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18. Discuss the characteristics of male hypoactive sexual desire disorder and female sexual interest/arousal disorder. Give and discuss two examples from biological causes of these disorders.

It is a type of disorder and mental and physical sexual dysfunction that affects women who lack the desire to have sexual relations for a period of six months. That also causes significant levels of personal distress—an integral part of an HSDD diagnosis.

Male hypoactive sexual desire disorder (MHSDD) is defined in the DSM-5 as the persistence of erotic thoughts and fantasies for the desire for sexual activity. These symptoms, according to studies, remain for around six months and can cause clinically significant distress. Formerly in the DSM, hypoactive sexual desire disorder was gender-neutral and could therefore apply to either men or women. This says that as "sexual desire and arousal problems have been combined into a single disorder for women in the DSM-5, MHSDD now accounts only for men."

Similarly, it presents the man with a low level of sexual desire; rarely, or within this condition, we see the male figure with a low level of sexual desire. Research studies have asked men if they have a lack of interest in sex, but not whether the problem is consistent over a period of 6 months and distressing. One study did examine the prevalence of distressingly low sexual interest in men

over at least a two-month period. In this study, 14.4% of men in Portugal, Croatia, and Norway reported a distressing lack of sexual desire lasting at least 2 months (Carvalheira, Traeen, & stulhofer, 2014). Men between the ages of 30 and 39 were most likely to report low sexual interest. Self-reported prevalence rates of problems with desire range from 4.8% in the U.S. (Laumann, Glasser, Neves, & Moreira, 2009) to 17% in the U.K. (Mercer et al., 2003). Desire problems appear to increase with age.

In an assessment and treatment of male hypoactive sexual desire disorder, it was found that: treatment for MHSDD differs based on the etiology of the disorder, but the most common biological treatment centers on increasing testosterone levels. Although treatments targeting testosterone have been effective, they have recently been overprescribed and overused by men with normal testosterone levels. Psychosocial treatment for MHSDD includes cognitive and behavioral components as well as attention to building strong communication between partners.

Studies point out that the different treatments for low sexual desire in men should be etiologically oriented. If the low testosterone level is determined to be the likely cause of MHSDD, biological treatment focuses primarily on increasing testosterone levels. As mentioned earlier, hypogonadism in males typically leads to low testosterone production, decreased sexual interest, and difficulties sustaining an erection. Also, cognitive-affective-behavioral therapy for MHSDD includes relationship skills-building and communication training, which are important for men who are having trouble talking about sexual preferences with their partners.

On the other hand, we have Female Sexual Interest and Arousal Disorder (FSIAD), which is defined in the DSM-5 as a lack of, or significantly reduced, sexual interest and arousal. Studies show that HSDD is characterized by the absence of sexual fantasies and a lack of desire for

sexual activity, while FSAD is characterized by the continuous or recurrent inability to retain or maintain sufficient lubrication or swelling.

One of the most frequently cited prevalence studies found low sexual interest in 22% of women in the general U.S. population (Laumann, Paik, Rosen, & Page, 1999). In a survey of women from 29 countries, rates of self-reported low sexual interest ranged from 26 to 43% (Laumann et al., 2005). For a clinical diagnosis of HSDD, which takes levels of distress into account, rates range from 7.3% (Bancroft, Loftus, & Long, 2003) to 23% (Witting et al., 2008), depending on a woman's age, cultural background, and reproductive status.

Prevalence studies of sexual arousal problems in women have focused primarily on self-reported lack of vaginal lubrication. These studies have not always included all the information necessary to diagnose FSAD, as many did not inquire about distress or level of stimulation. Also, lubrication problems have been found to increase with age and menopausal status.

The different associated factors that involved this symptom these elements are broken down into biological factors including medical health, hormones, and medications, and psychological factors including stress, relationships, comorbid mental illness, and history of sexual abuse.

In the biological aspects, endocrine levels are the most commonly discussed biological factor that may be related to low sexual interest in women. Lack of sexual desire has been associated with menopause, during which decreased ovarian function results in lower estrogen production. Androgens and estrogens govern the structure and function of the cervix, vagina, labia, and clitoris. With respect to sexual interest, androgens may be most influential, as they represent the immediate precursor to estrogen synthesis and thus affect sexual desire, mood, and energy (Goldstein, Traish, & Kim, 2004). Also, Though low androgen levels may contribute to

hypoactive sexual desire in women, the lack of reference ranges for androgens in women have made it difficult to determine when a clinical insufficiency is present.

It is very important to know that many psychoactive medications affect sexual desire. There are both intra-class and inter-class variations among antidepressants with respect to sexual dysfunction and particularly sexual desire. These variations are largely dependent on neurotransmitter receptor profiles and genetics (Clayton, El Haddad, Iluonakhamhe, Ponce Martinez, & Schuck, 2014).

Research has shown that endocrine levels play a role in female sexual arousal. Specifically, estrogens influence the physiological function of tissues, including the lower genital tissues.

In terms of psychological factors, low sexual interest and/or arousal has also been linked with a number of psychosocial factors in both men and women. After controlling for age, relationship satisfaction, and sexual satisfaction, Murray and Milhausen (2012) found that relationship duration significantly predicted variance in sexual desire. Specifically, women's sexual desire decreased as relationship duration increased.

Psychological conditions most commonly associated with a lack of sexual interest include social phobia, obsessive-compulsive disorder, panic disorder, and mood disorders—depression in particular. It is feasible that sexuality becomes of secondary importance when an individual is experiencing substantial distress in other areas of his or her life.

During an assessment, consider factors known to affect sexual functioning such as the person's age, religion, culture, the length of the relationship, the partner's sexual function, and the context of the person's life.

During treatment, have a consideration that Treatment for women experiencing low sexual desire as a result of biologically compromised natural levels of androgens, treatment with testosterone replacement therapy can be an effective option.

Also, psychological treatments for low desire include education about factors that affect sexual desire, couples exercises (scheduling times for physical and emotional intimacy), communication training (e.g., opening up about sexual issues and needs), cognitive restructuring of dysfunctional beliefs (a good sexual experience does not always end with an orgasm), sexual fantasy training (e.g., training people to develop and explore mental imagery), and sensate focus.

Finally, For women in satisfying relationships, treatment may include identifying potential distracting, negative thoughts and helping them let go of these thoughts during sexual activity. Leiblum and Wiegel (2002) described four such types of distracting thoughts in women: myths and misconceptions, like: body image, that women cannot enjoy having sex; in the same way negative emotions, performance anxiety, and body image concerns.

19. Select three of the following sexual dysfunctions: erectile disorder, early ejaculation, female orgasmic disorder, vaginismus. Define and discuss possible causes of each dysfunction.

Erectile disorders (ED) are the inability to get and keep an erection firm enough for sex. It has been reported that more than half of men between the ages of 40 and 80 experience a form of ED. Having erection problems now and then is not a bad thing. But if it happens too often, it can cause a high level of stress, affect your self-confidence, and contribute to problems in your relationships.

Many times it may be that due to certain conditions, if this happens often, it is better to contact a

doctor. ED can be caused by physical and psychological problems. Sexual eros is a process because it involves your brain, your hormones, your nerves, your muscles, and your veins.

Who can experience ED? Generally speaking, any man at any age can experience ED; of course, the older the person is, the more likely they are to experience ED. Many factors contribute to this, such as heart disease, high cholesterol, high blood pressure, diabetes, obesity, and smoking. On the other hand, depression, anxiety, stress, relationship problems, and other mental health concerns can interfere with sexual feelings.

Some of the symptoms indicate that if it makes it difficult for a man to have and maintain an erection during sexual activity, this is the first sign. This can be treated with medication, self-injection, or urethral suppositories.

Early ejaculation (Ee) or premature ejaculation: here is described where males ejaculate (comes) too soon or quickly during sexual intercourse and it's a common ejaculation problem. A study involving 500 couples found the average time for ejaculation was about 5-and-a-half minutes after starting sex. This time could be longer for men who have sex with men. International guidelines define premature ejaculation as regularly ejaculating within 1 minute of entering your partner. There are two premature ejaculations: is when the male always had the problem or when recently developed the problem.

Studies demonstrated that the causes of primary premature ejaculation are often psychological, such as having had a traumatic sexual experience at an early age. Secondary premature ejaculation can be caused by both psychological and physical factors.

The different treatments that are available as self-help, such as masturbating 1 to 2 hours before having sex, using a thick condom to help decrease sensation, and taking a deep breath to briefly shut down the ejaculatory reflex (an automatic reflex of the body, during which you ejaculate), Having sex with your partner on top (to allow them to pull away when you're close to ejaculating). Taking breaks during sex and distracting yourself by thinking about something completely different. Also, try to have couple's therapy.

In medical terms, selective serotonin reuptake inhibitors (SSRIs) can be used if self-help techniques do not improve the problem. SSRIs are mainly used to treat depression, but one of their side effects is delayed ejaculation. Also, Dapoxetine is an SSRI specifically designed to treat premature ejaculation. It can be used "on demand". You'll usually be advised to take it between 1 and 3 hours before sex, but not more than once a day. However, there are more indications that can help the person.

Female orgasmic disorder: this is a persisting or a constant delay in or absence of orgasm after the sexual arousal and adequate sexual stimulation. This diagnosed female orgasmic disorder can cause marked distress or interpersonal difficulty. The different causes of this disorder, and the main ones, are due to not being stimulated sufficiently. Worrying about sexual performance. Mood disorders, such as depression, On the other hand, problems with physical health, such as a long-term pain condition like arthritis, A previous traumatic sexual experience. And problems in the relationship, as well as hormonal changes or problems. Among others.

When can the orgasmic problem start? This can begin in two ways, the first being that a woman has never experienced orgasm. Secondary: She has had orgasms in the past, but she cannot have one now. Also, some women find they can orgasm when masturbating but not when they are

with their partner. This could be due to problems with the relationship or not being stimulated sufficiently. Some women do not need an orgasm to enjoy sex. However, for other women and their partners, being unable to have an orgasm can be a problem. Also, sexual problems in women are common, especially in older women. The different techniques that can help you with the orgasm problem: go to your doctor and check about it, read and do pelvic floor exercises. Lastly, if the cause is psychological, it may help to see a sex therapist.

20. Discuss the changes in the understanding and treatment of sexual dysfunction over the last 40 years.

In general terms, sexual dysfunction can be any problem that prevents a person or couple from experiencing satisfaction from sexual activity. Some 43% of women and 31% of men report some degree of sexual dysfunction. The different types of sexual dysfunction are sexual disorders, arousal disorders, orgasm disorders, and pain disorders. The different symptoms of this dysfunction are: Inability to achieve or maintain an erection. Absent or delayed ejaculation despite enough sexual stimulation Inability to control the timing of ejaculation.

"Data from the US National Health and Nutrition Examination Survey indicate that the prevalence of ED increased from 8.2% in men aged 40–49 years to 77.5% in those aged ≥75 years. In addition to increasing age, ED is associated with comorbidity and lifestyle factors, such as diabetes mellitus, obesity, smoking, cardiovascular disease, stroke, hypertension, and lower urinary tract symptoms."

Also, new research suggests that women's sexual function and desire can decrease significantly after age 40 several years before they reach menopause. The study, published on October 31, 2019, in the journal Menopause, found that sexual satisfaction scores decreased while sexual

dysfunction increased by about 30 percent during the perimenopause years, in large part due to vaginal dryness. Among the changes found equally are vaginal atrophy is the thinning, drying, and inflammation of the vaginal walls that can occur during age-related hormone flux, when the body produces less estrogen.

22. Discuss three approaches for treating erectile disorder and how each works.

The different treatments for ED, Most of the best-known treatments for ED work well and are safe. The different options are:

ED starts with taking care of your heart and vascular health. Your doctor may point out ‘risk factors' that can be changed or improved.

You may be asked to change certain food habits, stop smoking, increase workouts, or stop using drugs or alcohol. Your health care provider may also suggest treating emotional problems. These could stem from relationship conflicts, life's stressors, depression, or anxiety from past problems with ED (performance anxiety).

On the other hand, specific ED treatment, like: Oral drugs or pills known as phosphodiesterase type-5 inhibitors are most often prescribed in the U.S. for ED (Viagra, Cialis, Levitra, Stendra). Testosterone Therapy (when low testosterone is detected in blood testing). Penile Injections (ICI, intracavernosal Alprostadil). Intraurethral medication (UI, Alprostadil). Vacuum Erection Devices. Penile Implants. And surgery to bypass penile artery damage for some younger men with a history of severe pelvic trauma. Penile vascular surgery is not recommended for older men with hardened arteries.

Resources:

https://labs.la.utexas.edu/mestonlab/hypoactive-sexual-desire-disorder/

https://labs.la.utexas.edu/mestonlab/female-sexual-interestarousal-disorders/

https://www.mayoclinic.org/diseases-conditions/erectile-dysfunction/symptoms-causes/syc-20355776#:~:text=Physical%20issues%20like%20heart%20disease,also%20interfere%20with%20sexual%20feelings.

https://www.nhs.uk/common-health-questions/sexual-health/can-premature-ejaculation-be-controlled/#:~:text=The%20causes%20of%20primary%20premature,both%20psychological%20and%20physical%20factors.

https://www.uptodate.com/contents/treatment-of-female-orgasmic-disorder/print#:~:text=INTRODUCTION,or%20interpersonal%20difficulty%20%5B1%5D.

https://www.nhs.uk/common-health-questions/sexual-health/what-can-cause-orgasm-problems-in-women/#:~:text=Common%20causes%20of%20orgasm%20problems,mood%20disorders%2C%20such%20as%20depression

https://my.clevelandclinic.org/health/diseases/9121-sexual-dysfunction

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5540144/

https://www.everydayhealth.com/womens-health/sexual-dysfunction-in-some-women-can-occur-years-before-menopause-research-suggests/

https://www.urologyhealth.org/urology-a-z/e/erectile-dysfunction-(ed)