Human Sexuality

By

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NORMAL SEXUALITY

- Sexuality depends on four interrelated factors:

1. sexual identity,
2. gender identity,
3. sexual orientation,
4. sexual behavior.

- These factors affect personality growth, development, and functioning.
- Sexuality is something more than physical sex, coital or non-coital, and 'something less than all behaviors directed toward attaining pleasure.

- **Sexual identity** is personal biological (anatomical sexual organs, and chromosmoal).
- **Gender identity** is a person's sense of being male or female. When this sense of identity is at variance with the anatomical sex, the person is said to have a gender identity disorder.
- **Sex** is what you **see** **(biological organs)** **gender** is what you **feel** **(psychological feeling).**
- **Sexual orientation** refers to the various aspects of sexual attraction towards members of the opposite or the same sex.
- **Sexual dysfunction** denotes impaired or dissatisfying sexual enjoyment or performance. Such conditions are common.
- **Abnormalities of sexual preference** are uncommon, *but they take many forms*. Sexual excitement occur only certain circumstant.

SEXUAL IDENTITY AND GENDER IDENTITY

- **Sexual identity** is the pattern of a person's biological sexual characteristics: chromosomes, external genitalia, internal genitalia, hormonal composition, gonads, and secondary sex characteristics.
- **In normal development**, these characteristics form a cohesive pattern that leaves a person in no doubt about his or her sex.
- **Gender identity** is a person's **sense** of maleness or femaleness.

SEXUAL IDENTITY

- Modem embryological studies have shown that all mammalian embryos, whether genetically male (XY genotype) or genetically female (XX genotype), are anatomically female during the early stages of fetal life.
- Differentiation of the male from the female results from the action of fetal androgens; the action begins about the sixth week (1.5 month) of embryonic life and is completed by the end of the third month.

- **Fetal hormones** affect the **masculinization** or **feminization** of the **brain** which is necessary for male and female reproductive.
- The **fetus** is **also vulnerable** to **exogenously administered androgens** during that period. For instance, if a **pregnant woman** receives sufficient **exogenous androgens**, her **female fetus** possessing ovaries can develop **external genitalia** resembling those of a **male**.

GENDER IDENTITY

- By the age of 2 to 3 years, almost everyone has a firm conviction that "I am male" or "I am female."
- Yet even if maleness and femaleness develop normally, people must still develop a sense of masculinity or femininity.
- Gender identity, according to **Robert Stoller,**

1. "connotes psycho-logical aspects of behavior related to masculinity and feminity."
2. He considers ***gender social and sex biological***:
3. Most often the two are relatively congruent, that is, males tend to be→ manly and females → womanly.
4. But less common sex and gender may develop in conflicting or even opposite ways.

- **Gender identity** results from an almost unlimited series of cues derived from experiences with family members, teachers, friends, and coworkers and from cultural phenomena.
- **Physical characteristics** derived from a person's biological sex such as physique, body shape, and physical dimensions-interrelate with an intricate system of stimuli, including rewards and punishment and parental gender labels, to establish gender identity.
- Thus, formation of gender identity arises from:

1. parental and cultural attitudes,
2. the infant's external genitalia,
3. genetic influence, which is physiologically active by the sixth week of fetal life.

Gender Role.

- Related to, and in part derived from, gender identity is gender role behavior.
- John Money and Anke Ehrhardt described gender role behavior as all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively.
- A gender role is not established at birth but is built up cumulatively through experiences encountered and transacted through casual and unplanned learning, through explicit instruction and inculcation, and through spontaneously putting two and two together to make sometimes four and sometimes five.
- The usual outcome is a con-gruence of gender identity and gender role. Although biological attributes are significant, the major factor in achieving the role appropriate to a person's sex is learning.

- Sex differences in children's behavior (similarities and differences).

❖ However, girls are found to be less prone to tantrums after the age of 18 months than are boys, and boys generally are more physically and verbally aggressive than are girls from age 2 onward.

❖ Little girls and little boys are similarly active, but boys are more easily stimu-lated to sudden bursts of activity when they are in groups.

❖ Some researchers speculate that although aggression is a learned behavior, male hormones may have sensitized boys' neural orga-nizations to absorb these lessons more easily than do girls.

- People's **gender roles can** seem to be **opposed** to **their gender identities**.

1. People may identify with the opposite sex and yet for usefulness adopt many behavioral characteristics of their own sex (و احدة يعجبها راجل معين و تتصرف ذية في بعض التصرفات).
2. Or the may identify with their own sex and yet adopt the dress, hairstyle, or other characteristics of the opposite sex (وحدة مسترجلة مع احساسها انها انثي).

NORMAL SEXUAL BEHAVIOR

- **Physiological Responses**
- Sexual response is a true psycho-physiological experience.
  - ❖ Arousal is triggered by both psychological and physical stimuli
  - ❖ levels of tension are experienced both physiologically and emotionally
  - ❖ with orgasm, there is normally a subjective perception of a peak of physical reaction and release of tension.
  - ❖ Psychosexual development, psychological attitudes toward sexuality, and attitudes toward one's sexual partner are directly involved with and affect the physiology of human sexual response.
  - ❖ Normal men and women experience a sequence of physiological responses to sexual stimulation.

- the physiological process involves increasing levels of vaso-congestion and myotonia (tumescence) and the subsequent release of the vascular activity and muscle tone as a result of orgasm (detumescence).
- The text revision of the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) defines a four-phase response cycle: **phase 1, desire; phase 2,excitement; phase 3, orgasm; phase 4, resolution.**

Phase 1: Desire.

- The classification of the desire (or appetitive) phase, reflects the psychiatric concern with motivations, drives, and personality.
- The phase is characterized by sexual fantasies and the desire to have sexual activity

Phase 2: Excitement.

- The excitement and arousal phase, brought on by psychological stimulation (fantasy or the presence of a love object) or physiological stimulation (stroking or kissing) or a combination of the two, consists of a subjective sense of pleasure.
- During this phase, penile tumescence leads to erection in men and vaginal lubrication occurs in women.
- The nipples of both sexes become erect, although nipple erection is more common in women than in men.

- A woman's clitoris becomes hard and turgid, and her labia minora become thicker as a result of venous engorgement.
- Initial excitement may last from several minutes to several hours.
- With continued stimulation,
  1. a man's testes increase 50 percent in size and elevate.
  2. A woman's vaginal barrel shows a characteristic constriction along the outer third, known as the *orgasmic platform.*
  3. The clitoris elevates and retracts behind the symphysis pubis, and as a result is not easily accessible.

- Stimulation of the area, however, causes traction on the labia minora and the prepuce and there is intrapreputial movement of the clitoral shaft.
- Women's breast size increases 25 percent.
- Continued engorgement of the penis and the vagina produces color changes, particularly in the labia minora, which become bright or deep red.
- Voluntary contractions of large muscle groups occur, the rates of heartbeat and respiration increase, and blood pressure rises.
- Heightened excitement lasts from 30 seconds to several minutes.

Phase 3: Orgasm.

- The orgasm phase consists of a peaking of sexual pleasure, with the release of sexual tension and the rhythmic contraction of the perineal muscles and the pelvic reproductive organs.
- A subjective sense of ejaculatory inevitability triggers men's orgasms. The forceful emission of semen follows.
- The male orgasm is also associated with four to five rhythmic spasms of the prostate, seminal vesicles, vas, and urethra.

- In women orgasm is characterized by 3 to 15 involuntary contractions of the lower third of the vagina and by strong sustained contractions of the uterus. flowing from the funds down-ward to the cervix.
- Both men and women have involuntary contractions of the internal and external anal sphincters. These and the other contractions during orgasm occur at intervals of 0.8 second.
- Other manifestations include voluntary and involuntary movements of the large muscle groups, including facial grimacing and carpopedal spasm.
- Blood pressure rises 20 to 40 mm (both systolic and diastolic), and the heart rate increases up to 160 beats a minute.
- Orgasm lasts from 3 to 25 seconds and is associated with a slight clouding of consciousness.

Phase 4: Resolution

- Resolution consists of the disgorgement of blood from the genitalia (detumescence), which brings the body back to its resting state.
- If orgasm occurs, resolution is rapid and is characterized by a subjective sense of well-being, general relaxation, and muscular relaxation.
- If orgasm does not occur, resolution may take from 2 to 6 hours and may be associated with irritability and discomfort.

- After orgasm, men have a refractory period that may last from several minutes to many hours; in that period they cannot be stimulated to further orgasm.
- Women do not have a refractory period and are capable of multiple and successive orgasms.

Hormones And Neuro-hormones And Sexual Behavior

- ***substances that increase dopamine*** levels in the brain increase desire,
- ***substances that augment serotonin*** decrease desire.
- ***Testosterone*** increases libido in both men and women,
- ***estrogen*** is a key factor in the lubrication involved in female arousal and may increase sensitivity in the woman to stimulation.
- ***Progesterone, prolactin and cortisol*** mildly depresses desire in men and women.
- ***Oxytocin*** is involved in pleasurable sensations during sex and is found in increased levels in men and women after orgasm.

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Masturbation

- Masturbation is usually a normal precursor of object related sexual behavior.
- Research by Alfred Kinsey into the prevalence of masturbation indicated that nearly all men and three fourths of women masturbate sometime during their lives.
- Longitudinal studies of development show that sexual self-stimulation is common in infancy and childhood. Just as infants learn to explore the functions of their fingers and mouths, so too do they learn to do the same with their genitalia.

- At approximately 15 to 19 months of age, both sexes begin genital self-stimulation.
- Pleasurable sensations result from any gentle touch to the genital region, Those sensations, coupled with the ordinary desire for exploration of the body, produce a normal interest in masturbatory pleasure at that time.
- Children also develop an increased interest in the genitalia of others parents, children, and even animals.
- As youngsters acquire playmates, the curiosity about their own and others' genitalia motivates episodes of exhibitionism or genital exploration.
- Such experiences, unless blocked by guilt) fear, contribute to continued pleasure from sexual stimulation.

- With the approach of puberty, the upsurge of sex hormones, and the development of secondary sex characteristics, sexual curiosity is intensified, and masturbation increases.
  - Adolescents are physically capable of coitus and orgasm but are usually inhibited by social restraints. Masturbation is a normal way to reduce sexual tensions.
  - In general, males learn to masturbate to orgasm earlier than females and masturbate more frequently.
  - This autoerotic activity is usually maintained into the young adult years, when it is normally replaced by coitus.

- Couples in a sexual relationship do not abandon masturbation entirely.
  - When coitus is unsatisfactory or is unavailable because of illness or the absence of the partner.
  - Kinsey reported that when women masturbate, most prefer clitoral stimulation.
  - Most men masturbate by vigorously stroking the penile shaft and glans

- Moral taboos against masturbation have generated myths that masturbation causes mental illness or a decrease in sexual potency.

  - No scientific evidence supports such claims.
  - Masturbation is a psychopathological symptom only when it becomes a compulsion beyond a person's willful control. Then it is a symptom of emotional disturbance, not because it is sexual but because it is compulsive.

SEXUAL ORIENTATION

- Sexual orientation describes the object of a person's sexual impulses:
  1. heterosexual (opposite sex),
  2. homosexual (same sex),
  3. or bisexual (both sexes).
- Kinsey et al. (1948) found that
  - people cannot be divided sharply into those with homosexual and those with heterosexual orientation.
  - In-between (continuum) people who experience in varying degrees both homosexual and heterosexual attraction and fantasies, who engage in varying mixtures of homosexual and heterosexual behaviour.

HOMOSEXUALITY

- In 1973, homosexuality was eliminated as a diagnostic category by the American Psychiatric Association (APA) and in 1980 was removed from DSM.
- The 10th revision of *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) states: "Sexual orientation alone is not to be regarded as a disorder."
- This change reflects a change in the understanding of homosexuality, which is now considered to occur with some regularity as a variant of human sexuality, not a pathological disorder.
- As David Hawkins wrote, "The presence of homosexuality does not appear to be a matter of choice; the expression of it is a matter of choice."

- **sexual orientation should be assessed against six criteria**:

1. sexual attraction,
2. sexual fantasies,
3. sexual behaviour,
4. affectional relationship preference,
5. lifestyle,
6. self-identification.

The expression of homosexual and heterosexual behavior varies in the same person with age and with circumstances.

1. The potential for bisexual attraction and behavior seems to be greater in adolescence than in adult life.
2. Also, homosexual behaviour is more likely to be expressed when heterosexual behaviour is unavailable, for example in prisons
3. homosexual behaviour more likely to be suppressed when religious beliefs or the attitudes in the society are strongly disapproving.

- **Determinants of sexual orientation**
- The determinants of sexual orientation are not known.
- Several theories have been proposed, concerned with:
  1. genetic factors,
  2. hormonal influences,
  3. neuroanatomical differences,
  4. psychological factors.

A) Genetic determinants:

Twin and adoption studies

- Several investigators have reported that MZ twins are more often alike in respect of homosexuality than are DZ twins.
- These findings are compatible with a genetic etiology, but could also arise if the early environment of MZ twins is more similar in crucial ways than that of DZ twins.
- Adoption studies could exclude this possibility.

Chromosome studies

- No convincing evidence has been reported of chromosome differences homosexuals.
- Although a linkage with chromosome Xq28 has been reported, the methodology of the study has been criticized and the finding was not confirmed in a subsequent study .

B) Hormonal theories

- the intrinsic pattern of the mammalian brain is female, and that the development of male brain characteristics depends on androgen production by the fetus.
- Moreover, although male animals engage at times in sexual behaviour with other males, exclusively homosexual behaviour probably occurs only in humans

- **If prenatal hormonal levels determine sexual orientation,**

1. there should be an excess homosexual orientation among males with syndromes of prenatal androgen deficiency or insensitivity,
2. among females with syndromes involving androgen excess.
3. No such increase has been observed among men with androgen deficiency or insensitivity
4. However, an increased rate of homosexual orientation has been reported among women with congenital virilizing adrenal hyperplasia.
5. The interpretation of this finding is uncertain because these females are born with masculinized external genitalia, and it is possible that sexual orientation in adult life was affected by this feature rather than by a direct effect of hormones on the brain.

C) Neuroanatomical differences

- There have been reports of differences, between homosexual and heterosexual men,

1. in the structure of the hypothalamus and suprachiasmatic nucleus,
2. but these studies have been criticized on technical grounds.

Psychological causes

- Theories about psychological causes of sexual orientation derive mainly from psychoanalytical studies.
- The theories generally suppose that homosexual orientation among males is determined by:
  - poor relationships with the parents in early childhood:
  - a distant relationship with, or prolonged absence of the father; or an overprotective mother.
  - Identification with other sex (mother)
- homosexual orientation among females is supposed to result from problems in early relationships with a mother who is rejecting or indifferent and identification with father

Sexuality & Adolescent Development

- Social factors shape and interact with biology.

- Learn how to act out sexual feelings on the basis of social attitudes, extracted from cultural contexts.

Social Influences on Adolescent Sexuality

A. Proximal Social Influences

- Parents

  Attitudes initially formed at home and so parental models and Teachings are important.
- Peers

  Later children are influenced by peer groups and the wider social arena.

- The Religious environment influence sexual attitudes and sexual guilt.

- The education level and work experience of parents
- Peer influence and positive or negative pressure can be through:
  - peer information
  - peer attitudes
  - peer behaviour

Studies show in Adolescent sexual activity and FP use

Peers have 70-73% of influence,
Mothers have 33-37% influence ***Fathers*** have 15% influence

B. Distant Social Influences

1. **The Youth Culture**

(a) **Sets of beliefs, fashions, leisure, music influenced by:**

(a) print, media, definitions of female femininity and desirability, definitions of maleness, lyrics, etc.

(b) **Adult models of sexual behaviour**

- Parents are not the only role models→ other adults in society

(c) **Media models of sexual behaviour**

Movies and videos reinforcing roles and messages -

- women as passive victims
- women as sexual beings
- women as play things

2. **Social Institutions**

(a)School

(b) Religion

(c)The Law

Psychological problems related to sexual orientation

- People may consult doctors about five kinds of problem related to sexual orientation.
- Many of these problems are related to:
  1. public attitudes,
  2. religious convictions,
  3. personal beliefs that conflict with the person's sexual orientation.

1. Uncertainty about sexual orientation

- Shy and sexually inexperienced young men may seek advice because they are uncertain of their sexual orientation.
- Treated by sympathetic discussion in which they are allowed time to reflect on their situation.

II. Problems in adolescence

- uncertain about the implications for their lives especially if they encounter intolerant attitudes.
- ask whether their sexual orientation is likely to change, as they grow older. **(There are no reliable data, but it seems that a person who has reached adult life without experiencing heterosexual attraction or fantasies is unlikely to develop these later.)**

III. Problems in early adult life

- ask for help with emotional disorders related to sexual or social relationships, or when their sexual urges conflict with religious or other beliefs.
- ask for help with problems related to the unfavourable attitudes of other people.
- Some homo-sexual women marry and then seek advice, about dysfunction in heterosexual intercourse.

IV. Problems in middle age

- People who have not formed a stable sexual relationship may become lonely and depressed if they do not have close friends and family.
- Men who have depended previously on casual sexual experiences may find these harder to arrange as they grow older and may turn towards prostitutes.

Other problems

- Other problems are often related to fears of sexually transmitted diseases, AIDS,
- People with these problems require appropriate medical treatment and counselling.

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نور الحياه

للطب النفسى وعلاج الادمان

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