KAPITEL 6 / *CHAPTER 6* [7]
PSYCHOLOGICAL THERAPY OF SEXUAL PROBLEMS

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Introduction.

Sexual dysfunctions may be observed in many people during their life; they are often transient, arising as a result of specific stress between partners. These dysfunctions are particularly easy to treat. The factors causing anxiety (cognitive, behavioural, and emotional) are identified, and the couples receive behavioural tasks doing which aims to reduce the anxiety connected with sexual intimacy, leading to elimination of the symptoms. However, in some cases, sexual dysfunctions are caused by less deep psychological factors.

Sex therapy as a behavioural approach developed by Masters and Johnson. They offered currently known techniques focused on sensitivity, genital stimulation, and optional sexual intercourse, used in most approaches to the treatment of sexual dysfunctions. Focusing on the sensitivity involves gentle stroking of the body, without touching the genitalia and without sexual contact.

Sex therapy techniques are most effective in treating loving, attached partners who have no serious psychopathologies or marital conflicts. E. Kaplan believes that predictors of poor outcome of sex therapy may also be substance abuse, severe depression or anxiety, and lack of motivation for treatment. In the absence of these contraindications, up to 80% of cases of sexual dysfunctions can be successfully treated using the methods of short-term behavioural therapy.

6.1. Family Sex Therapy

Sex therapy can be described as an attempt to modify relations in the context of the family system. Sex therapy sees symptomatic behaviour and problems as a result of an improper interaction and not as an individual characteristic of a family member. Therefore, sex therapy mostly practises interpersonal, not intrapsychological approach.

This systematic theory, from the therapeutic point of view, proposes to consider the family process as the one in which each member of the family plays a certain role in maintaining the system. The “identified patient” can be seen as a “problem,” but the “reason” is the dysfunctional family system itself. The task of the therapist is to change the system through appropriate interventions. This systematic theory of therapeutic standpoint proposes to consider the process as a family in which each member of the family plays a role in maintaining the system. "Identified patient" can be seen as a "problem", but "reason" is a very dysfunctional family system. The task of the therapist

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is to change the system through appropriate interventions. There are many areas that apply different techniques, but what they all have in common is the principle that the problem is in the system, not its individual element.

The system consists of interdependent elements with mutual causality; their dynamic connection provides relative stability of the system over time. There are open systems (i.e., tending to continual development or undergoing some changes) or closed. A family is an open system; characterised by three qualities: integrity, relationships, and equifinality.

Integrity means that the system is formed by interactions, not just a certain number of people. Relationships mean interactions within the system, everything that happens in the family among its members, their constant interactions and repetitive patterns of such interactions. Equifinality is the quality of the systems, through which they operate regardless of the initial reasons, and may change due to current factors. They are not defined by their output parameters.

Below are the earliest concepts that form the basis of the four leading contemporary theories.

1. *Interlocking pathology.* R. Nathan Ackerman introduced the concept of interlocking pathology, when the problems of one family member lock with other members through interactions. Ackerman watched these mixed roots in the family system and became convinced that they were mostly not admitted by family members. The notion of interlocking unconscious pathologies is supported by the object relations school.

2. *Fusion.* Murray Bowen introduced the concept of fusion – a phenomenon first mentioned in families of patients with schizophrenia, but also seen in the so-called normal families. The fusion means that individual family members cannot act independently of each other and fuse together to form an indefinite amorphous mass. Psychotherapy by Bowen aims to "split" the family members.

3. *Pseudo-mutuality.* Lyman Wynne and his co-authors studied the wrong type of closeness or intimacy, which they called "pseudo-mutuality," characterised by the loss of boundaries between individual family members. As a way of correcting this pseudo-intimacy, Wynne proposed to change the boundaries by removing the existing alliances, splitting them, and creating new coalitions. Minuchin called the same phenomenon "enmeshment." The aim of structural sex therapy is to create new alliances to help the members "unmesh" or allow the "split" family members become more independent. Structural family therapy is based on Wynne's ideas.

4. *The Double Bind.* The double bind can be briefly described as a pattern of interaction characterised by severe restrictions imposed by the paradoxical communication within the important, emotionally meaningful relationships, which results in an unacceptable solution, from which its members are not able to get out (Ebelis). These processes in their strong manifestation are found in families with schizophrenia, their milder forms may also be found in the healthy ones. The discovery

of the "double bind" forced researchers to pay more attention to the laws controlling communication. According to Bateson, each message has two aspects: a message and a command. The command follows a number of rules that are formed over time and tend to become self-reinforced.

This observation led to the idea that there is no need to delve into the search for symptoms to trigger a therapeutic change – you just need to pay attention to the behaviour supporting the system.

Psychological examination in case of sexual dysfunction. The examination of people with sexual dysfunction has its own peculiarities. It includes a description of the sexual status, life history with an emphasis on family history, medical and psychiatric history, and, finally, psychosexual history.

During the interview (preferably together with a sexual partner), forms a detailed and complete picture of sexual experience of the couple, which reflects the current status and the previous dynamics. Initially we specify the features of sexual dysfunction and look into the circumstances of the first unsuccessful intercourse. Determine the intensity of libido, nature of arousal, duration of foreplay and intercourse, nature of orgasm, feeling and mood before and after the intercourse. Should be noted the dynamics of the disorder and each partner's reaction to it to obtain the information about the previous counselling, if any.

When describing sexual status, it seems reasonable to use various special questionnaires that assess the state of sexual function in every phase of sexual response W. Masters and his co-authors distinguish four phases of sexual response: excitement, plateau, orgasm, and resolution. H. Kaplan and B.J. Sedok also divide sexual response into 4 phases: desire (a new phase missing in W. Masters, et al.), excitement (which includes the phases of excitement and plateau according to W. Master and B. Johnson), orgasm, and resolution. An example is the Eysenck Inventory of Attitudes to Sex (EIAS).

Family history includes clarifying such issues as age and reasons of entering into marriage, number and age of children. If present, the causes of divorce and nature of the relationship with the ex-husband and children. If possible, the information about possible extramarital affairs, their motives and impact on marriage.

Medical history is intended to exclude the possibility that the sexual dysfunction is caused by somatic disease and pharmacological effects. Take into account the role of neuroendocrine disorders, urological and gynaecological diseases, alcohol and drugs, psychotropic and hypotensive drugs, and sex hormones.

Psychological and psychiatric examination solves the following tasks:

1) Identifying and defining the nature of psychopathology in each;
2) Defining the character and relationship type of the partners;
3) Preliminary assessment of the sexual dysfunction in the dynamics of intimate relations.

First, identify the presence of pathological heredity and pathological influences in

early childhood, personal characteristics of parents and the nature of their relationship, number of children in the family, which of them by number is the client. How the parents treated the client's gender, how relationships with siblings and peers of both sexes developed. What education the client has, how their employment developed, what material living conditions they have at present, what plans for the near future they have. Sexual dysfunctions are often caused by neurotic and psychopathic mechanisms. In these cases sexual symptoms not only reflect the actual interpersonal conflict, but also serve as a psychological defence, which is a part of the intrapersonal conflicts. [1] Therefore, great importance is given to the analysis of psychosexual development of the client, considering their relationship with their father and mother, first sexual experiences, repressed desires, fears and unresolved intrapsychic conflicts.

Psychosexual history is problem-oriented, i.e., it takes into account peculiarities of the particular case. Diagnosis is made using Friedman questionnaire. Find out the client's attitude to sexuality, their own gender role, the opposite sex in general and to a specific sexual partner in particular; determine their attitude to their father, mother and other family members; learn about the first sexual information, first erotic relationships, and possible sexual trauma they experienced. Specify what the person expects from their sex partner, which behaviour attracts and which pushes away.

Psychosexual history includes the following subjects:

- First signs of libido;
- First appearance and regularity of pollutions (for women – menstruation);
- Factors that help form the idea of sexual norms;
- Age and subjective evaluation of the first sexual intercourse;
- Dynamics of sex life before and during marriage;
- Age of adopting a relatively physiological rhythm;
- Age and maximum level of excesses;
- Periods of sexual abstinence in marriage and tolerance to them;
- Influence of physical and psychological stress, psychoactive substance, medicine, and diseases on the sexual function;
- Influence of pregnancy, childbirth, and abortions on the sexual function.

H. Kaplan (1994), during an interview on psychosexual history, proposed each of the partners to answer the following questions:

- What excites you?
- What makes sex fade away?
- What are your fantasies, unconscious hopes and fears?
- Did you have a normal sexual development?
- When did you feel the first sexual experience?
- Have you ever felt the prohibition on sexual experiences in childhood?
- Was it due to unpleasant circumstances?
- What were your first erotic fantasies?
- What did you feel about them?

- Was there any sexual experience in your childhood, which you failed to hide?
- What was your attitude to sex?
- How do you remember your first sexual contact?
- Did you experience a feeling of pleasant excitement? Or guilt? How did your partner behave? How did you break up?
- What erotic feelings and situations excited you in the past?
- How and under what circumstances did you manage to achieve satisfaction?
- How do you experience orgasm?
- What is most exciting for you?
- What are your common fears in the intimate sphere?
- What do you feel towards your body, breasts, genitalia, buttocks?
- How do you perceive your body?

In order to get the information on the stability of gender roles, we apply the autobiography method. "Autobiography" is a questionnaire designed by psychologists and psychiatrists at the Family Reproduction Center for people who want to change their sex. Analysis of responses is based on the following gender role components:

- Self-perception;
- Attitude to own and another gender's clothes;
- The nature of friendly relations;
- The development of sexual relations;
- The focus of sexual desire;
- The nature of sexual relations;
- The concept of family life;
- The desire to change anything.

Psychologists, psychiatrists, and sexologists note that people with gender role instability see themselves as people with the wrong sex, they usually have friends among the peers of the opposite sex (until adolescence). Sexual desire is directed at the people of the same sex. During sexual games, they never fully undress because they cannot stand the look of their genitalia, being even more embarrassed to show them to somebody else. First, they want to change their sex and persistently strive for it.

Thus, currently the main schools of sex therapy are the following: the object relations theory, Bowen theory, structural family therapy, and the communication theory.

6.2. The Main Schools of Family Therapy

6.2.1. Object Relations Theory

This approach owes its origin to Melanie Klein, who claimed that interaction with other people does not meet the instinctive needs, but helps developing Self towards splitting itself from the objects.

Following this perspective, the therapist draws attention primarily on denied unconscious projections and especially the cooperation of family members in this process. Therapists of this school spend longer working on biographical aspects and problems of relationships between generations, not the symptoms, considering the latter as a consequence of the former.

6.2.2. Bowen Theory

Bowen theory evolved into an integrated system and includes the following eight interrelated concepts:

a) Triangles (under stress, one of the participants of the interaction gets involved into a relationship with a third party);

b) Differentiation of Self (the degree or amount of fusion);

c) Nuclear Family Emotional System (emotional functioning of a single generation family);

d) Family Projection Process (how children develop symptoms when they get caught up in the previous generation's anxiety about relationships);

e) Emotional Cutoff (relationships between the generations);

f) Multigenerational Transmission Process (how pathology is passed down from generation to generation);

g) Sibling Position (defines a person's understanding of the world);

h) Societal Emotional Process (social problems similar to those revealed in the family).

The purpose of Bowen theory is to help an individual in their differentiation or psychological separation from the family, in transition from the state of fusion to forming a "solid" self (as opposed to "pseudo-self," in which a person is still psychologically fused with the family system). The therapist appears as a "coach" who teaches differentiation to family members. The importance of not feelings, but thinking is emphasised. The process of differentiation continues throughout life, as an individual seeks to keep the connection with the family system, while remaining an autonomous unit.

Triange is "the building block or "molecule" of larger emotional systems" (Bowen).

When the inevitable anxiety in a dyad grows, it involves a third party to keep the balance of the system. This idea proved fruitful for sex therapy and helped many therapists understand the role of symptoms, relationships, and psychosomatic diseases in the aspect that leads to new options for intervention.

6.2.3. Structural Family Therapy

Salvador Minuchin developed a short-term therapy method aimed at the reconstruction of family structures.

S. Minuchin's method goes back to the ideas of leveling tendency defined by

Lyman Wynne, and the theories of G.S. Sullivan. S. Minuchin aims to change the structure of alliances and coalitions among family members and change their "perception" of one another.

S. Minuchin focuses on the actual interaction between family members, reinforcing watching behaviour. He sees the family structure as a source of the problem of family maladjustment, because it needs a symptoms carrier to operate. He strives for changing the existing structure without bothering about its origin. The family system is dysfunctional in the here-and-now" situation and the cause of its existing organisation, not as a result of past events. The past does not interest structural sex therapists.

6.2.4. Communication Theory

This approach directly back to the Bateson's theory of the double bind, in which the pathology is presented as a problem of communication. The focus here is entirely placed on the actual system interaction without the cause or origin of the problem.

The aim of this approach is to change the rules of the system. This may mean injuction of the symptoms or the use of paradox as a way to change the rules.

Nonetheless, a relatively high theoretical elaboration in science of the issues of psychosexual development does not increase the level of understanding of the importance of this aspect in shaping the child's personality. It seems to us that everyday practice can still be characterised as "asexual pedagogy" and "feminine pedagogy" for sure. It is quite optimistic to see over the recent years expanding teaching personnel in many educational institutions with the positions of psychologist, counselling psychologist, as well as modernisation, quality upgrade, multivariate course of "Ethics and Psychology of Family Life," and numerous developments of modern sex education curricula. Sadly, though, most of public educational institutions remain uninvolved into the problems of sexual self-identity formation and personal psychosexual culture.

6.3. The Main Sexual Disorders from Psychological Point of View

Sexual deviations mean socially unacceptable forms of sexual behaviour. So far there has been no consensus on the causes of sexual perversions. Their roots are explained by organic diseases and genetic factors, hormonal metabolism disorders and psychological trauma, especially in the early period of development.

There are two types of sexual deviations: by the choice of object (fetishism, paedophilia, bestiality, etc.) and by the purpose of sexual desire (transvestism, exhibitionism, voyeurism, sadism, masochism, etc.).

Fetishism is a sexual fixation on clothing or non-genital body parts. It is more common among men.

Paedophilia is an abnormal sexual attraction to children. A paedophile usually has masochistic inclinations and is impotent. The child is treated as a non-threatening sexual object.

Transvestism is receiving sexual pleasure from dressing in clothes of the people of the opposite sex or taking the role of another gender. It is more common among men. These people display undifferentiated gender identity since childhood.

Exhibitionism is deriving sexual pleasure from exposing one's genitalia in front of the opposite sex. It means a compensatory desire to confirm one's sexuality, and is more common in men. The victim's fear is a prerequisite for sexual pleasure.

Voyeurism is a sexual deviation opposite to exhibitionism, when sexual gratification is obtained from spying on a naked person of the opposite sex. This is the ultimate goal of sexual desires.

As the attitude to homosexuality in many countries is changing rapidly, it is distinguished among sexual dysfunctions and deviations.

Homosexuals also include bisexuals engaging into sexual contacts with people of both sexes. Homosexuality is quite common (1-4% of men, 1-3% of women). As before, there is a discussion on whether homosexuality is a sexual deviation – some experts attribute it to social deviations. Some authors consider homosexuality as a normal variation of sexual preference, which excludes the question of its treatment, and during counselling one can only discuss the problem of social prejudice. [2] Most counsellors have a considerable difficulty impartially listening to homosexuals talking about their relationships problems, even though these are in fact the same difficulties that occur in heterosexual relations, e.g., jealousy, competition, domination, boredom, infidelity, etc.

Let us look into sexual disorders and gender identity disorders.

Sexual desire plays a key role in personal development, sex is connected with satisfaction of basic needs and affects self-esteem. Most of us are interested in the manifestation of pathological forms of sexual behaviour and all of us care how normal is our own sexuality.

There are two types of sexual disorders: sexual dysfunctions and perversions. People with sexual dysfunctions do not show a normal sexual response. People prone to all sorts of paraphilias (distortions, perversions) experience constant and strong sexual impulses in such situations or in relation to those objects which others would find inappropriate. People with the tendency to paraphilias fantasise about having sex with these objects or express their impulses in the relevant act. They can be aroused by having sex with a child or exposing their genitalia to strangers. In addition to these common sexual disorders, there is also a gender identity disorder, which is directly related to gender identity when an individual identifies with the opposite sex.

Sexual dysfunction is a disorder when people show no natural sexual responses and experience difficulty during sexual interaction or do not get pleasure from sex. Typically, such dysfunctions cause suffering, frustration or guilt, decreased self-

esteem, and problems in interpersonal communication.

Many people may suffer from multiple dysfunctions simultaneously. We are going to describe the most typical sexual dysfunctions among heterosexual couples. These observations may also apply to homosexual couples because they display the same dysfunctions that require almost the same technique of therapy.

Sexual response represents a cycle of four phases: desire, arousal, orgasm, and resolution. Sexual dysfunctions affect the first three phases of the cycle. Satisfaction means a simple relaxation and discharge of tension after an orgasm. Some people have a lifetime struggle with sexual dysfunction; in other cases, normal sexual functioning may precede the appearance of dysfunction. Sometimes dysfunction occurs in all sexual situations, and sometimes it is only connected with particular cases.

Disorder of the desire phase.

Desire in sexual response cycle involves encouraging sex, sexual fantasies, and sexual drive. Two dysfunctions – reduced sexual drive and sexual aversion – affect desire.

Sexual dysfunction is a disorder in which a person is not able to function normally in certain phases of the sexual response cycle.

Desire is the phase of sexual response cycle, consisting of sexual impulse, sexual fantasies and sexual drive to other people.

Psychological note. In the film "Annie Hall," the protagonist's psychotherapist asks how often she and her boyfriend Elvi Singer have sex. At the same time, across town, Elvi's therapist asks him the same question. Elvi says, "It is very rare, maybe three times a week," and Annie replies, "All the time, I would say, three times a week."

The reduced sexual desire disorder is a disorder caused by a low interest in sex.

Low sexual (sex) desire is a lack of interest in sex, which leads to low levels of sexual activity. When a person with reduced sexual desire still has sex, he or she behaves quite normally or even feel pleasure. Despite the fact that our culture often describes men as those who always want to have sex if they have the opportunity, about 15% of men experience Low sexual desire, and over the past decade, the number of men going to therapists has increased significantly. Low sexual desire is found in 20-35% of women.

The handbook DSM-IV defines lack or loss of sexual desire as a few or no sexual fantasies and desire to have sex, however, it does not specify exactly what kind of level is insufficient. In one study, the happily married couples were asked to answer how often they have sex. Almost all of them – 93% – said they want to have sex at least once a week. About 85% said that they want to have sex several times a week or more. Based on this survey, sexual desire can be considered low, only when people are willing to have sex less than once a fortnight. Many people exhibit normal sexual interest and arousal, but their lifestyle does not stimulate them to have sexual contacts. These people do not show low sexual desire.

People with sexual aversion find sex unpleasant or repulsive. Sexual offers make

them feel nauseous, disgusted or frightened. Some are averted by some aspects of sex, others feel a general aversion to any sexual stimuli, including kisses and touches. Aversion to sex rarely occurs in men and is more common in women.

Sexual desire is caused by a combination of biological, psychological, and socio-cultural factors and may be weakened by any of them. In most cases, low sexual desire or sexual aversion is mainly caused by socio-cultural and psychological factors, but biological conditions can greatly reduce it, too.

Sexual aversion is a disorder characterised by aversion to sex and desire to avoid sexual activity.

Biological causes.

Hormones play an important role in the intensity of sexual desire and sexual behaviour. Deviations in hormone levels can lower the desire. Men and women alike can experience low sexual desire due to elevated levels of prolactin, low testosterone, and significant deviations of the sexual female hormone estrogen. Thus, low sexual impulse, is particularly connected with high levels of estrogen contained in some birth control pills, and vice versa – with low estrogen in women after menopause and immediately after birth. Prolonged diseases may also decrease the desire.

The disease can directly reduce sexual impulse or cause stress, pain and subsequent depression, which consequently affects sex life.

Sexual drive may decrease due to analgesics, psychotropic substances, and illegal drugs. Alcohol sometimes increases low sexual drive, because it weakens the prohibitions, but if a person is already quite excited, alcohol may reduce the arousal. Despite the centuries-old search, people have not found a true aphrodisiac, a substance that increases sexual desire yet.

Psychological causes.

Overal increase in anxiety or anger may decrease sexual desire in both men and women. Theorists note that people with low sexual desire and sexual aversion often keep some attitudes, fears or memories that lead to dysfunction, e.g., the idea that sex is immoral or dangerous. Other people are so afraid of losing control over their sexual impulses that completely suppress them, and some women have a panic terror of pregnancy.

Certain psychological disorders can lead to a decrease in sexual desire and to sexual aversion. Even a low level of depression may affect libido, and some people suffering from obsessive-compulsive disorder and phobias feel extremely uncomfortable at any physical contact with another body.

Socio-cultural causes.

Attitudes fears and psychological disorders, determining low sexual desire and sexual aversion, emerge in a certain social context, therefore, some socio-cultural factors may also be the cause of disorders. Many patients with low sexual impulse feel the pressure of the situation – they are going through divorce, death in the family, loss of job or work stress, infertility or pregnancy. Other people may have problems in

relationships. People who are in unhappy relationships lose sexual interest the most, when partners have no attraction to each other or one of them feels their own helplessness and domination of the other.

Even happy couples, when one partner appears an akward and slow lover, the other gradually loses interest in sex. Sometimes the partners have different needs for intimacy. The partner who needs more personal space may experience low sexual desire, thus being distant.

Cultural standards may also lay the ground for low sexual desire or form sexual aversion. Some men take a double standard of our culture and do not feel sexual attraction to the woman they love and respect. A husband may lose sexual interest in his wife after she gives birth to the first child because he cannot imagine a mother as a sexually attractive woman.

Trauma after sexual assault or rape most frequently causes attitudes and memories that lead to sexual dysfunction. Sexual aversion is very common in victims of rape and can last for several years and even decades. When a person during sex suddenly remembers about the assault, this may lead to an extreme manifestation of dysfunctions.

Let us consider ways of coping with disabilities in early adulthood.

For most people, the years of early adulthood is a period of bloom. In this period of life they have maximum power, endurance and energy. They usually have good health and no diseases. If they are in a good physical shape, they are active and feel satisfied, competent, and with high self-esteem. What happens with young adults who have physical disabilities? How do they go through psychological adaptation at a time when their peers have an active life?

Adapting to disruption of physical abilities is not easy at any age. However, older adolescence and early adulthood are particularly vulnerable periods. At this stage of life people usually form close relationships and take such important decisions as the choice of a job. At this period directed at the future, people with disabilities may experience depression due to their limitations.

There are at least three factors that influence adaptation to disability.

Firstly, it is important to understand what exactly the disability and related restrictions are. Any such disability is determined by the correlation of person's capabilities and the tasks set by the environment. A simple analogy of such cooperation is the following example: if you do not speak Japanese, you will be functionally incapable of studying in a Japanese class. The second aspect of adaptation to physical disabilities includes coping with attitudes and values of others, as well as their social expectations. There is a stereotypical perception of people with disabilities. Therefore, a disabled person often has to deal with unwanted prejudices and attitudes towards them. [3] They may be pitied or humiliated, considered incompetent and passive. People very often judge any person with disabilities according to social stereotypes, without looking at the whole picture.

Finally, the process of adaptation includes coping with lots of hopes and fears, dreams and disappointments, missed opportunities, guilt and anger. When a person becomes disabled suddenly, perhaps due to an accident, they may go through the critical period, accompanied by grief and sorrow, as well as shock and hopelessness. It is usually followed by a period of anger and disappointment, when the incapacitated individual tries to cope with everyday tasks, simple and ordinary for other people. They may also feel anger and frustration when faced with unnecessary social difficulties created by other people who have prejudices towards the disabled or avoid them because they feel uncomfortable around them.

During this process, some people begin to define themselves more as "people with physical problems" rather than as disabled. This trend is particularly prevalent among athletes with disruption of physical abilities. Sometimes, simply by changing definitions and terminology, it is easier to perceive specific physical obstacles as a problem that requires a solution, rather than as a label or category that defines a person.

Unfortunately, the term "people with problems" has become something of a cliché and is often a subject of ridicule and jokes.

Young people with physical disabilities have actively fought for the change in social attitudes and laws that affect all people with such problems. Numerous actions of the interested parties and groups resulted in the adoption of the ADA – the Americans with disabilities act in the US in 1990. This Act prohibited discrimination against people with such disabilities in employment, access to public places and services, transport and telecommunications. Among other things, it requires from companies a sufficient flexibility on the needs of employees with disabilities so that they can perform the work they are trained for; if it proves impossible, they should be trained to work using the relevant skills. It is important that it prohibits to fire people due to their physical disability, because the Act requires the policy of acceptance rather than exception.

Sex and sexuality.

Most people during early adulthood have a greater ability to reproduce than before or after it. As a rule, they are also more active in sexual terms, more sensitive and have a clear sense of sexual identity.

Sexual attitudes and behaviour.

University of Chicago carried out a study of sexual habits on a random sample of almost 3 500 people aged 18 to 59 years. The researchers attempted to avoid the usual problems connected with studying such sensitive issues as sex, such as the tendency of respondents not to report socially "undesirable" behaviour and exaggerate their preference of the "desired" behaviour.

The main results of this study are as follows:

- Vast majority of people adhere to a monogamous relationship. Eight out of ten respondents have only one sexual partner during the year (or have no partner). A typical woman normally has two partners over the life, while a typical men

has six;

- There are three basic patterns of sexual relations: one third of respondents have sexual intercourse at least twice a week, another third – a few times a month, and one more third – a few times a year or none at all;
- Married couples have sex and experience orgasm more often. Only one out of the four single or unmarried people has sexual intercourse twice a week, while a married person – two of five times;
- Contrary to popular stereotypes, there is only a small difference between ethnic groups in the frequency of sexual intercourse.

Previously, researchers noted significant changes in the sexual behaviour of married couples in the USA over the past decades. There has been a significant increase in the average duration of sexual intercourse, which suggests more pleasure, relaxation, and reciprocity between partners during the intercourse. There has likely been a change of attitudes and priorities of both men and women. Increasingly more couples try to receive more pleasure from sex rather than to achieve a fast resolution.

There has also been a change in the ways of achieving satisfaction; having sex can now include previously "unwanted" actions, such as the woman's initiative, etc.

For decades, adult sexual behaviour has undergone considerable dynamics. In 1937 and then in 1959 only 22% of the US population were tolerant of premarital sexual relations of both men and women. In a study conducted in 1974 (Hunt, 1974), 75% of men approved of premarital sex for men and over 50% considered it acceptable for women. However, some types of behaviour have not changed significantly; these include swinging partners, group and extramarital sex. In the 1970s, there were still double standards, when 50% of male students disapproved of premarital sex for women, but 75% preferred virgin brides.

Although nowadays sexuality has become more open and accepted than it was before the 1960s, in the 1980s, college students had sex more rarely than in the 1960s or 1970s. For example, one study reported that in 1978, 51% of female sophomores engaged in sexual intercourse at least once a month, and in 1983 that number dropped to 37% (Gerrard, 1987). Continuing tendency toward a more conservative sexual behaviour among female college students can almost certainly be attributed to the growing fear of sexually transmitted diseases. It may also reflect the growing confidence of young women who feel less need to have sex to "give pleasure" to their partner. Now women are mostly guided by their own system of beliefs than the one imposed from outside.

Fertility.

During early adulthood, the stock of eggs in women remains relatively stable. Women are born with a living reserve of about 400,000 eggs which are used every month, starting shortly after menarche and lasting till menopause. This process is relatively stable from 25 to 38 years. However, after 38 there is a sharp decline in the number and frequency of the release of eggs. This does not mean that older women

cannot get pregnant. On the contrary, more and more women decide to have a child at the age of about 40, when they feel more confident emotionally and financially, and may already have built a good career. Genetic screening procedures, such as amniocentesis and chorionic sampling, reduce the risks during late pregnancy.

Sexual sensitivity.

In the 1990s, the dominant model of sexual intimacy between a man and a woman most probably was the model of improved communication of mutual satisfaction. However, the study of sexual attitudes and behaviour repeatedly stressed the difference between male and female satisfaction models. In the 1970s, the studies showed that in some couples the man usually achieves physical pleasure, but the woman remains unsatisfied. [4] Women complained that men were too hasty, rude and inattentive, did not take into account the importance of a soft and slow erotic romantic arousal. Men complained that women were frigid and unresponsive. Perhaps sexual intimacy did not always lead to mutual satisfaction, as it was portrayed in the media.

The results of the study of the University of Chicago led to somewhat different conclusions.

A large percentage of men and women living in official or civil marriage reported an extraordinary physical and emotional pleasure from sexual relations with their partner.

In the 1990s, key components of sexual intimacy between men and women were communication and mutual pleasure from sexual life; there is no particular interdependence between their presence and satisfactory sex. In addition, as one might expect, the highest frequency of sexual activity, regardless of marital status, was informed by people aged 20 to 40 years.

Sexual orientation.

Sexuality does not permeate our experience so far as S. Freud supposed, but hardly anyone would deny that it is nevertheless an important part of our lives. In its turn, sexual orientation, which is related to what kind of sex is physically attractive to you, and which sexual partners you may wish to have, is an important part of self-concept and sense of identity of most people. Just as we form our views on who we are according to our ethical, religious and philosophical convictions, vocation and life goals, we determine who we are in our sexuality.

Defining sexual identity and its accompanying relationships can be tricky for anyone who lives in such a diverse society as the United States, where views on gender attributes and behaviour are different and are still in a state of transition. This has a certain compensation for most adolescents and young adults, who have at least one aspect of sexual identity, which seems durable and can serve as a point of support: “I'm a woman and men like me” or “I am a man and women like me.” In turn, this leads to a significant acceptance and support from family and peers. However, for a small but significant minority that discovered their complete or partial sexual orientation towards people of the same sex, sexual identity formation often goes through extraordinary

difficulties.

The realisation that you are sexually and romantically attracted to the people of the same sex, i.e., you are potentially gay or, to some extent, bisexual, often comes with the feeling of your "otherness," an intense process of doubt in yourself and an internal struggle for agreeing this aspect of self with your whole identity as a personality.

In addition, as it is noted by many authors, when openly acknowledging their sexual identity, gays, lesbians and bisexuals face various negative reactions of the dominant heterosexual majority, which could harm their psychological development.

This deeply rooted homophobia is not a true phobia, and it might be better to call it sexual prejudice, but this term is still used both in everyday speech, and in professional journals, as well as quite an unfortunate definition of "homosexual."

Homophobia refers to a set of extremely negative attitudes that may include unfounded fear and unfounded and strong hatred, disgust, anger towards other people only due to their sexual attraction to the people of the same sex. Family, peers and society in general often display sheer contempt for people who openly show this orientation, avoid them or condemn them for immorality, and discriminate against them. For example, a mass survey of gays, lesbians and bisexuals revealed that approximately one in four of men and one in five of women faced with offenses or harassment on the grounds of intolerance during the year before the survey.

For instance, they include such aggressive actions as verbal and physical abuse, stalking, throwing objects or spitting at them, trying to push or hit. The media regularly tell us about increasingly violent cases of abuse, including beatings and killings.

Obviously, we should not assume that all or even most heterosexuals are infected with homophobia. The degree of its prevalence remains unknown. Moreover, we should not assume that homophobia and other forms of sexual prejudice and discrimination strictly relate to such limited segment of the heterosexual population as under- or uneducated people.

For example, one study found significant sexual prejudices among second-year medical students, 9% of whom agreed with the outdated idea that homosexuality is a mental disorder (it was excluded from the classification of mental illnesses more than 30 years ago). The joint group of The Committee on Sexual Orientation and Gender Diversity of the 44th APA Administrative District, setting guidelines for psychotherapy with lesbian, gay and bisexual clients, emphasised the existence of numerous studies that point to the "heterosexual" trend among clinical psychologists and other therapists. In addition, the need for clear guidelines is quite obvious, and the existence of such prejudices is especially surprising with the high priority that the APA generally gave to egalitarian problems for decades.

Other authors noted that although in recent years, textbooks on psychology and sociology do not define homosexuality as a disorder; in many cases it is done implicitly, through the manner of discussing the issue. For the population as a whole,

there is only one typical factor connected with sexual prejudices: it is likely that heterosexual men have more negative attitudes towards people sexually oriented at the people of the same sex than heterosexual women, especially when it comes to gays.

This is how it influences the development of adolescents and young people.

One of the problems is that adolescents with different sexual orientation hide it from everyone except for few close friends or partners. They may intend to report it later, in early adulthood in college or in the city environment. During this period, they also face with negative attitudes and rejection, but they evidently find a friendly support among the peers experiencing the same problems, as well as among many heterosexuals without homophobia. Undoubtedly, some of them open only to the closest friends and not to the public. This is most likely if they choose to work in such areas where many employees are openly homophobic.

Causes of homosexuality.

We had better answer honestly: we do not know them, except for the fact that sexual orientation in general is a complex result of the interaction of heredity and environment. Theorists are divided into supporters of the role of biology and supporters of the influence of social learning in the development of homosexual orientation; every position has its evidence, but most of it is not exhaustive. The further statement is that "except for some obvious biological abnormalities caused by cross-gender structural abnormalities, we cannot clearly separate the influence of biological and psychological factors on differences in behaviour, constituting sexual orientation." Other researchers have repeated this observation and emphasised that it is much more important to understand the meaning of belonging to a homosexual minority than to understand the origins of homosexuality.

Sexual aversion is a negative attitude to the sexual partner as a whole or a negative attitude to sexuality only, with the positive evaluation of the partner in other areas. It is the most severe form of partner sexual dysfunction.

Bisexuality is a simultaneous presence of male and female sexual desires in the psyche.

Sexual deviation is any form of deviation from the norm in sexual behaviour, regardless of its manifestations and nature, intensity, and etiological factors. It includes sexual abuse in terms of deviation from social and medical norms.

Sexual disharmony is a particular state between the sexual norm and sexual pathology.

Thus, there are the following types of sexual disorders from the psychological point of view.

Sexual deviations or paraphilias are psychosexual disorders characterised by sexual arousal directed at objects and situations that are not part of the standard model of sexual arousal and activity and that can in varying degrees disrupt the ability of mutual emotionally intense sexual activity. This notion simply emphasises that the deviation (para-) is what attracts the individual (philia). It covers a number of variations

of sexual behaviour, which is currently at variance with accepted social norms and standards of sexual behaviour to the degree sufficient to consider them as "deviant."

The American Psychiatric Association DSM gives several types of paraphilia:

a) using non-human objects to cause arousal;

b) sexual activity characterised by the true or imitated suffering or humiliation;

c) repeated sexual activity with non-consenting persons.

Features of paraphilia can be seen in normal sexuality. It is safe to speak about the paraphilia only when such activity appears in the focus of sexual satisfaction, replacing direct sexual behaviour with a consenting adult partner.

Causes of paraphilia are more psychogenic than biological, therefore greatly dependent on the paradigm adopted in psychopathology. For instance, within psychoanalytic paradigm, these disorders are seen as a consequence of disruption of psychosexual development in early childhood; in the behaviourist paradigm, they are regarded as maladaptive sexual behaviour, learnt through the conditional-reflexive way; within the humanistic paradigm, they are most probably a private component of a unique, albeit distorted, world of subjective perception of each individual.

Definition and types of sexual violence:

a) Methods of the forced sexual relations: physical, economic, and psychological.

Abusive behaviour from adults, including relatives. Sexual harassment by peers. Forced sex and rape at the date.

b) Personality and behaviour of potential rapist. Dangerous situations, signs that speak of the possibility of harassment.

c) What to do if it happened: protective measures against the physiological and psychological effects.

d) Social and cultural causes of sexual violence: the stereotype of "courage," double standard in assessing sexual behaviour of the sexes. Assault prevention: the development of empathy, self-control, and responsibility for sexual behaviour in boys.

From the history of the same-sex love.

Among the philosophers of the ancient times, who studied the issues of sexuality mainly from an ethical point of view, we should mention the founders of the great philosophical systems – Plato and Aristotle, and the founders of hedonism – Aristippus and Epicurus. In ancient Greece, the legislation of Solon was the first to consider prostitution as a social institution. In Athens, in line with the views of Solon, sexual contact with teens was considered to be the most harmful form of sexual pleasure that also had educational value because of communication with friends. It was believed that homosexual inclinations were related to aesthetics, ethics, intelligence, and courage. Homosexual couples performed the pilgrimage to the grave of Hylas, the lover of Hercules, to bring a vow of eternal love.

Then, already in the IV century BC, Emperor Constantine, guided by religious and political reasons, introduced the death penalty for homosexuality. Even before, the ancient Jews rejected any extra-marital sexual relations, which did not result in

procreation, and homosexuality was condemned and punished by death.

Contrary to popular belief about the legitimacy and approval of homosexuality in ancient Greece, we should say that, in fact, neither the Greeks nor the Romans ever had the concept of homosexuality.

The word "homosexuality" appeared in 1869 (a term introduced by Hungarian doctor Maria Benkert, who also wrote under the pseudonym Kertbeni). The word "heterosexuality" appeared in 1890. These terms came out in an attempt to understand the formation of sexual orientation. Neither the Greeks nor the Romans saw the difference between homosexuality and heterosexuality. They distinguished between different notions – activity and passivity. They opposed the phallus (fascinus) to all holes (spintrias) in human body. Greek sodomy was a ritual of social initiation.

The object of love is subordinated to an older citizen, thus involving a person into hunting and culture.

The participants in a Greek sodomitical couple did not change roles. In Athens, male prostitution entailed deprivation of civil rights; passive homosexual convicted of engaging in politics resorted to the death. Such people were despised even more than unfaithful wives (adultery was not punished by death). In the Middle Ages, homosexuality (sodomy) was strictly condemned by the church. However, strict customs did not really scare homosexuals.

The fact that the monks often engaged in sodomy was mentioned in Boccaccio's "Decameron" and, much later, by Voltaire.

Boccaccio showed homosexuality as a sin, but he says the position of condemnation is not always clear. The medieval concept of "sodomy," in addition to its ambiguity, meant not a person, but the type of prohibited actions without any connection with a particular social or psychological identity. During the Renaissance, sex became a very fashionable topic for conversations and discussions, not excluding homosexuality. The most stringent laws against homosexuality were in Spain – a zealous defender of Catholicism, where in the period of Arab rule, homosexuality was common, hence regarded as a pernicious influence of Islam – the enemy's religion. The only punishment for homosexuality was death.

In the new conditions of the Reformation in the XVI century, Pope Paul IV burned homosexuals at the stake along with heretics. Overall, till the mid XIX century, the attitude to homosexuality was negative; moreover, homosexuality was punished by execution. However, in France after the revolution in 1791, due to philosophy of education and the fight for human rights, all laws punishing homosexuality were abolished, as a person, according to the revolutionaries, was free to do as they like.

In the XIX century, homosexuality was studied from the standpoint of the new sciences of psychology and sociology. In the medical literature of the XIX century, the issue of homosexuality was put differently. The word "homosexuality" was the substantivised and meant not only a special psychophysiological state, an illness, but a particular lifestyle, a kind of human species, which by all major indicators was different

from other people.

Even the first specialised theories of homosexuality were already quite ambiguous. According to French psychiatrist A. Tarde, sexual desire to the people of the same sex was an innate moral and physical disability, the result of degeneration, which manifests even in a special form of the penis, and the only way to deal with it is to use punitive measures, up to castration.

This time denoted the work of the first activist in the history, a fighter for equal rights for gays and lesbians K. Ulrichs, who spoke about the need not only to legalise homosexuality, but also allow same-sex marriages. Ulrichs's views were also taken into account in compiling Brockhaus and Efron Encyclopedic Dictionary in the article "Perversion of Sexual Feeling." They believed that in social and psychological sense, homosexuals are perfectly normal, and it is cruel and stupid to persecute them.

The famous German neurologist and psychiatrist Karl Westphal defined homosexuality as innate contrary sexual feeling.

In 1882, French psychiatrists J. Charcot and V. Magnan in their article "Inversion of the Genital Feeling" reported that they had successfully used hypnosis to treat such cases. Although it is difficult to understand how hypnosis can cure a congenital disease (that it was congenital the authors did not question), the article had great resonance, bringing the term "inversion" into the scientific language. However, clinical evidence did not fit into the concept of biological certainty. The result was the emergence of dualistic theories. Thus, Russian dermatologist and venereologist V.M. Tarnovski in the late XIX century suggested distinguishing between innate, genetically determined and acquired forms of homosexuality arising from external influences, sexual excesses, thirst for diversity, and so on.

Theoretical arguments about the "causes" of homosexuality continued at the beginning of the XX century. Forel and Molly considered it as a sexual perversion, a specific psychopathology. Kraft Ebing and Ellis saw it as an anomaly, like colour blindness, which could not be described as a "mental illness," because homosexuality was compatible with normal mental functioning. Bloch and Hirschfeld believed homosexuality was an innate tendency, a kind of idiosyncrasy that you should simply accept as a fact. However, following Ulrichs, Hirschfeld considered homosexuals as a kind of the "third sex," an intermediate stage of development, like hermaphroditism when physical characteristics of one sex are combined with sexual or emotional characteristics of the other.

Based on the idea of congeniality and incurability of homosexuality, Hirschfeld insisted on abolishing its persecution, and eventually succeeded.

Scientific debate over the causes of homosexuality has not ceased since the XX century, but the attitude to this phenomenon is gradually becoming more and more tolerant. Published in England in the 1957, the Wolfenden report recommended introducing a law allowing any form of private sexual behaviour between consenting adults. In 1991, homosexuality is excluded from the WHO list of psychiatric diseases.

Types of paraphilia. The following is a brief description of the types of paraphilia according to the DSM.

Fetishism. Fetishism is primarily characterised by using non-human objects or, at least, parts of the human body as a standard or exclusive method of experiencing sexual arousal. These objects or body parts (designated as a fetish) are extremely important to achieve sexual satisfaction and are the focus of sexual arousal. Fetishists are primarily male. Fetish objects can be different, but most often they are some female items of clothes (underwear, shoes, socks, gloves) as well as body parts typical for fetishism – breasts, hair, ears, hands, and feet.

Tansvestism. This disorder typically includes men's cross-dressing to become sexually aroused. The range of the manifestations of transvestism extends from the secret and secluded wearing women's clothes up to having sex with one's wife in these clothes, appearance in public in them, accompanied by members of this group.

Bestiality. It is characterised by using animals as a repeatedly standard or exclusive method of achieving sexual arousal. This disorder supposes giving preference to animals regardless of other available sources of sexual pleasure.

Paedophilia. Paedophilia (from the Greek "love for children") is characterised by repeated sexual activity with children. This activity varies in its intensity and involves stroking the hair of a child, pressing against them, and others.

Exhibitionism. It is characterised by repetitive acts of exposing one's genitalia to strangers who do not expect this in order to achieve sexual arousal. Usually no attempts to have a further contact are made.

Voyeurism. Voyeurism is characterised by recurrent search for the situations in which an individual looks at ("spies on") the unsuspected people. Such people are almost always male; they receive intense sexual arousal from spying. There is normally no attempt to have a further contact with the woman that has been spied on (usually a stranger), since most voyeurs, like exhibitionists, do not pose any physical danger.

Sexual sadism. The widespread term "sadism" comes from the notorious Marquis de Sade, who on erotic purposes did such atrocities with his victims, that he was admitted as mentally ill. Sexual sadism is a disorder where the main feature is causing physical or psychological pain to another person in order to achieve sexual arousal and orgasm. The deviant also likes to bring up sexually stimulating fantasies of this kind. In some cases, sadistic behaviour stimulates the formation of sexual relations, while in others it is enough in itself to achieve sexual satisfaction. Most of sadistic behaviour occurs in relations with a consenting partner.

Sexual masochism. The main feature of sexual masochism is sexual arousal that occurs in the individual because of their own suffering. This means that this disorder has as an exclusive way of achieving sexual satisfaction through suffering in the form of humiliation, binding, beating, whipping or else. These situations may be sufficient to achieve sexual satisfaction, or they may be a necessary prelude to direct sexual behaviour in the form of sexual intercourse. Like sadism, masochism involves

suffering; unlike sadism, suffering is caused not by others, but by yourself.

Atypical paraphilia. The category of atypical paraphilia in the DSM classification is designed for the individuals who cannot be attributed to any of the other categories. These disorders include coprophilia (excrement), frotteurism (friction), mysophilia (dirt), necrophilia (corpse), telephone scatologia (obscenity), and urophilia (urine).

Conclusions.

Sex therapy can be described as an attempt to modify relations in the context of the family system. Sex therapy sees symptomatic behaviour and problems as a result of an improper interaction and not as an individual characteristic of a family member. Therefore, sex therapy mostly practises interpersonal, not intrapsychological approach.

Sexual dysfunctions may be observed in many people during their life; they are often transient, arising as a result of specific stress between partners. These dysfunctions are particularly easy to treat. The factors causing anxiety (cognitive, behavioural, and emotional) are identified, and the couples receive behavioural tasks doing which aims to reduce the anxiety connected with sexual intimacy, leading to elimination of the symptoms. However, in some cases, sexual dysfunctions are caused by less deep psychological factors.

Sexual deviations mean socially unacceptable forms of sexual behaviour. So far there has been no consensus on the causes of sexual perversions. Their roots are explained by organic diseases and genetic factors, hormonal metabolism disorders and psychological trauma, especially in the early period of development. There are two types of sexual deviations: by the choice of object (fetishism, paedophilia, bestiality, etc.) and by the purpose of sexual desire (transvestism, exhibitionism, voyeurism, sadism, masochism, etc.).