychological or physical suffering of a victim is sexual exciting to the individual)
- ICD-9-CM code 302.84 sadomasochism
- ICD-10-CM code F65.51 sexual masochism
- ICD-10-CM code F63 Impulse disorders (habitual excessive use of alcohol or psychoactive substances)
- ICD-10-CM code F10.981 alcohol use, unspecific with alcohol-induced sexual dysfunction
- ICD-9-CM code 302.9 unspecified psychosexual disorder
- ICD-10-CM code F45 somatoform disorders
- ICD-9-CM code 259.1 precocious sexual development and puberty
- ICD-9-CM code 302.89 Other specific psychosexual disorders
- ICD-10-CM code F52.9 Unspecific sexual dysfunction not due to a substance or known physiological condition
- ICD-9-CM code 302.72 psychosexual dysfunction with inhibited sexual excitement
Sexual disorders and dysfunctions:

- **Common characteristics:**
  The primary characteristic in this category is the impairment in normal sexual functioning. This can refer to an inability to perform or reach an orgasm, painful sexual intercourse, a strong repulsion of sexual activity, or an exaggerated sexual response cycle or sexual interest. A medical cause must be ruled out prior to making any sexual dysfunction diagnosis and the symptoms must be hindering the person's everyday functioning.
  Gender Identity Disorder has also been placed in this category, although no outward dysfunction needs to be present for this disorder. Basically, it includes strong feelings of being the wrong gender, or feelings that your outward body is inconsistent with your internal sense of being either male or female.

- **Disorders:**
  Dyspareunia
  Female orgasmic disorder
  Female sexual arousal disorder
  Gender Identity disorder
  Hypoactive sexual desire disorder (HSDD)
  Male erectile disorder
  Male orgasmic disorder
  Premature ejaculation
  Sexual aversion disorder (SAD)
  Vaginismus
  Hypersexuality
  Vulvodynia
  Medication induced sexual dysfunction
  Paraphilias
Dyspareunia:

- **Definition**: Painful intercourse can occur due to variety of reasons- ranging from structural problems to psychological concerns. Many woman experience painful intercourse at some point in their lives. Pain can be persistent or recurrent and occurs just before, during or after sexual intercourse. The effects might be devastating for the woman and to her relationship with her partner even if the pain may not be as serious as other complications.

- **Causes**: Related with emotional factors **psychological problems** (Anxiety, depression, concerns about physical appearance, fear of intimacy or relationship problems can contribute to a low level of arousal and a resulting discomfort or pain) **stress** (your pelvic floor muscles tend to tighten in response to stress in your life) **History of sexual abuse** (Most women with dyspareunia don’t have a history of sexual abuse, but if you have been abused, it may play a role). May also be cause by menopause STDs, infections of certain organs such as the vagina or even skin disorders.

- **Symptoms**: Pain only at sexual penetration (entry), pain with every penetration (even while putting on a tampon), New pain after previously pain free-sexual intercourse, deep pain during thrusting, Burning pain or aching pain and throbbing pain lasting hours after sexual intercourse. Recurrent or persistent pain related with sexual intercourse. Can be diagnosis in males and females, is not better accounted by other diagnosis (psychological or physical) and is not the direct effect of substance use.

- **Test and diagnosis**: **Thorough medical history** (when the pain began, exactly where it hurts, how it feels, if it happens with every sexual parter and every sexual position, sexual history, surgical history and previous childbirth experiences. **Pelvic exam** (pelvic ultrasound if necessary).

- **Treatment and management**: Resolving underlying sexual and relationship issues can be very helpful in many cases (counselling or sex therapy) Drugs to increase lubrication can be used, like Osphen. One of the best solution will be therapy if the cause is psychological or emotional in nature. Not having sex immediately would be a good advise for someone who just delivered a child.

- **Prognosis**: In general prognosis is good in those cases.
**Female orgasmic disorder:**

- **Definition:** Female orgasmic disorder (FOD) involves difficulty in achieving orgasm, substantially decreased intensity or of orgasm or both.

- **Types:**
  - Lifelong: The disturbance has been present since the individual became sexually active.
  - Acquired: The disturbance began after a period of relatively normal sexual function.
  - Generalized: Not limited to certain types of stimulation, situations or partners.
  - Situational: Only occurs with certain types of simulation, situation or partners.

- **Severity:**
  - Mild: Evidence of mild distress over the symptoms.
  - Moderate: Evidence or moderate distress over the symptoms.
  - Severe: Evidence of severe or extreme distress over the symptoms.

- **Causes:** Some studies suggest that failure to achieve and orgasm for women is related to intimacy issues, feelings or fear and anxiety, and a sense of not being safe within the intimate relationship or relationships in general.

- **Symptoms:** Chronic and acute medical conditions (including psychiatric problems like rape or sexual abuse), stress, substance abuse and sexual complains.
  1. Marked delay, marked infrequency, or absence of orgasm.
  2. Marked reduced intensity of orgasmic sensations.

- **Diagnosis:** In psychiatry a deep medical interview asking the beginning of her sexual life and her first time, trying to make that the patient can explain it with details, without embarrassed her, create a nice and distended environment is so important.

  Other test from other departments can be necessary to perform a final diagnosis: CBC, chemistry test, Hormone test, Thyroid test, vitamin B12 and folate levels.

- **Treatment and management:** Cognitive-Behavioral therapy, sensate focus therapy, adjective approaches (sexual education, training in communications skills and Kegel exercises), directed masturbation, Eros clitoral therapy device, couples or family therapy, individual or couples sex therapy.

  Pharmacological treatment for secondary anorgasmia: Antidepressants induced anorgasmia, if this is the reason the amount of antidepressant should be decrease if is possible; anorgasmia related to substance abuse, identify and treat the underlying abuse; anorgasmia in postmenopausal women with decrease sexual desire (consider testosterone plus estrogen or tibolone). Medication that can be use: Bupropion, Phosphodiesterase type 5 inhibitors (e.g. sildenafil and tadalafil) and Apomorphine.

- **Prognosis:** Once the situation is manage, the prognosis for those patients is good.
**Female sexual arousal disorder:**

- **Definition:** Sexual arousal disorder is an aberration during any stage of the sexual response cycle (Desire, arousal, orgasm and resolution) that prevents the experience of satisfaction through sexual activity. A woman with this disorder may be interested in sexual intercourse but has difficulty becoming stimulated enough to go through it. Lack of or significantly reduced sexual interest/arousal as manifested by at least three of the following:
  1. Absence or reduced interest in sexual activity.
  2. Absence or reduced sexual erotic thoughts or fantasies.
  3. No reduced initiation of sexual activity and typically unreceptive to a partner's attempts to initiate.
  4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all sexual encounters.
  5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues.
  6. Absent/reduced genital or nongenital sensations during sexual activity in almost all sexual encounters.

  - **Types:**
    - Lifelong: The disturbance has been present since the individual became sexually active.
    - Acquired: The disturbance began after a period of relatively normal sexual function.
    - Generalized: Not limited to certain types of stimulation, situations, or partners.
    - Situational: Only occurs with certain types of stimulation, situations, or partners.

  - **Severity:**
    - Mild: Evidence of mild distress over the symptoms.
    - Moderate: Evidence of moderate distress over the symptoms.
    - Severe: Evidence of severe or extreme distress over the symptoms.

- **Causes:** Some evidence suggest that relationships issues and/or sexual trauma during childhood may play a role in the development of this disorder. The cause can be physical or psychological (depression, sexual fear or guilt, past sexual trauma).

- **Symptoms:** Lack of interest and desire of sex, inability to feel aroused, pain with intercourse, infertility, inability to relax vagina muscles enough to allow intercourse, inadequate vaginal lubrication and inability to attain orgasm.

- **Diagnosis:** Little interest in sex, few thoughts related to sex, decreased start and rejecting of sex, little pleasure during sex most of the time, decreased interest in sex even when exposed to erotic stimuli and little genital sensations during sex most of the time.
American psychiatric association says:

- Persistent or inability to attain or maintain until completion of the sexual activity, and adequate lubrication-swelling response to sexual excitement.
- The disturbances causes marked distress or interpersonal difficulty.
- The sexual disfunction is not better accounted for by another axis I disorder and is not exclusively to the direct psychological effects of a substance (drug abuse) or a general medical condition.

- **Treatment and management:** Typical treatment would involve discovering and resolving underlying conflict or life difficulties. In case is due to depression antidepressants drugs will be recommended. Couple therapy.

- **Prognosis:** Varies, but increase with the ability to gain insight and work through relationship issues or issues steaming from childhood which are playing a role in this disorder.

### Gender identity disorder (gender dysphoria)

- **Definition:** Diagnosis that refers to people whose gender at birth is contrary to the why they identify with.

- **Causes:** Theories suggest that childhood issues may play a role in this disorder, such as the parent child relationship at and early age and the identification a child is able to make with the parents of the same gender.

- **Symptoms:** A strong and persistent identification with the opposite gender. There is a sense of discomfort in their own gender and may feel they were born “the wrong sex”. This has been confuse with cross-dressing but is a different diagnosis.

- **Diagnosis:** Marked incongruence between the patient,s experience or expressed gender and his or her primary or secondary sex characteristic, Strong desire to be rid of his or her primary or secondary sex characteristics, strong desire for the primary or secondary sex characteristics of the other gender, strong desire to be of the other (or some alternative) gender, strong desire to be treated as the other (or some alternative) gender and strong conviction of having the typical feelings and reactions of the other (or some alternative) gender.

- **Treatment and management:** Modalities that may be consider in the treatment of gender dysphoria include pharmacologic therapy, psychological and nonpharmacologic therapies, and sexual reassignment surgery (SRS). Negative attitudes towards SRS appear to be changing among professionals, and scientific interest is increasing. Nevertheless it must been keep in mind that SRS does not promote a trouble-free life. Post-SRS psychotherapy may substantially improve overall outcome.

Other disorders may be present with this one, including depression, anxiety, relationship difficulties, and personality disorders, and homosexuality is present.
in majority of the cases. Treatment is likely to be long-term with small gains made on underlying issues and treatment progresses.

- **Prognosis:** Mixed. The goal of treatment are not as clear as in other disorders, as same-sex identification maybe be very difficult to achieve. More achievable goals may include acceptance or assigned gender or resolution of other difficulties such as depression or anxiety.

- **Hypoactive sexual desire disorder (HSDD):**
  
  - **Definition:** Inhibited sexual desire (ISD) refers to a low level of sexual interest resulting in a failure to initiate or respond to sexual intimacy. ISD may be a primary condition (where an individual has never felt much sexual desire), or secondary (where lack of interest is something new). ISD may also be specific to the partner, or it may be a general attitude toward any potential partner.
  
  A diagnosis of hypoactive sexual desire disorder refers to a persistent or recurring lack of desire or an absence of sexual fantasies. However, sexual performance may be adequate once activity has been initiated. This disorder occurs approximately 20 percent of the population and is more common in women, though it does affect both sexes.
  
  Sexual aversion disorder refers to a condition in which the concept of genital sexual contact seems repulsive. This disorder probably occurs less frequently than hypoactive sexual desire.

  - **Causes:** Mostly stress due to life circumstances.

  - **Symptoms:** Deficient or absent sexual fantasies and desire for sexual activity. This judgement must be made by a clinician taking into account the individual’s age and life circumstances. The lack of desire must result in significant distress for the individual and is not better accounted for by another disorder or physical diagnosis.

  - **Diagnosis:** Deep patients life history take by a psychiatrist.

  - **Treatment:** In most cases, medical evaluation and lab test will not reveal a physical cause. However, because testosterone is the hormone responsible for creating sexual desire in both men and women, it may be useful to check testosterone levels. For men taking this test, blood should be drawn before 10 a.m., when male hormone levels are at their highest. Interview with specialist in sex therapy are more likely to reveal possible causes.
  
  Treatment must be individual- some couples will need relationship or marital therapy prior to focusing directly or enhancing sexual activity. Of course, many couples may need to focus on the sexual relationship itself, and through education and assignments they can expand the variety and time devoted to sexual activity.
Prognosis: The course of this disorder can be consistent or periodic, and can therefore resurface after a period of remission if relationship or life-stressor remerges.

Male erectile disorder (impotence):

Definition: Erectile dysfunction (ED) is the inability to attain and maintain an erection sufficient for satisfactory sexual performance. Although a benign disorder, it can have a significant impact on the quality of life of sufferers, partners and families. It is important also to consider the physical and psychological health of the sufferer. Patients should be properly assessed and investigated before performing any treatment.

Sometimes the men might be able to have sex with his prostitute but no with his partner.
- Types:
  - Lifelong: The disturbance has been present since the individual became sexually active.
  - Acquired: The disturbance began after a period of relatively sexual dysfunction.
  - Generalized: Not limited to certain types of stimulation, situations or partners.
  - Situational: Only occurs with certain types of stimulation, situations or partners.
- Severity:
  - Mild: Evidence of mild distress over the symptoms.
  - Moderate: Evidence of moderate distress over the symptoms.
  - Severe: Evidence of severe or extreme distress of the symptoms.

Causes: Generalised anxiety states, depression, psychosis, alcoholism (the relationship between alcohol is not straightforward) in psychiatry field. Can be due to organic, neurological, hormonal, anatomical, drugs abuse, and psychological causes too.

Symptoms: Recurrent inability to achieve or maintain an erection until completion of the sexual activity. Must result in significant distress for the individual and is not better accounted for by another disorder (e.g. drugs abuse) or physical diagnosis. Symptoms can be:
1. Marked difficulty in obtaining an erection during sexual activity.
2. Marked difficulty in maintaining an erection until the completion of sexual activity.
3. Marked decrease in erectile rigidity.

Diagnosis: Urologist should be consulted (Fasting glucose or HbA1c and lipid profile for all patients, morning sample of testosterone, PSA test, if low testosterone is found follicle stimulating hormone (FSH), luteinising hormone (LH) and prolactin).
Normal penis tumescence and rigidity studies, vascular studies (Duplex ultrasound cavernous arteries, Intracavernous vasoactive drug injection, dynamic infusion cavernosonography and arteriography (internal pudendal). Neurologist, endocrinologist and psychologist should be also consulted. Psychiatrist should perform a deep interview with the patient asking for any kind of problems during childhood, puberty and adult life.
Treatment: The main of management is to diagnose and treat the cause of ED when possible, associated modifiable and reversible factors (lifestyle, drug related factors) should be considered as well as specific therapies. Management of any specific underlying psychological problem, psychosexual therapy and drug treatment (phosphodiesterase type-5 inhibitors, for example, sildenafil, tadalafil or verdenafil) may be affective and sometimes need only be used short-term.

Prognosis: Very good. Very high success rates have been reported.

- Male orgasmic disorder:

  Definition: Male orgasmic disorder is the inability for a male to reach orgasm during sexual stimulation. This disturbance must cause marked distress or interpersonal difficulty. Male orgasm disorder is often thought of as beginning in adolescence or early adulthood because sexual intimacy becomes related with a negative life event or aspect. The disorder might present itself as an inability to reach orgasm during sexual intercourse or as ejaculation after prolonged intense non-intercourse stimulation. This is disorder is more common in female than in male.

  Causes: Drugs and alcohol may lessen orgasmic responsiveness and boredom and monotony in sexual activity, mostly.

  Symptoms: Delay or absence of orgasm following normal excitement and sexual activity. Due to the widely varied sexual response in men, it must be judged by a clinician to be significant, taking into account the person’s age and situation. The condition is persistent or occurs frequently and causes significant distress. Is not a direct effect of substance use.

  Diagnosis: The main diagnosis method in this case, is take a completed and detailed patients anamnesis trying find out, the reason of the problem, to solve it posteriorly.

  Treatment: Typically when the cause is ruled out, working through the underlying causes. Some therapist also use Behavioural techniques such as sensate focus which is more direct approach if underlying issues are not significant.

  Prognosis: In most of this cases data reveals that prognosis is really good.
**Premature ejaculation:**

- **Definition:** Premature (early) ejaculation is the most common sexual disorder in men younger than 40 years. In premature ejaculation, men persistently or recurrently achieve orgasm and ejaculation before they wish to. The diagnosis is made when a man regularly ejaculates before or within approximately 1 minute after penetration.

  - **Types:**
    - Lifelong: The disturbance has been present since the individual became sexually active.
    - Acquired: The disturbance began after a period of relatively sexual dysfunction.
    - Generalized: Not limited to certain types of stimulation, situations or partners.
    - Situational: Only occurs with certain types of stimulation, situations or partners.

  - **Severity:**
    - Mild: Evidence of mild distress over the symptoms.
    - Moderate: Evidence of moderate distress over the symptoms.
    - Severe: Evidence of severe or extreme distress of the symptoms.

- **Causes:** Previous physiological difficulties, early sexual experiences, family relationships during childhood and adolescence, peer relationships, work or school, general attitude toward sex, context of the event, sexual attitude and response of the female partner, nonsexual aspects of current relationships and level of involvement of the sexual partner in treatment.

- **Symptoms:** Ejaculation with minimal sexual stimulation before or shortly after penetration and before the person wishes it. The condition is persistent or occurs frequently and causes significant distress. Is not a direct effect of substance use.

- **Diagnosis:** Asking about health history and sex life. Perform a full general examination. Some cases urinary test and blood test can be added.

- **Treatment:**
  - **Non-pharmacological management:** efforts to relief of underlying performance pressure on the male, sex therapy, second attempt at coitus.
  - **Pharmacological management:** Topical desensitising agents (e.g. lidocaine and prilocaine) for the male, Selective serotonin reuptake inhibitors (SSRI) therapy (e.g. sertraline, paroxetine, fluoxetine, citalopram or dapoxetine), phosphodiesterase type 5 (PDE5) inhibitor therapy (e.g. sildenafil, tadalafil, possibly vardenafil) and other agents (e.g. pindolol or tramadol).

- **Prognosis:** Studies said that is really good.
**Sexual aversion disorder (SAD):**

- **Definition:** Sexual aversion disorder is a disorder characterised by disgust, fear, revulsion or lack of desire in consensual relationships involving genital contact.

- **Causes:** The most common causes are interpersonal problems and traumatic experiences. Interpersonal problems generally cause situation-specific sexual aversion disorder, in which the symptoms occur only with a specific partner or under certain conditions. Reasons for unhappiness with the relationship may include the discovery of marital infidelity, major disagreement over children, money and family roles, domestic violence, lack of personal hygiene on the partners side; or similar problem.

- **Symptoms:** Persistent or recurring aversion to or avoidance of sexual activity. The aversion must result in significant distress for the individual and is not better accounted for by another disorder or physical diagnosis. When presented with a sexual opportunity, the individual may experience panic attacks or extreme anxiety.

- **Diagnosis:** A diagnosis of sexual aversion disorder is usually made when the affected person or his or her partner mentions the problem itself or their dissatisfaction with the relationship to their family physician, gynaecologist, or psychotherapist. An important first step in diagnosis is through physical examination, preferably of both partners, to rule out physical causes of the disorder in the affected person, and to rule out a sexually transmitted disease, physical deformity, or lack of personal clean in the partner that may contribute to the affected person’s avoidance sex.

- **Treatment:** Sexual aversion disorder is not thought to have any common place underlying physiological causes. The usual treatment is a course of psychotherapy for the psychological conditions that may be causing the problem. Marriage counselling or couples counselling, is often appropriate if the disorder concerns a spouse. Medications can be used to treat some symptoms that may be associated with sexual aversion disorder such as panic attacks, if they are severe enough to be causing additional distress.

- **Prognosis:** When sexual aversion disorder is addressed as a psychological disorder, treatment can be very successful. Psychotherapy to treat the underlying psychological problems can be successful as long as the patient is willing to attend counselling sessions regularly. For sexual aversion disorder that is situational or acquired, psychotherapy for both the patient and his or her partner may help to resolve interpersonal conflicts that may be contributing to the disorder. Panic attacks caused by or associated with the disorder can be treated successfully by medication if doctor consider this form of treatment necessary.

  The prognosis varies easily.
Vaginismus:

- **Definition:** Vaginismus is a sexual disorder that is characterized by the outer third of the vaginal muscles tightening, often painfully. A woman with vaginismus does not wilfully or intentionally contract her vaginal muscles. However, when the vagina is going to be penetrated, the muscles tighten spontaneously due to physiological or other reasons. Vaginismus can occur in different circumstances. It can begin the first time vaginal penetration is attempted. This is known as "lifelong vaginismus". Alternately, vaginismus can begin after a period of normal sexual functioning. This is known as "acquired-type vaginismus". There is a relationship of this disorder with victims of rape or sexual abuse, strict religious upbringings, and issues of control.

- **Causes:** There are many possible causes of vaginismus. One example is an upbringing in which sex was considered wrong or sinful—such as in the case of some strict religious background. This is common among women with this disorder. Concern that penetration is going to be painful, such as during a first sexual experience, is another possible cause. It is also thought that women who feel threatened or powerless in their relationship may subconsciously use this tightening of the vaginal muscles as a defense or silent objection to the relationship. A traumatic childhood experience, such as sexual molestation, is thought to be a possible cause of vaginismus. Acquired-type vaginismus is often the result of sexual assault or rape.

- **Symptoms:** Vaginismus can occur when any kind of penetration of the vagina is attempted. This includes attempted penetration by a penis, speculum, tampon, or other objects. The outer third of the vagina muscles contract severely. This either prevents penetration completely, or makes it difficult and painful. The woman may truly believe that she wants to have sexual intercourse or allow the penetration. She may find that her subconscious desires or decision do not allow her to relax the vaginal muscles.

- **Diagnosis:** When a physician or gynaecologist is consulted, involuntary spasm during pelvic examination can confirm the diagnosis of vaginismus, and the physician will rule out any physiological causes for the condition. When psychological causes are suspected, referral should be made to a psychologist or psychiatrist. The symptoms must cause physical or emotional distress, or, in particular, problems with relationships. The symptoms cannot occur during the course of another mental disorder that can account for them—they must exist on their own. As mentioned, the muscle spasms cannot be the direct result of any sort of physical or medical condition for vaginismus to be diagnosed.

- **Treatment:** There are many different treatments of vaginismus, as there is a multitude of ways to treat most sexual disorders. Therapist can use behavioural, hypnotic, psychological, educational, or group therapy techniques. Multiple techniques are often used simultaneously for the same patient. Much treatment is aimed as reducing the anxiety associated with penetration.
Prognosis: Vaginismus is generally considered to be the most treatable sexual disorder. Successful treatment has been reported to be 63% higher. For different people, the possibility of success using different treatments varies, because different cases of vaginismus disorder have varying causes. Generally, a treatment plan combining two or more therapeutic techniques is recommended.

Hypersexuality:

Definition: Different terms such as sexual addition, sexual compulsivity, sexual preoccupation and hypersexuality have been used to describe hypersexual behaviours in an individual, clarifying that the cause of hypersexual behaviours was and still is controversial.

Causes: In psychiatric field, bipolar disorder, schizophrenia, mania disorder and autism, those patients are mostly suffering for hypersexuality.

Symptoms: Excessive time is consume by sexual fantasies and urges, dysphoric mood (anxiety, depression, boredom, irritability), unsuccessful efforts to control the desire to have any kind of sexual activity and often use of masturbation, pornography, cybersex, telephone sex, strip club etc.

Diagnosis: The main diagnosis method would be a deeply anamnesis from the patient, trying to find out if the patient has excessive time consumed by sexual fantasies and urges, repetitively engaging in those sexual fantasies and urges, mood state (boredom, depression...), unsuccessful control of the desire to have any kind of sexual activity and risk of emotional or physical harm (to him/her self or to others).

Treatment: psychotherapy, group therapy, family and couple therapy, medication (antidepressants, anti-androgens, luteinaizing hormone-realising hormone (LHRH), mood stabilizers and naltrexone)

Prognosis: Prognosis is good, on average, if the patient is taking medication properly and following the therapy.
- **vulvodynia:**

  - **Definition:** Chronic vulvar pain with no known cause.

  - **Types:**
    1. **Generalized vulvodynia:** is pain in different areas of the vulva at different times. Vulvar pain may be constant or occur every once in a while. Touch or pressure may or may not prompt it. But this may make the pain worst.
    2. **Vulvar vestibulis syndrome:** is pain in the vestibule. This is the entrance to the vagina. Often a burning sensation, this type of vulvar pain comes on only after touch or pressure, such as during intercourse.

  - **Causes:** Cause is unknown for now, but many researches include those as possible causes: Nerve injury or irritation, abnormal response in vulvar cells to an infection or trauma, genetic factors that make the vulva respond poorly to chronic inflammation, hypersensitivity to yeast infections, muscle spasms, allergies or irritation to chemicals or other substances, hormonal changes, history of sexual abuse and frequent antibiotic use.

  - **Symptoms:** Burning, stinging or rawness, aching, soreness, throbbing or itching

  - **Diagnosis:** Interview, asking details about sexual life when is it painful, if there is stress in those moments, past history.

**Treatment:**

1. Self care
2. Avoid potent irritants: Dermatology approve soap, soft and white toilet paper, 100% white cotton underwear, avoid shampoo in the vulvar area, avoid perfumed and contraceptive creams, avoid pools with lots of chlorine, rinse the vulva with cool water after urination or intercourse, avoid food that makes urine more irritating and keep the vulva clean and dry.
3. Use water soluble lubricants during sex, avoid activities that put direct pressure on the vulva. This includes bicycling and horseback riding.
4. Relieve pain: Soak in lukewarm or cool sit baths, after intercourse apply ice or a frozen gel pack wrapped inside a hand towel.
5. Alternatively, topical heat applied with a heating pad can reduce pain in some women with vulvodynia and try relaxation techniques.
6. Medications: local anesthetics such as lidocaine, topical oestrogen creams, tricyclic antidepressants, anticonvulsants, nerve blocks, interferon injections.
7. Therapies: physical therapy and biofeedback.
8. Surgery: there is a type of vulvodynia called vulvar vestibulitis syndrome, your doctor may suggest surgery to remove painful tissue, specially if other options are not working.

- **Prognosis:** In general prognosis is good when we reach to the right treatment.
Medication induced sexual disfunction

This is a problem that appears mostly in psychiatric patients who are taking antipsychotics.

- **Abstract:** Sexual dysfunction is a common condition in patients taking antipsychotics, and is the most bothersome symptom and adverse drug effect, resulting in a negative effect on treatment compliance. It is known that hyperprolactinemia is a major cause of sexual dysfunction. Based on the blockade of dopamine D2 receptors, haloperidol, risperidone, and amisulpride are classed as prolactin-elevating antipsychotics, while olanzapine, clozapine, quetiapine, ziprasidone, and aripiprazole are classed as prolactin-sparing drugs. Risperidone and the other typical antipsychotics are associated with a high rate of sexual dysfunction as compared to olanzapine, clozapine, quetiapine, and aripiprazole. With regard to treatment in patients suffering from sexual dysfunction, sildenafil was associated with significantly more erections sufficient for penetration as compared to a placebo.

- **Management of antipsychotic-induced sexual dysfunction:** Dopamine agonist (bromocriptine, cabergoline) and dopamine releasing agent (amantadine) were tried in a patient suffering from sexual dysfunction secondary to antipsychotics, however most of the studies are open label, uncontrolled studies, or case reports.

- **Conclusion:** While the literature clarifying the influence of antipsychotic on sexual function is limited, these studies suggest that the relative impact of antipsychotics on sexual dysfunction can be summarized as risperidone, and typical antipsychotics are associated with a high rate of sexual dysfunction as compared to olanzapine, clozapine, quetiapine, and aripiprazole. Thus, it is possible for psychiatrists to minimize the risk of sexual dysfunction through the appropriate choice of antipsychotics. With regard to treatment in patients suffering from sexual dysfunction, sildenafil was associated with significantly more erections sufficient for penetration as compared to a placebo. Subsequent studies are needed in order to provide physicians with a better understanding of this problem, thereby leading toward efficacious and safe solutions.
Paraphilias: Historically, paraphilias were termed perversions. Paraphiliac disorders are characterized by repetitive or preferred sexual fantasies or acts that involved non-human objects or non-consenting partners. In order to make the diagnosis of paraphilia, the fantasies must have existed for at least six-months, and the person should have either acted on the fantasies or suffered serious distress because of them. There are numerous categories of paraphilias including:

I. Exhibitionism: Involves exposing the genital to an unsuspecting stranger. Exhibitionist may expose their genitals to children, adolescents or adults, and in some cases masturbate while exposing their genitals.

II. Frotteurism: A frotteur is an individual who achieves sexual gratification by rubbing up against a non-consenting person. The behavior usually occurs in crowded places, such as elevators, bus, or subways.

III. Fetishism: The sexual attraction is to inanimate objects and these often include woman’s clothing, such as shoes, stockings or undergarments. Or, person can be attracted to a specific body part. Usually, the person with a fetish fondles the article to which he or she is attracted, to achieve sexual gratification.

IV. Pedophilia: The sexual arousal to prepubescent children. Some pedophiles are exclusively attracted to girls or boys while other pedophiles, termed bisexual pedophiles do not discriminate in their attraction, and might sexually molest both male and female children.

V. Sexual Sadism: A sexual sadist is an individual who is sexually aroused by inflicting pain or suffering on another person. There can be an escalation in the severity of the maltreatment of the victim over time.

Epidemiology: The majority of individuals who experience paraphilias are male in gender. About 50% of the people with paraphilias experience the development of the paraphilic disorder in adolescence. Furthermore, it is not unusual for the person to develop two or more paraphilias. The majority of people may have both a paraphilic and non-paraphilic, (nonsexually deviant) arousal pattern at the same time. An individual who has paraphilia is rarely distressed by the paraphilia and when this person presents for an evaluation or treatment, it is usually because of sexual partner or criminal justice system has recommended or mandated that an evaluation and/or treatment be given. This is particularly true of individuals who are pedophiles or ephebophiles (engage in sexual activity with those of pubertal age). The reason for this is that the individual with a paraphilia, in the majority of cases, finds the fantasies and behavior exciting and rewarding, and does not want to give up what he or she finds to be sexually exciting. In making the diagnosis of paraphilia, it is important for the clinician to remember that not all forms of inappropriate sexual behavior are the result of a paraphilic interest pattern. For example, a patient with a psychosis may, as part of his delusional system, engage in sexual activity that he might not ordinarily engage in. On occasion, individuals who are diagnosed as manic may become hypersexual and engage in forms of paraphilic behavior. Once the mania is treated pharmacologically, the inappropriate behavior may cease.
Treatment:

I. Cognitive behavioural therapy: Comprehensive Cognitive-behavioral Therapy Program for sex offenders generally includes components in the following areas: (a) behavior therapy to reduce inappropriate sexual arousal and to enhance or maintain appropriate sexual arousal, (b) training to develop or to enhance prosocial skills, (c) modification of distorted cognitions and development of victim empathy, and (d) relapse and development to enhance maintenance of treatment gains.

II. Behaviour therapy: The primary goal of behavior therapy is to teach patients techniques that they can employ to decrease and/or to control their deviant sexual urges and behaviors. A number of behavior therapies have been developed or adapted for use with sexual offenders, including electrical aversion, olfactory aversion, covert sensitization, various masturbatory reconditioning techniques, modified aversive behavioral rehearsal, and imaginal desensitization training.

III. Medication therapy: Anti-androgenic medication has been utilized with paraphilias. Their mechanism of action is, to decrease testosterone, upon which sexually motivated behavior depends, and thus libido or the sexual drive. This consequently diminishes the individual’s pattern of compulsive paraphilic behavior. Once the medication is discontinued, sexual drive returns. Consequently, it is important that the patient also receive other forms of therapy that will help redirect their sexual interests.

The main anti-androgens currently in use are the gonadotropin releasing hormone analogues that are also used for a broad range of other illnesses, including prostatic cancer, endometriosis and premature onset of puberty.

The serotonin re-uptake inhibitors are a class of antidepressants that have also been used with success to treat hypersexual states.

Paraphilic behavior is frequently accompanied by antecedent anxiety, depressive symptoms or obsessive-compulsive disorder.
Research methodology and methods:
The research was carried in the Lithuanian University of Health Sciences (LSMU) performing interviews to students, during the period from April 2014 till April 2016. The research permit was issued by LUHS biomedical and ethics committee (No.BEC-MF-58). The goals of study, confidentiality and anonymity were explained to the research respondents. The study, sample was based on 250, students from medical, odontology and physiotherapy faculty, 60% were females and 40% males. The age varies from 18 till 34 years old. The research data was collecting by interviewing to LUHS students. Results were evaluated using the CHI square test. The study consist about 68 questions, based on sexual habits and behaviours, students answered that according their prefferences.

Results and their discussion:
The sample consists on 250 LSMU students in total, from Spain, Germany, Israel, Lebanon, Sweden, Korea, Czech Republic, Portugal, Italy and Poland. Those students were asking about his sexual habits and behaviours to evaluate if they are safety and if they know what are they doing in a correct way. Also to know the different things that people like from different countries.

Relation between Oral sex and religion:

Table Nº1 Oral sex and religion.

It shows that none religious people feel more comfortable and free with oral sex, than those who are religious.
Relation between anal sex and country: Countries were divide into warm countries (Spain, Portugal…) and cold countries (Sweden, Poland…)

Table Nº2 perform of anal sex and country.

That warm countries feel much more confortable with anal sex than cold one, in this graph is one of the ones that has more marked diference between two variants.
Relation between sex in public places and age: Average from all the ages participating in this research (from 18 till 34) was calculated to perform this comparison. Average of age is 23.

Table Nº3 sex in public places and age.

It shows that people older than 23 years like to perform sex in public places more than people younger than 23 years, but results are so close to each other in general.
Conclusion:

1. The sexual habits among students were similar, there was no difference in relation to the nation.
2. Students from warm countries have tendency to feel more comfortable in different sexual habits.
3. The sexual habits among students were similar, but young students have tendency to perform sex in public places, have different sexual habits comparing with the older ones.
References:

1. webmd.com/sexual-conditions/guide/female-pain-during-sex


