

# **Systematic Review of Egyptian Studies on Sexual and Gender Identity Disorders**

*Essay*

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in Neuropsychiatry*

*By*

***Sameh Ibrahim Abd El Atti***

**M.B.B.CH**

*Supervisors of*

**Prof. Dr. Naglaa El Mahallawy**

*Professor of Neuropsychiatry*

*Faculty of Medicine-Ain Shams University*

**Dr. Nivert Zaki Mahmoud**

*Assistant Professor of Neuropsychiatry*

*Faculty of Medicine-Ain Shams University*

**Dr. Doaa Nader Radwan**

*Lecturer of Neuropsychiatry*

*Faculty of Medicine-Ain Shams University*

*Faculty of Medicine*

*Ain Shams University*

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Recently, the information center of Faculty of Medicine-Ain Shams University develops a medical site on the internet which contains every M.D thesis since year (2006), the web address is:

***<http://med.shams.edu.eg> – academics – MD thesis (full text).***

## **List of abbreviations**

<b>AIDs</b>	: Acquired Immuno-deficiency disease.
<b>BDI</b>	: Beck Depression Inventory.
<b>BUN</b>	: Billirubin.
<b>CSA</b>	: Childhood Sexual Abuse.
<b>CT</b>	: Computerized Topography.
<b>CTQ</b>	: Childhood Traumatic Questionnaire.
<b>DM</b>	: Diabetes Mellitus.
<b>DSFI</b>	: Derogatis Sexual Functioning Inventory.
<b>DSM-III</b>	: Diagnostic and Statistical Manual of Mental Disorders -Third Edition.
<b>DSM-IV</b>	: Diagnostic and Statistical Manual of Mental Disorders - IV (1994).
<b>DVT</b>	: Deep Venous Thrombosis.
<b>ECG</b>	: Electrocardiogram.
<b>ECT</b>	: Electro-convulsive therapy.
<b>EDHS</b>	: Egyptian Demographic Health Survey.
<b>EEG</b>	: Electro-encephalogram.
<b>EPQ</b>	: Eysenk Personality Questionnaire.
<b>ESRD</b>	: End Stage Renal Disease.
<b>FGM</b>	: Female Genital Mutilation.
<b>FLE</b>	: Frontal Lobe Epilepsy.
<b>FSH</b>	: Follicle Stimulating Hormone.
<b>GHQ</b>	: General Health Questionnaire.
<b>GRISS</b>	: Golombok Rust Inventory of Sexual Satisfaction.
<b>GTC fits</b>	: Generalized Tonic Clonic fits.
<b>ICD-10</b>	: International Classification of Diseases -10.

<b>IIEF</b>	: International Index of Erectile Function.
<b>ILAE</b>	: International League Against Epilepsy.
<b>LH</b>	: Luteinizing Hormone.
<b>LL</b>	: Lower Limb.
<b>MINI</b>	: Mini International Neuropsychiatric Interview.
<b>MRI</b>	: Magnetic Resonance Imaging.
<b>MSI</b>	: Marital Satisfactory Inventory.
<b>NPT</b>	: Nocturnal Penile Tumescence.
<b>NSSQ</b>	: Norbeck Social Support Questionnaire.
<b>OCD</b>	: Obsessive Compulsive Disorders.
<b>PANSS</b>	: Positive and Negative Symptoms Syndrome Scale.
<b>PCR</b>	: Protein Catabolic Rate.
<b>PHC</b>	: Primary Health Care.
<b>PRL</b>	: Prolactin.
<b>RBPC</b>	: Revised Behaviour Problem Checklist.
<b>SAS-SR</b>	: Social Adjustment Scale, self-reported version.
<b>SBQ</b>	: Sexual Behavioural Questionnaire.
<b>SEBA.A</b>	: Sexual Behaviour Assessment Schedule – Adult.
<b>SFQ</b>	: Sexual Functioning Questionnaire.
<b>STDs</b>	: Sexually Transmitted Diseases.
<b>TLE</b>	: Temporal Lobe Epilepsy.

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# **Introduction**

This work is considered as the 12th essay of master degree among series of essays that discusses "*Systematic review of Egyptian studies done on different psychiatric disorders*", whereas *Professor Afaf Hamed* is the head of the teamwork of these series. The previous M.Sc essays are:

- 1) Systematic review of the Egyptian studies on substance abuse. *By Dr. Mohamed Khaled (2006).*
- 2) Systematic review of the Egyptian studies on mood disorders. *By Dr. Magdy Ahmed (2006).*
- 3) Systematic review of the Egyptian studies on schizophrenia. *By Dr. Naser Zahran (2006).*
- 4) Systematic review of the Egyptian studies on old age psychiatric disorders. *By Dr. Ahmed Farouk (2008).*
- 5) Systematic review of the Egyptian studies on neurotic disorders. *By Dr. Heba Fakher (2008).*
- 6) Systematic review of the Egyptian studies on biological studies. *By Dr. Nivin Ahmed (2008).*
- 7) Systematic review of the Egyptian studies on psychiatric disorders in women. *By Dr. Suzy Mohamed (2008).*
- 8) Systematic review of the Egyptian studies on liaison psychiatry. *By Dr. Al Shaimaa Aly (2008).*
- 9) Systematic review of the Egyptian studies on child psychiatric disorders. *By Dr. Sherif Helal (2008).*
- 10) Systematic review of the Egyptian studies on personality disorders. *By Dr. Rehab Naguib (2009).*

11) Systematic review of the Egyptian studies on epidemiology of psychiatric disorders. By *Dr. Madiha Lotfi (2009)*.

Sexuality is more than a mere drive or instinct. Bonding with a sexual partner is a matter of far greater importance than just the gratification of lust (*Stevens and Price, 2000*).

The sexual relationship is a complex one, and the factors responsible for problems are not only quite numerous but in most cases multiple causes are present. They can be fairly crudely divided into three categories: (1) physical factors, (2) individual psychological factors and (3) relationship factors (*Bancroft, 1989*). Many sexual problems that are psychological in nature stem from the self- and other-evaluative component of sexual response (hence the common reference to sexual “performance”) (*Rowland and Incrocci, 2008*).

Unlike most physical problems and many psychological ones, sexual performance deficits may not be freely admitted; the influence of subculture standards is likely to be evident in both the recognition of and admission to sexual difficulties (*Swan and Wilson, 1979*).

According to DSM-IV-TR classifications, sexual and gender identity disorders are classified into: sexual dysfunctions, paraphilias and gender identity disorders (*Sadock and Sadock, 2005*).

Many commentators point to a need to distinguish sex and gender, where sex refers to (biological male/femaleness) and gender refers to (psychological or behavioral characteristics associated with biological males and females);

Gender Identity refers to (basic discrimination of males from females and a sense of belonging to one sex) (*Zucker, 2006*).

Because the prevalence of Gender Identity Disorder (GID) in children and adolescents is low, only a small number of clinician-researchers have directed their attention to this population, but, beginning in the mid-1960s, several specialty clinics or programs were established . Thus, in a gradual manner, a fair bit of knowledge has accumulated about children and adolescents with GID. In the past few years, GID has become a topic of fascination in the mass media: both print and television media have provided a great deal of coverage (*Rosenberg, 2007*).

Gender Identity Disorder is defined as an incongruence between the physical phenotype and the gender identity, that is, the self identification as male or female (*Allen and Gorski, 1990*).

The first medical writing of Gender Identity Disorder was by Friedreich in 1830, although the condition was not considered worthy of further investigation until many years later (*Roberto, 1983*).

A major concept has led the quest for sex determining genes that sex determination was equivalent to testis determination, since it is the presence of the testes that determines maleness, and their absence that determines femaleness (*Jost, 1947*). Patient with gender identity disorder is convinced that his/her own psychological gender is the opposite of his/her anatomical sex (*Roberto, 1983*).

In the United States during the 1950's and 1960's, transsexuals were viewed by society as people who were



mentally disturbed, weird, or immoral. The community as a whole did not understand the idea of transsexualism. Transsexualism has come a long way from the stigmatism that it gained in the past, and giving definition to the idea of choice by using case studies. A transsexual is: “Someone who has the feeling that they are a different sex than the one that they were born – to some extent” (*Stein, 1999*).

The estimated prevalence of persons with severe GID, specifically transsexualism, in the adult general population appears to be 1 in 11.000 men and 1 in 30.000 women, the estimate emanates from Netherlands and appears to represent national population data (*Green, 2005*).

Ideally, evaluation of a sexual problem involves an in-depth analysis of the specific problem, its severity, etiology, and contributing/maintaining factors. In practice, evaluation procedures vary widely, depending on the door through which the man enters the health system when seeking help (*Rowland and Incrocci, 2008*).

A portion of all sexual disorders can be prevented through education alone, but because our society generally shies away from providing such education people end up with problems in sexual functioning (*Barlow, 2005*).

The present scene in Egypt is characterized by an unprecedented shift toward “demand reduction” at the primary prevention level, hand in hand with efforts to provide services at both secondary and tertiary healthcare levels (*El Akabawi, 2001*).

As regards the systematic review, *Greenhalgh (2001)* summarizes its methodology into the following points:

- 1) State objectives of the review and outline eligibility criteria.
- 2) Search for studies that seem to meet eligibility criteria.
- 3) Tabulate characteristics of each study identified and assess its methodological quality.
- 4) Apply eligibility criteria, and justify any exclusion.
- 5) Assemble the most complete dataset feasible, with assistance from investigators, if possible.
- 6) Analyze results of eligible studies, using statistical synthesis of data (meta-analysis) if appropriate and possible.
- 7) Compare alternative analyses if appropriate and possible.
- 8) Prepare a critical summary of the review, stating aims, describing materials and methods and preparing reports.

## **Rationale of the Work:**

As there are previous Egyptian studies discussing the sexual and gender identity disorders. So, it is important to make use of this effort to have a clear system for reviewing these studies and planning for future researches, in order to have complementary research system. And as medicine moves to be evidence-based; the need for having the criteria for critical appraisal to determine the value of the published researches and to decide their applicability in clinical practice. So, this work was done to review these studies with the intent to collect their results and critically appraise the findings, to identify the missing points in the Egyptian researches to overcome the defects in the future.

So, we hope that this study will be a step to know where the Egyptian studies of sexual and gender identity disorders stand and what is needed to be done further.

## **Aim of the work**

The aim of the work is:

- 1- To systemically review, appraise the available Egyptian studies on sexual and gender identity disorders.
- 2- To generate recommendations for further studies.
- 3- To provide a summary of clinical M.S.c thesis and M.D. thesis on sexual and gender identity disorders (this will be included as an appendix).

## **Methodology (Procedures)**

In order to fulfill the aim of the work, a systematic review of all available Egyptian studies on sexual and gender identity disorders will be done.

The following databases will be explored:

- 1) Library of Faculty of Medicine, Ain Shams University.
- 2) Library of Faculty of Medicine, Al-Azhar University.
- 3) Library of Faculty of Medicine, Cairo University.
- 4) Library of Faculty of medicine, Suez Canal University.
- 5) Egyptian Journal of Psychiatry and Current Psychiatry Journal for Egyptian studies.

The obtained studies from these databases will be categorized according to the following categories:

- 1) Epidemiology.
- 2) Etiology.
- 3) Clinical description.
- 4) Management.
- 5) Outcome.
- 6) Knowledge and opinion about human sexuality.

These studies will be critically appraised and important findings will be discussed. Following these steps recommendations for further studies would be generated.

After exploring the following databases; 1- Library of faculty of medicine- Ain Shams University. 2- Library of faculty of medicine- Cairo University. 3- Library of faculty of medicine- El Azhar University. 4- Library of faculty of medicine- Suez Canal University. 5- Databases of Egyptian Journal of Psychiatry and Current Psychiatry Journal. We obtained the following Egyptian studies done on sexual and gender identity disorders which were listed in the following table:

Appendix	Researcher/s & supervisors	Article Title	Year	Source
1	Demerdash A.M., supervised by Prof. Hassan A., Prof. Soueif M., Prof. Ghaliounghi P. & Dr. Okasha A.	<b>A psycho-social study of cases of psychogenic impotence.</b>	1970	M.D Thesis, Faculty of medicine, Ain Shams University
2	Abdelmessih M.S., Wagih. I.M. & Assaad F.	<b>A psychological and forensic study of rape in Cairo.</b>	1980	Egy. J. Psych.
—	سليمان ع.ع. تحت اشراف ا.د/ شعلان م.م. , ا.د/ عبدالعال ح. د/ العقباوى ا.ش.	تقويم العلاج النفسى لمرضى الضعف الجنسى.	1981	رسالة ماجستير - كلية الطب-جامعة الازهر.
3	El Akabawi A.S. & Idarous A.	<b>Sex therapy compared with placebo in the treatment of impotence.</b>	1982	Egy. J. Psych. 5: 271 – 281

—	بحرى م.ة. تحت اشراف ا.د/ شعلان م.م. , ا.د/ دمرداش ع.م. , د/ عثمان ع.م.	السلوك الجنسى لمرضى الصرع الرجال المصريين.	1983	رسالة ماجستير - كلية الطب-جامعة الازهر.
—	النجدى د.ع. تحت اشراف ا.د/ شعلان م.م. , ا.د/ صادق ع.	الاضطرابات النفسجنسية فى الرجال.	1984	رسالة ماجستير - كلية الطب-جامعة الازهر.
—	عاشور ع.د. تحت اشراف ا.د/ شعلان م.م. , ا.د/ الجارم ع.ع. , ا.د/ حفى ق.م. , ا.د/ سلطان ع.	دراسة فى ظاهرة الاغتصاب الجنسى.	1984	رسالة دكتوراة - كلية الطب- جامعة الازهر.
4	Loutfi I., El Geneidy M.M., El Geneidy M.M. & Ali F.A.	<b>Knowledge and opinion of educated females about human sexuality.</b>	1984	Egy. J. Psych. 7: 107 – 120
5	Demerdash A.M., Shaalán M.M., Osman A.M. & Kamal M.H.	<b>The sexual behaviour of a sample of male Egyptian epileptics.</b>	1986	Egy. J. Psych. 9: 83 – 105
—	بحرى م.ة. تحت اشراف ا.د/ شعلان م.م. , ا.د/ دمرداش ع.م. , د/ المدنى ع.م.	دراسة السلوك الجنسى لمرضى الصرع الاناث.	1987	رسالة دكتوراة - كلية الطب- جامعة الازهر.
—	زين العابدين ف.ع. تحت اشراف ا.د/ العقباوى ا.ش. , د/ المدنى ع.م.	علاقة الاضطرابات النفسية بالغنة فى مرضى البول السكرى فى الرجال.	1988	رسالة ماجستير - كلية الطب-جامعة الازهر.

—	محمد م.ح. تحت اشراف ا.د/ يونس م.ن. د/ المدنى ع.م. د/ بحرى م.ة.	الوظيفة الجنسية والعقم الاولى العضوى فى الزوجين.	1989	رسالة ماجستير - كلية الطب - جامعة الازهر.
6	Ahmed M.M. & Ezz El-Din S.	<b>Sexual dysfunction in patients with major depression.</b>	1992	Egy. J. Psych. 15: 2 July.
7	El-Defrawi M.H., Atef A., Ragab L. & Sobhy S.A.	<b>Assessment of knowledge of child abuse in Suez Canal Area.</b>	1993	Egy. J. Psych. 16 : 57 – 67
8	Hashem A. & El-Orabi H.	<b>Effect of heroin abuse on pituitary- gonadal axis in male subjects.</b>	1993	Egy. J. Psych. 16: 91 – 97
9	Abdel Rahman S. & Nashed E.R.	<b>Psychiatric aspects of child abuse in Egypt.</b>	1994	Egy. J. Psych. 17: 137 – 145
10	Lotaief F., Asaad T., El-Mahalawy N., Shawky I., Ghanem M. & Refaat M.R.	<b>A socio- demographic study of homosexuality in an Egyptian sample.</b>	1994	Current Psychiatry Vol. 1 No. 2 December.
11	Lotfy G. & El-Defrawi M.H.	<b>Psychosexual impact of female circumcision.</b>	1995	Egy. J. Psych. 18: 123 – 131
12	Ibrahim M.A., Ghanem M., Barakat S., Abdel Ghani M. & El Said W.	<b>Sexual dysfunction in relation to dialysis adequacy in haemodialysis patients.</b>	1995	Egy. J. Psych. 18: 231 – 239
13	Fahmy E.M., Michael V.S., Abdo A.S. & Al-Sheikh H.A.	<b>Remote psychiatric sequelae of sexual abuse in childhood.</b>	1995	Current Psychiatry Vol. 2 No. 2 December.



14	El-Defrawi M.H., Lotfy G., Megahed H.E. & Sakr A.A.	<b>Female circumcision in Ismailia. A descriptive study.</b>	1996	Egy. J. Psych. 19: 137 – 145
15	El Sheikh H.E. & El Fouly M.	<b>ECT and sexual activity in males with major depressive illness.</b>	1997	Current Psychiatry Vol. 4 No. 1 July.
16	Awany T.M.M. supervised by Prof. Osman A.M. & Prof. Afifi F.M.	<b>Sex hormones serum levels in men with temporal lobe epilepsy.</b>	1997	M.D Thesis, Faculty of medicine, Al-Azhar University.
17	Abed M.G. supervised by Prof. Ismail M.K., Prof. Kamel S.M. & Prof. Ragheb K.M.	<b>Presentation of female sexual dysfunctions in medical practice.</b>	1998	M.D Thesis, Faculty of medicine, Al-Azhar University for Girls.
18	Sayed H.Y. supervised by Prof. Ali S.A., Assist. Prof. El-Raey L. & Assist. Prof. El- Bakrey A.	<b>Late psychiatric sequelae of childhood sexual abuse</b>	1998	M.Sc Thesis, Faculty of medicine, Cairo University.
19	Refaat A., Dandash K. & El-Defrawi M.H.	<b>Domestic violence and female genital mutilation.</b>	1999	Egy. J. Psych. 22: 209 – 218
20	Owida M.A. & Amin A.E.	<b>Descriptive study of some Egyptian females having sexual dysfunction.</b>	1999	Egy. J. Psych. 22: 257 – 265
21	Soliman A., Okasha T. & El Rasheed A.H.	<b>Childhood sexual abuse in female depressed psychiatric inpatients: Prevalence and relationship to depression.</b>	1999	Current Psychiatry Vol. 6 No. 3 July.

22	Soliman A.E. & Effat S.M.	<b>Childhood sexual abuse in depressed female inpatients: A 2-year follow-up study and an explanatory cognitive model.</b>	2000	Egy. J. Psych. 23:1 January.
23	Sarhan Z., El-Gindy T., Abdel Latif A.M., El Batrawi M. & Ezat M.	<b>Marital satisfaction in parents living with a schizophrenic offspring: a neglected topic.</b>	2000	Egy. J. Psych. 23: July.
24	Abdel Azim E., Shalanda A.A., Abdellatef R.R., Basiouny M., Khashaba A.M., Sweelem Sh. & Askar A.	<b>Some psychosexual aspects of female circumcision: A pilot study in Sharkia.</b>	2000	Current Psychiatry Vol. 7 No. 2 July.
25	Ismail I.A. & Hafez A.S.	<b>The prevailing sexual activities in substance use culture in Egypt using focus group technique.</b>	2000	Current Psychiatry Vol. 7 No. 2 July.
26	Habeeb B.F. supervised by Prof. Abdel Azim S., Prof. Zaki K. & Prof. Abdel Latif A.	<b>Sexual dysfunction and paraphilias of general medical hospital male in-patients.</b>	2000	M.Sc Thesis, Faculty of medicine, Cairo University.
27	Nagia I., Akram K.W., Mervat M.G. & Abdulmajeed A.	<b>Gender difference regarding knowledge and attitude towards sexuality among university students in Port Said, Egypt.</b>	2001	Current Psychiatry Vol. 8 No. 1 March.

28	Mohammed H.T. supervised by Prof. Ragheb K.M. & Prof. Demerdash A.M.	<b>Psychiatric aspects of juvenile delinquency.</b>	2001	M.Sc Thesis, Faculty of medicine, Al-Azhar University for Girls.
—	حسين ا.ا. تحت اشراف ا.د/ العقباوى ا.ش. , ا.د/ بحرى م.ة. , ا.د/ عويضة م.ا.	دراسة للعلاقات الزوجية فى عينة من الفصامين المصريين.	2002	رسالة دكتوراة - كلية الطب - جامعة الازهر.
29	El-Azoony A.A. supervised by Prof. El-Etribi M., Prof. Ashour S., Prof. Nabil N. & Dr. Abd El-Nasser A.	<b>Study of changes of sex hormones and sexual functions in a sample of Egyptian male epileptics.</b>	2002	M.D Thesis, Faculty of medicine, Ain Shams University.
30	El Fangary N.M. supervised by Prof. Abd-El Azim S., Prof. Askar M.A. & Prof. Ahmed M.M.	<b>Sexual dysfunction in female psychiatric patients.</b>	2003	M.D Thesis, Faculty of medicine, Cairo University.
31	Abolmagd S., Erfan S.M.F., Abdel Wahab M. & Abdel Gawad T.M.S.	<b>Role of the spouse in addiction: Is there a contribution.</b>	2004	Egy. J. Psych. Vol. 23 No. 1 January.
32	Mohammed H.Y. supervised by Prof. Hashem A., Prof. Abd El-Gawad T.M. & Prof. Arafa M.E.	<b>A study of sexual aspects in a sample of male schizophrenic patients.</b>	2005	M.Sc Thesis, Faculty of medicine, Cairo University.

33	Hashem A.H., Abd El-Gawad T., Ezzat M., Assal A., Goueily T. & El Rakhawy M.	<b>A comparative study of sexual function in paranoid versus non- paranoid schizophrenic patients and its relation serum prolactin level.</b>	2006	Current Psychiatry Vol. 13 No. 2 July.
34	Hamed R.A. supervised by Prof. Ragheb K.M., Prof. Abdel Azim S., Prof. Seif El-din A.G., Assist. Prof. Attia H.M. & Dr. Ismail R.M.	<b>Child abuse among preparatory school students in Cairo and its psychiatric sequelae.</b>	2006	M.D Thesis, Faculty of medicine, Al-Azhar University for Girls.
35	Abdel Azim E., Khashaba A., Sherra Kh. & Shalendah A.	<b>Sexual dysfunction and relation to used drugs and smoking in a sample of chronic schizophrenic patients.</b>	2007	Current Psychiatry Vol. 14 No. 2 July.
36	Riyadh M., Hassan A., Algammal M. & Abdelrahman A	<b>The prevalence of child abuse and its effect on the mental health.</b>	2007	Current Psychiatry Vol. 14 No. 3 November.
37	Mourad H.S.A. supervised by Prof. El Ghoneimy A.T., Prof. Farid M.M., Prof. Abd El Naseer M. & Prof. Samir H.	<b>Sexual dysfunction in epileptic male patients.</b>	2009	M.D Thesis, Faculty of medicine, Cairo University.

Systematic review is a scientific investigation in itself, with pre-planned methods and an assembly of original studies as their subjects. They synthesize the results of multiple primary investigations by using strategies that limit bias and random error. When the results of primary studies are summarized but not statistically combined the review is called a "qualitative systematic review". A quantitative systematic review or meta-analysis is a systematic review that uses statistical methods to combine the results of two or more studies. The term "overview" is sometimes used to denote a systematic review whether quantitative or qualitative, summary of research that lack explicit descriptions of systematic methods are often called narrative reviews (*Greenhalgh, 2001*).

*Oxman and Guyatt (1993)* summarize the advantages of systematic reviews into the following points:

- 1) Explicit methods limit bias in identifying and rejecting studies.
- 2) Conclusion hence is more accurate and reliable.
- 3) Large amounts of information can be assimilated quickly by health care providers, researchers, and policymakers.

- 4) Delay between research discoveries and implementation of effective diagnostic and therapeutic strategies is potentially reduced.
- 5) Results of different studies can be formally compared to establish generalizability of findings and consistency of results.
- 6) Reasons for heterogeneity can be identified and new hypothesis generated about particular subgroups.
- 7) Quantitative systematic reviews increase the precision of the overall results.

## **Epidemiology of sexual and gender identity disorders**

### **(A) Prevalence:**

#### **(I) Sexual dysfunctions not caused by organic disorders:**

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 5 out of 163 (3.1%) wives have excessive masturbation, 3 out of 163 (1.8%) wives have marked feeling of inadequacy of body and sex organs and 65 out of 163 (39.9%) wives have more than one diagnosis (table 1).

***Table (1) Prevalence of sexual dysfunctions:***

Author/s	Sample	Site	Tools	Prevalence
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	3.1% excessive masturbation, 1.8% marked feeling of inade-quacy of body and sex organs, 39.9% more than one diagnosis.

#### **Excessive sexual drive:**

*Owida and Amin (1999)* (see appendix 20) found that 7 out of 163 (4.3%) wives have excessive sexual drive (table 2).

**Table (2) Prevalence of excessive sexual drive:**

Author/s	Sample	Site	Tools	Prevalence
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	4.3% have excessive sexual drive.

**(1) Dysfunction of the desire phase (sexual desire disorders):**

**a) Hypoactive sexual desire disorder:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17) and he reported that 5 out of 33 (15.2%) women of sexual group, 10 out of 33 (30.3%) women of disguised group and 12 out of 33 (36.4%) women of comparative group have lack or loss of sexual desire (table 3). *Owida and Amin (1999)* (see appendix 20) found that 5 out of 163 (3.1%) wives with sexual dysfunction have lack or loss of sexual desire (table 3).



**Table (3) Prevalence of sexual desire disorder:**

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Prevalence</b>
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecological outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	15.2% women of sexual group, 30.3% women of disguised group, 36.4% women of comparative group have lack or loss of sexual desire.
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	3.1% have lack or loss of sexual desire.

**b) Sexual aversion disorder and lack of sexual enjoyment:**

*Abed (1998)* (see appendix 17) reported that 1 out of 33 (3%) women of sexual group, 1 out of 33 (3%) women of disguised group and no one of comparative group have sexual aversion disorder (table 4). *Owida and Amin (1999)* (see appendix 20) found that 3 out of 163 (1.8%) wives with sexual dysfunction have sexual aversion disorder (table 4).

***Table (4) Prevalence of sexual aversion disorder:***

Author/s	Sample	Site	Tools	Prevalence
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecological outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	3% women of sexual group, 3% women of disguised group, no one of comparative group have sexual aversion disorder.
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	1.8% have sexual aversion disorder.

*Owida and Amin (1999)* (see appendix 20) found that 9 out of 163 (5.5%) wives with sexual dysfunction have lack of sexual enjoyment (table 5).

***Table (5) Prevalence of lack of sexual enjoyment:***

Author/s	Sample	Site	Tools	Prevalence
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	5.5% have lack of sexual enjoyment.

**(2) Dysfunction of the excitement phase (sexual arousal disorders):**

**a) Female sexual arousal disorder:**

**Abed (1998)** (see appendix 17) reported that 9 out of 33 (27.3%) women of sexual group, 22 out of 33 (66.7%) of women of disguised group and 9 out of 33 (27.3%) of women of comparative group have failure of genital response (sexual arousal disorder) (table 6). **Owida and Amin (1999)** (see appendix 20) found that 2 out of 163 (1.2%) wives with sexual dysfunction have failure of genital response (sexual arousal disorder) (table 6).

**Table (6) Prevalence of female sexual arousal disorder:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecological outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	27.3% women of sexual group, 66.7% women of disguised group, 27.3% women of comparative group have failure of genital response (sexual arousal disorder).
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	1.2% have failure of genital response (sexual arousal disorder).

**b) Male erectile disorder (impotence):**

*El Nagdy*<sup>\*</sup> (1984) studied 47 sexual disorders male patients and he reported that 25 out of 47 (53.2%) sexual disorders male patients have erectile dysfunction (table 7).

**Table (7) Prevalence of male erectile disorder (impotence):**

Author/s	Sample	Site	Tools	Prevalence
<b>El Nagdy (1984)</b>	47 sexual disorders male patients.	Outpatient psychiatric clinic in a private psychiatric hospital.	Psychosexual interview.	53.2% have erectile dysfunction.

**(3) Dysfunction of the orgasm phase (orgasmic disorders):****a) Female orgasmic disorder:**

*Abed (1998)* (see appendix 17) reported that 2 out of 33 (6.1%) women of sexual group, no one of women of disguised group and no one of women of comparative group have orgasmic dysfunction (table 8). *Owida and Amin (1999)* (see appendix 20) found that 20 out of 163 (12.3%) wives with sexual dysfunction have orgasmic dysfunction (table 8).

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\* Arabic Reference.

**Table (8) Prevalence of female orgasmic disorder:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecological outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	6.1% women of sexual group, no one of disguised group, no one of comparative group have orgasmic dysfunction.
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	12.3% have orgasmic dysfunction.

**b) Male orgasmic disorder:****i) Delayed ejaculation:**

*Al Nagdy*<sup>\*</sup> (1984) reported that 2 out of 47 (4.2%) sexual disorders male patients have delayed ejaculation, as shown in table (9).

**ii) Premature ejaculation:**

*Al Nagdy*<sup>\*</sup> (1984) reported that 20 out of 47 (42.6%) sexual disorders male patients have premature ejaculation, as shown in table (9).

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\* Arabic Reference.

***Table (9) Prevalence of delayed and premature ejaculation among sexual disorders male patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>Al Nagdy (1984)</b>	47 male patients with sexual disorders.	Outpatient psychiatric clinic in a private psychiatric hospital.	Psychosexual interview.	4.2% have delayed ejaculation, 42.6% have premature ejaculation.

***(4) Sexual pain disorders:***

***Non organic vaginismus and dyspareunia:***

**Abed (1998)** (see appendix 17) reported that 9 out of 33 (27.2%) and 6 out of 33 (18.2%) women of sexual group have non organic vaginismus and dyspareunia respectively, no one of women of disguised group and no one of women of comparative group have vaginismus or dyspareunia (table 10).

**Owida and Amin (1999)** (see appendix 20) found that 19 out of 163 (11.7%) and 25 out of 163 (15.3%) wives with sexual dysfunction have non organic vaginismus and dyspareunia respectively (table 10).

***Table (10) Prevalence of sexual pain disorder:***

Author/s	Sample	Site	Tools	Prevalence
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecological outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	27.2% and 18.2% women of sexual group have non organic vaginismus and dyspareunia respectively, no one of disguised group and no one of comparative group have vaginismus or dyspareunia.
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	11.7% and 15.3% wives have non organic vaginismus and dyspareunia respectively.

## **(II) Sexual dysfunctions in psychiatric patients:**

*Ahmed and Ezz El-Din (1992)* studied 50 male patients diagnosed as major depression (DSM III R) (see appendix 6) and they reported that 27 out 50 (54%) depressed male patients have sexual dysfunction, 19 out 50 (38%) depressed male patients have no sexual dysfunction and 4 out 50 (8%) depressed male patients have organic sexual dysfunction (prostatic), as shown in table (11). *Mohammed (2005)* (see appendix 32) *and Hashem et al. (2006)* (see appendix 33) studied 60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia) and they reported that 24 out of 30 (80%) paranoid male schizophrenics and 26 out of 30 (86.7%) non-paranoid male schizophrenics have at least one sexual dysfunction with insignificant difference between them, as shown in table (11). *Abdel Azim et al. (2007)* studied 68 male and 52 female chronic schizophrenics compared with healthy controls (see appendix 35) and they reported that 48 out of 68 (69%) male patients and 27 out of 52 (53%) female patients have sexual dysfunction, as shown in table (11). Also, they found that male and female schizophrenics have significantly sexual dysfunction than controls.

**Table (11) Prevalence of sexual dysfunctions among depressed and schizophrenic patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ahmed &amp; Ezz El-Din (1992)</b>	50 male patients diagnosed as major depression (DSM III R).	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psychosexual interview.	54% sexual dysfunction, 38% no sexual dysfunction, 8% organic sexual dysfunction (prostatic).
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psychosexual interview.	80% of paranoid and 86.7% of non-paranoid male schizophrenics have at least one sexual dysfunction. (P > 0.05 (N.S).
<b>Abdel Azim et al. (2007)</b>	68 male and 52 female chronic schizophrenics.	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire.	69% male and 53% female chronic schizophrenics have sexual dysfunction.

### **(1) Sexual dissatisfaction:**

*Ahmed and Ezz El-Din (1992)* (see appendix 6) reported that 3 out 27 (11.11%) depressed male patients with sexual dysfunction have lack of sexual satisfaction, as shown in table (12). *Hussein\** (2002) studied 37 schizophrenic patients (32 males and 5 females) and their spouses and he reported that the mean (SD) of sexual dissatisfaction subscale of Marital

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\* Arabic Reference.



Satisfactory Inventory (MSI) of the patients ( $48.86 \pm 8.61$ ) (table 12) is less than their spouses ( $49.89 \pm 7.22$ ), but without significant difference. *Mohammed (2005)* (see appendix 32) *and Hashem et al. (2006)* (see appendix 33) reported that 12 out of 30 (40%) paranoid male schizophrenics and 15 out of 30 (53.57%) non-paranoid male schizophrenics have lack of sexual satisfaction with insignificant difference between them, as shown in table (12).

***Table (12) Prevalence of sexual dissatisfaction among depressed and schizophrenic patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>Ahmed &amp; Ezz El-Din (1992)</b>	27 male patients diagnosed as major depression (DSM III R) with sexual dysfunctions.	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psychosexual interview.	11.11% depressed male patients have lack of sexual satisfaction.
<b>Hussein (2002)</b>	37 schizophrenic patients (32 males and 5 females) and their spouses.	Dar El Mokattam for mental health.	Marital Satisfactory Inventory (MSI).	Mean (SD) of sexual dissatisfaction subscale of MSI of patients is ( $48.86 \pm 8.61$ ).
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psychosexual interview.	40% of paranoid and 53.57% of non-paranoid male schizophrenics have lack of sexual satisfaction. ( $P > 0.05$ (N.S.))

**(2) Dysfunction of the desire phase (sexual desire disorders):**

**Ahmed and Ezz El-Din (1992)** (see appendix 6) reported that 10 out of 27 (37.03%) depressed male patients with sexual dysfunctions have lack of sexual desire (see table 13). **El Fangary (2003)** studied 60 psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction (see appendix 30). He reported that 59 out of 60 (98.3%) psychiatric patients with sexual dysfunctions have sexual desire disorder (see table 13) with insignificant difference with the non psychiatric patients with sexual dysfunction. **Mohammed (2005)** (see appendix 32) **and Hashem et al. (2006)** (see appendix 33) found that 11 out of 30 (36.7%) paranoid male schizophrenics and 14 out of 30 (46.7%) non-paranoid male schizophrenics have sexual desire disorder with insignificant difference between them (see table 13). **Abdel Azim et al. (2007)** (see appendix 35) reported that 43 out of 68 (62%) male chronic schizophrenics and 31 out of 52 (61%) female chronic schizophrenics have reduced libido, as shown in table (13). Also, they found that this prevalence are significantly higher than prevalence of reduced libido among the healthy persons.

**Table (13) Prevalence of sexual desire disorders among psychiatric patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ahmed &amp; Ezz El-Din (1992)</b>	27 male patients diagnosed as major depression (DSM III R) with sexual dysfunctions.	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psycho-sexual interview.	37.03% have lack of sexual desire.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psycho-sexual interview.	98.3% have sexual desire disorder.
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psycho-sexual interview.	36.7% of paranoid and 46.7% of non-paranoid male schizophrenics have sexual desire disorder. P > 0.05 (N.S.)
<b>Abdel Azim et al. (2007)</b>	68 male and 52 female chronic schizophrenics.	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire.	62% male and 61% female chronic schizophrenics have reduced libido.

### **(3) Dysfunction of the excitement phase:**

#### **a) Sexual arousal disorder:**

*El Fangary (2003)* (see appendix 30) reported that 41 out of 60 (63.3%) psychiatric female patients with sexual dysfunction have arousal dysfunction (see table 14) and they have significantly arousal dysfunction more than the females of non psychiatric patients with sexual dysfunction. *Mohammed (2005)* (see appendix 32) *and Hashem et al. (2006)* (see

appendix 33) reported that 9 out of 30 (42.9%) paranoid male schizophrenics and 12 out of 30 (44.8%) non-paranoid male schizophrenics have excitement dysfunction (see table 14) with insignificant difference between them. *Abdel Azim et al. (2007)* studied 68 male and 52 female chronic schizophrenics compared with healthy controls (see appendix 35) and they reported that 34 out of 68 (51%) male schizophrenics and 17 out of 52 (33%) female schizophrenics have arousal problems, as shown in table (14). Also, they found that male schizophrenics have significantly arousal problems than controls but without significant difference between female chronic schizophrenics and controls as regards arousal problems.

***Table (14) Prevalence of sexual arousal disorder among psychiatric patients:***

Author/s	Sample	Site	Tools	[Prevalence
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psycho-sexual interview	63.3% patients have arousal dysfunction.
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psycho-sexual interview	42.9% of paranoid and 44.8% of non-paranoid male schizophrenics have excitement dysfunction. (P > 0.05 (N.S.))
<b>Abdel Azim et al. (2007)</b>	68 male and 52 female chronic schizophrenics.	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire.	51% male and 33% female chronic schizophrenics have arousal problems.

**b) Male erectile disorder (impotence):**

**Ahmed and Ezz El-Din (1992)** (see appendix 6) reported that 6 out 27 (22.22%) and 3 out 27 (11.11%) depressed male patients with sexual dysfunctions have lack of erection and failure to maintain erection respectively (see table 15). **Mohammed (2005)** (see appendix 32) **and Hashem et al. (2006)** (see appendix 33) reported that 6 out of 30 (20%) paranoid male schizophrenics and 10 out of 30 (35.71%) non-paranoid male schizophrenics have failure to achieve erection and 11 out of 30 (36.7%) paranoid male schizophrenics and 9 out of 30 (32.14%) non-paranoid male schizophrenics have failure to maintain erection with insignificant difference between them, as shown in table (15). **Abdel Azim et al. (2007)** (see appendix 35) reported that the prevalence of erectile dysfunction is significantly higher among the male chronic schizophrenics (35/68; 52%) (table 15) than among the healthy controls.

**Table (15) Prevalence of male erectile disorder (impotence) among depressed and schizophrenic patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ahmed &amp; Ezz El-Din (1992)</b>	27 male patients diagnosed as major depression (DSM III R) with sexual dysfunctions.	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psycho-sexual interview.	22.22% have lack of erection, 11.11% have failure to maintain erection.
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psycho-sexual interview.	20% of paranoid and 35.71% of non-paranoid male schizophrenics have failure to achieve erection. 36.7% of paranoid and 32.14% of non-paranoid male schizophrenics have failure to maintain erection. (P > 0.05 (N.S.))
<b>Abdel Azim et al. (2007)</b>	68 male chronic schizophrenics.	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire.	52% have erectile dysfunction.

**(4) Dysfunction of the orgasm phase (orgasmic disorders):**

**a) Female orgasmic disorder:**

*El Fangary (2003)* (see appendix 30) reported that 57 out of 60 (95%) psychiatric female patients with sexual dysfunction have orgasm dysfunction (table 16) with insignificant difference with 30 non psychiatric female patients with sexual dysfunction. *Abdel Azim et al. (2007)* (see

appendix 35) found that the prevalence of orgasmic dysfunction is significantly higher among the chronic female schizophrenics (41/52; 82%) (see table 16) than among the healthy females.

***Table (16) Prevalence of female orgasmic disorder among psychiatric patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>El Fangary (2003)</b>	60 psychiatric patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychosexual interview.	95% have orgasm dysfunction.
<b>Abdel Azim et al. (2007)</b>	52 female chronic schizophrenics	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire.	82% have orgasmic dysfunction.

***b) Male orgasmic disorder:***

***Mohammed (2005)*** (see appendix 32) ***and Hashem et al. (2006)*** (see appendix 33) found that the prevalence of orgasmic dysfunction is significantly higher among the non-paranoid male schizophrenics (13/30; 46.4%) than among the paranoid male schizophrenics (6/30; 20%), as shown in table (17).

***Table (17) Prevalence of male orgasmic disorder among psychiatric patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psychosexual interview.	20% of paranoid and 46.4% of non-paranoid male schizophrenics have orgasm dysfunction. (P < 0.05, Sign.)

**Ejaculatory dysfunction (premature and delayed ejaculation):**

*Ahmed and Ezz El-Din (1992)* (see appendix 6) reported that 5 out of 27 (18.52%) depressed male patients have premature ejaculation (see table 18). *Mohammed (2005)* (see appendix 32) *and Hashem et al. (2006)* (see appendix 33) found that 4 out of 30 (13.3%) paranoid male schizophrenics and 7 out of 30 (25%) non-paranoid male schizophrenics have delayed ejaculation and 13 out of 30 (43.3%) paranoid male schizophrenics and 8 out of 30 (28.57%) non-paranoid male schizophrenics have premature ejaculation with insignificant difference between them, as shown in table (18). *Abdel Azim et al. (2007)* (see appendix 35) found that the prevalence of ejaculatory dysfunction is significantly higher among the chronic male schizophrenics (58/68; 86%) (see table 18) than among the healthy males.



***Table (18) Prevalence of ejaculatory dysfunction among depressed and schizophrenic patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>Ahmed &amp; Ezz El-Din (1992)</b>	27 male patients diagnosed as major depression (DSM III R) with sexual dysfunctions.	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psycho-sexual interview.	18.52% have premature ejaculation.
<b>Mohammed (2005) &amp; Hashem et al. (2006)</b>	60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia).	In-patient department of Dar El Mokattam for mental health.	Psycho-sexual interview.	13.3% of paranoid and 25% of non-paranoid male schizophrenics have delayed ejaculation. 43.3% of paranoid and 28.57% of non-paranoid male schizophrenics have premature ejaculation. (P > 0.05 (N.S.))
<b>Abdel Azim et al. (2007)</b>	68 male chronic schizophrenics.	Multi-center study at Riyadh, K.S.A.	Sexual Functioning Questionnaire	86% have ejaculatory dysfunction.

***(5) Sexual pain disorders:***

*El Fangary (2003)* studied 60 psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction (see appendix 30). He reported that 29 out of 60 (48.3%) and 14 out of 60 (23.3%) psychiatric patients with sexual dysfunction have dyspareunia and vaginismus respectively (see table 19) with insignificant difference between both groups as regards dyspareunia and vaginismus.

**Table (19) Prevalence of sexual pain disorder among psychiatric patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>El Fangary (2003)</b>	60 psychiatric patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychosexual interview.	48.3% have dyspareunia, 23.3% have vaginismus.

### **(III) Substance-induced sexual dysfunctions:**

#### **(1) Sexual dissatisfaction:**

*Abolmagd et al. (2004)* studied sample of 30 addict inpatients and their wives compared with 30 healthy male adults and their wives (see appendix 31) and they reported that the wives of addicts show significantly higher level of sexual dissatisfaction (table 20) than the healthy individuals (100% of sexual satisfaction). Also, they reported significantly disagreement of sexual satisfaction (table 20) as compared to controls (100% agreement of sexual satisfaction).

**Table (20) Prevalence of sexual dissatisfaction among couples of addicts husbands:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abolmagd et al. (2004)</b>	30 heroin addict inpatients and their wives and a control group of 30 male healthy adults and their wives.	Not mentioned.	Psychiatric interview and marital satisfaction inventory.	26.7% sexual satisfaction, 70% moderate sexual dissatisfaction, 3.3% severe sexual dissatisfaction. 50% agreement of sexual dissatisfaction, 50% disagreement of sexual dissatisfaction.

## **(2) Dysfunction of the desire phase (sexual desire disorders):**

### **Hypoactive sexual desire disorder:**

*Hashem and El-Orabi (1993)* studied 17 male chronic heroin abusers compared with 13 healthy male individuals (see appendix 8) and they reported that 6 out of 17 (35.5%) patients have decrease libido, as shown in table (21). Also, they found that male chronic heroin abusers have significantly decrease libido than the healthy individuals (0.0%).

## **(3) Dysfunction of the excitement phase:**

### **Male erectile disorder (impotence):**

*Hashem and El-Orabi (1993)* (see appendix 8) reported that 5 out of 17 (29.4%) male chronic heroin abusers have impotence, as shown in table (21). And by comparing this prevalence with the prevalence of impotence among 13 healthy male individuals which is 0.0% (0/13), they found significantly high prevalence of impotence among the male chronic heroin abusers.

**Table (21) Prevalence of decreased libido and impotence among male heroin abusers:**

Author/s	Sample	Site	Tools	Prevalence
<b>Hashem &amp; El-Orabi (1993)</b>	17 male chronic heroin abusers and a control group of 13 male healthy individuals.	Al-Salama Hospital in Jeddah, Kingdom of Saudi Arabia.	Psychiatric interview, clinical examination and laboratory investigation	35.5% have decreased libido, 29.4% have impotence, 52.9% have no sexual dysfunction symptoms.

## **(IV) Sexual dysfunctions among medical patients:**

*Ibrahim et al. (1995)* studied 60 1ry ESRD patients under regular haemodialysis (48 males and 12 females) (see appendix 12) and they reported that sexual performance is impaired post dialysis in 96.7% of cases and sexual petting in 68.3% (table 22). *El-Azoony (2002)* studied 100 epileptic male patients (see appendix 29) and he reported that 18 out of 100 (18%) patients have global sexual dysfunction [7 out of 49 (14.3%) patients with GTC fits and 11 out of 51 (21.6%) patients with partial fits] with insignificant difference between generalized and partial epileptic patients as regards global sexual dysfunction, as shown in table (22).

**Table (22) Prevalence of sexual dysfunction among medical patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ibrahim et al. (1995)</b>	60 1ry ESRD patients under regular treatment (48 males and 12 female).	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionn- aire	Sexual performance is impaired post dialysis in 96.7% of cases and sexual petting in 68.3%.
<b>El- Azoony (2002)</b>	100 epileptic male patients.	Outpatient clinics of Neurology department, Ain Shams University hospital and specialized Ain Shams University hospital.	Psycho- sexual questionn- aire	18% patients have global sexual dysfunction (14.3% patients with GTC fits and 21.6% patients with partial fits).  ( $\chi^2 = 2.1$ and $p > 0.05$ (N.S.))

**(1) Sexual dissatisfaction:**

**Ibrahim et al. (1995)** (see appendix 12) found that 85% of 60 1ry ESRD patients have sexual dissatisfaction after regular haemodialysis (table 23). **Mourad (2009)** studied 50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy) (see appendix 37) and he reported that all patients (100%) either on monotherapy or polytherapy have intercourse dissatisfaction, as shown in table (23).

**Table (23) Prevalence of sexual dissatisfaction among medical patients:**

Author/s	Sample	Site	Tools	Results
<b>Ibrahim et al. (1995)</b>	60 1ry ESRD patients under regular haemodialysis (48 males and 12 female).	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionnaire	85% have sexual dissatisfaction.
<b>Mourad (2009)</b>	50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy).	Kasr El-Aini Epilepsy Outpatient Clinic.	Psychosexual interview.	100% patients either on monotherapy or polytherapy have intercourse dissatisfaction.

## (2) Dysfunction of the desire phase (sexual desire disorders):

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 epileptic male patients with sexual disorders (see appendix 5) and they reported that 6 out of 17 (35%) patients have loss of libido (table 24). *Bahary*<sup>\*</sup> (1987) studied 127 epileptic female patients with sexual disorders and he reported that 31 out of 127 (24.4%) patients have inhibited sexual desire (table 24). *Ibrahim et al.* (1995) studied 601ry ESRD patients under regular haemodialysis (48 males and 12 female) (see appendix 12) and they reported that sexual desire is impaired post dialysis in 93.3% of cases. Also, they found that after haemodialysis 96.7% of 601ry ESRD patients have impairment in the frequency of sexual intercourse and 68.3% have impairment of sexual petting (table 24). *El-Azoony* (2002) studied 100 male epileptic patients (see appendix 29) and he reported that 20 out of 100 (20%) patients have desire dysfunction [8 out of 49 (16.3%) patients with GTC fits and 12 out of 51 (23.5%) patients with partial fits] with insignificant difference between generalized and partial epileptic patients as regards desire dysfunction (table 24). *Mourad* (2009) studied 50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy) (see appendix 37) and he reported that 15 out of 20 (75%) patients on monotherapy and 28 out of 30 (93.3%) patients on polytherapy have desire dysfunction, as shown in table (24).

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\* Arabic Reference.

***Table (24) Prevalence of sexual desire disorder among medical patients:***

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 epileptic male patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	(1) Sexual history questionnaire (Kinsey et al, 1948). (2) Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976).	35% loss of libido.
<b>Bahary (1987)</b>	127 epileptic female patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	24.4% inhibited sexual desire.
<b>Ibrahim et al. (1995)</b>	60 1ry ESRD patients under regular haemodialysis (48 males and 12 female).	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionnaire	Sexual desire is impaired post dialysis in 93.3% of cases and 96.7% have impairment in the frequency of sexual intercourse and 68.3% have impairment of sexual petting.
<b>El- Azoony (2002)</b>	100 epileptic male patients.	Outpatient clinics of Neurology department, Ain Shams University hospital and specialized Ain Shams University hospital.	Psychosexual questionnaire	20% patients have desire dysfunction (16.3% patients with GTC fits and 23.5% patients with partial fits). ( $\chi^2 = 0.8$ and $p > 0.05$ ).
<b>Mourad (2009)</b>	50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy).	Kasr El-Aini Epilepsy Outpatient Clinic.	Psychosexual interview.	75% patients on monotherapy and 93.3% patients on polytherapy have desire dysfunction.

### (3) Dysfunction of the excitement phase:

#### (a) Female sexual arousal disorder:

**Bahary**<sup>\*</sup> (1987) studied 127 epileptic female patients with sexual disorders and he found that 25.2% (32/127) epileptic female patients with sexual disorders have inhibited sexual excitement, as shown in table (25).

**Table (25) Prevalence of sexual arousal disorder among epileptic female patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 epileptic female patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	25.2% have inhibited sexual excitement.

#### (b) Male erectile disorder (impotence):

**Bahary**<sup>\*</sup> (1983) and **Demerdash et al.** (1986) (see appendix 5) reported that 4 out of 17 (24%) epileptic male patients with sexual disorders have erectile dysfunction (table 26). **Zein El Abedeen**<sup>\*</sup> (1988) studied 30 impotent diabetic male patients and he reported that 8 out of 30 (26.67%) impotent diabetic patients have psychogenic impotence, 2 out of 30 (6.67%) impotent diabetic patients have organic impotence, 19 out of 30 (63.33%) impotent diabetic patients have psychogenic and organic impotence and one out of 30 (3.33%) impotent diabetic patients the cause of impotence is

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<sup>\*</sup> Arabic Reference.



not known, as shown in table (26). ***Ibrahim et al. (1995)*** (see appendix 12) found that 45.8% of 48 male 1ry ESRD patients have impaired erection after regular haemodialysis (table 26). ***El-Azoony (2002)*** (see appendix 29) reported that 30 out of 100 (30%) epileptic male patients have erection failure [15 out of 49 (16.3%) patients with GTC fits and 15 out of 51 (23.5%) patients with partial fits] with insignificant difference between generalized and partial epileptic patients as regards erection failure (table 26). ***Mourad (2009)*** (see appendix 37) reported that 6 out of 20 (30%) epileptic male patients with sexual dysfunction on monotherapy and 3 out of 30 (10%) epileptic male patients with sexual dysfunction on polytherapy have erectile dysfunction, as shown in table (26).

**Table (26) Prevalence of male erectile disorder among medical patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 epileptic male patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	(1) Sexual history questionnaire (Kinsey et al, 1948). (2) Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976).	24% erectile dysfunction.
<b>Zein El Abedeen (1988)</b>	30 impotent diabetic male patients.	The clinic of the company of Misr El Gedida for Housing and Construction.	Psychiatric and physical examinations. Laboratory investigations and N.P.T. test.	26.67% psychogenic impotence, 6.67% organic impotence, 63.33% psychogenic and organic impotence, 3.33% not known.
<b>Ibrahim et al. (1995)</b>	48 male 1ry ESRD patients under regular haemodialysis.	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionnaire.	Erection in male is impaired post dialysis in 45.8% of cases.
<b>El- Azoony (2002)</b>	100 epileptic male patients.	Outpatient clinics of Neurology department, Ain Shams University hospital and specialized Ain Shams University hospital.	Psychosexual questionnaire.	30% patients have erection failure (30.6% patients with GTC fits and 29.4% patients with partial fits). ( $\chi^2 = 0.3$ and $p > 0.05$ ).
<b>Mourad (2009)</b>	50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy).	Kasr El-Aini Epilepsy Outpatient Clinic.	Psychosexual interview.	30% patients on monotherapy and 10% patients on polytherapy have erectile dysfunction.

**(4) Dysfunction of the orgasm phase (orgasmic disorders):**

*El-Azoony (2002)* (see appendix 29) reported that 27 out of 100 (27%) epileptic male patients have ejaculatory dysfunction [13 out of 49 (26.5%) patients with GTC fits and 14 out of 51 (27.5%) patients with partial fits] with insignificant difference between generalized and partial epileptic patients as regards ejaculatory dysfunction, as shown in table (27). *Mourad (2009)* (see appendix 37) reported that 11 out of 20 (55%) epileptic male patients with sexual dysfunction on monotherapy and 17 out of 30 (56.7%) epileptic male patients with sexual dysfunction on polytherapy have orgasmic dysfunction, as shown in table (27).

**Table (27) Prevalence of orgasmic disorders among epileptic patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>El-Azoony (2002)</b>	100 epileptic male patients.	Outpatient clinics of Neurology department, Ain Shams University hospital and specialized Ain Shams University hospital.	Psycho-sexual questionnaire	27% patients have ejaculatory dysfunction (26.5% patients with GTC fits and 27.5% patients with partial fits). ( $\chi^2 = 0.01$ and $p > 0.05$ )
<b>Mourad (2009)</b>	50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy).	Kasr El-Aini Epilepsy Outpatient Clinic.	Psycho-sexual interview.	55% epileptic patients on monotherapy and 56.7% patients on polytherapy have orgasmic dysfunction.

**a) Female inhibited orgasm:**

**Bahary\*** (1987) reported that 28 out of 127 (22%) epileptic female patients with sexual disorders have inhibited orgasm, as shown in table (28).

**b) Male and female inhibited orgasm:**

**Ibrahim et al. (1995)** (see appendix 12) reported that 78.3% of 60 1ry ESRD patients (48 males and 12 female) have impairment in sexual orgasm after regular haemodialysis, as shown in table (28).

**Table (28) Prevalence of orgasmic disorder among medical patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 epileptic female patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	22% inhibited sexual orgasm.
<b>Ibrahim et al. (1995)</b>	60 1ry ESRD patients under regular haemodialysis (48 males and 12 female).	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionnaire.	Sexual orgasm is impaired post dialysis in 78.3% of cases.

**c) Premature ejaculation:**

**Bahary\*** (1983) and **Demerdash et al (1986)** (see appendix 5) reported that 4 out of 17 (24%) epileptic male patients with sexual disorders have premature ejaculation. **Ibrahim et al (1995)** (see appendix 12) found that 78.3% of 48

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\* Arabic Reference.

male 1ry ESRD patients have premature ejaculation after regular haemodialysis, as shown in table (29).

**Table (29) Prevalence of ejaculatory dysfunction among medical patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 epileptic male patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	(1) Sexual history questionnaire (Kinsey et al, 1948). (2) Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976).	24% premature ejaculation.
<b>Ibrahim et al. (1995)</b>	60 1ry ESRD patients under regular haemodialysis (48 males and 12 female).	The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.	Sexual function questionnaire.	Premature ejaculation is reported post dialysis in 78.3% of cases.

### **(5) Sexual pain disorders:**

**Bahary\*** (1987) studied 127 epileptic female patients with sexual disorders and he reported that 4.7% (6/127) patients have dyspareunia and 7.1% (9/127) patients have vaginismus (table 30).

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\* Arabic Reference.

**Table (30) Prevalence of sexual pain disorders among epileptic female patients:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 epileptic female patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	4.7% have dyspareunia, 7.1% have vaginismus.

## **(V) Sexual assault can lead to sexual dysfunctions:**

### **a) Childhood sexual abuse (CSA):**

*Fahmy et al. (1995)* studied 627 psychiatric patients (see appendix 13) and they reported that 54 out of 627 (8.62%) patients have history of sexual abuse (before age of 15 years), as shown in table (31). *Sayed (1998)* studied 1651 psychiatric patients (see appendix 18) and he reported that 458 out of 1651 (27.75%) psychiatric patients have history of childhood sexual abuse (CSA), as shown in table (31). *Soliman et al. (1999)* studied 78 depressed women (see appendix 21) and they reported that 35 out of 78 (44.9%) depressed women report history of CSA, as shown in table (31). *El Fangary (2003)* studied 60 psychiatric patients with sexual dysfunction (see appendix 30) and he reported that 4 out of 60 (6.7%) patients have history of sexual abuse, as shown in table (31). *Hamed (2006)* studied 1500 preparatory school students (see appendix 34) and he reported that 78 out of 1500 (5.2%) students are subjected to sexual abuse (table 31) either by : (1) making him / her watching sexual act, exposing sexual organs to him / her or trying to touch him / her sexual organs (genital fondling). (2) trying to make him / her practice sex either by force or by

threat. Also, **Hamed (2006)** studied 1410 students of no physical health problems and 90 students of physical health problems (see appendix 34) and he reported that 78 out of 1410 (5.53%) of students of no physical health problems are subjected to sexual abuse and no one out of 90 students of physical health problems chronic problems are subjected to sexual abuse, as shown in table (31). Also, he found that health problems show no significant difference in students subjected to sexual abuse.

**Table (31) Prevalence of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Prevalence
<b>Fahmy et al. (1995)</b>	627 psychiatric patients.	Outpatient psychiatric clinics	Psychiatric interview.	8.62% have history of CSA.
<b>Sayed (1998)</b>	1651 psychiatric patients.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview and sexual abuse questionnaire.	27.75% have history of CSA.
<b>Soliman et al. (1999)</b>	78 depressed women.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Psychiatric interview.	44.9% have history of CSA.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	6.7% have history of CSA.
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	5.2% are subjected to sexual abuse.
<b>Hamed (2006)</b>	1410 students of no physical health problems and 90 students of physical health problems.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	5.53% of students of no physical health problems and no one of students of physical health problems chronic problems are subjected to sexual abuse.

**Fahmy et al. (1995)** studied 421 females and 206 males psychiatric patients (see appendix 13) and they reported that 38 out of 421 (9%) females patients and 16 out of 206 (7.77%) males patients have history of CSA, as shown in table (32). **Hamed (2006)** studied 1500 preparatory school students (801 male students and 699 female students) (see appendix 34) and he reported that 63 out of 801 (7.87%) male students are subjected to sexual abuse and 15 out of 699 (2.15%) female students are subjected to sexual abuse, as shown in table (32). Also, he found that male students are significantly liable to sexual abuse than female students. **Riyadh et al. (2007)** studied 304 children (see appendix 36) and they reported that 1.7% of the males and 15.7% of the females suffer from sexual abuse, as shown in table (32).

**Table (32) Prevalence of CSA in different sex:**

Author/s	Sample	Site	Tools	Prevalence
<b>Fahmy et al. (1995)</b>	421 females and 206 males psychiatric patients.	Outpatient psychiatric clinics.	Psychiatric interview.	7.77% of male psychiatric patients, 9% of female psychiatric patients.
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	7.87% of male students, 2.15% of female students.
<b>Riyadh et al. (2007)</b>	304 children.	Not mentioned.	Psychiatric interview.	1.7% of the males, 15.7% of the females.



**b) Rape:**

*Abdelmessih et al. (1980)* (see appendix 2) reported that 52.86% (157 / 297) of cases prosecuted to sexual offences are cases of rape (table 33). *Mohammed (2001)* studied 30 delinquent females committed one or more sexual crime aged from 12 to 20 years old (see appendix 28) and he reported that 20% (6 / 30) delinquent females are prepubertal rape victims, as shown in table (33). Also, *Mohammed (2001)* reported that 93.3% (28 / 30) delinquent females have postpubertal sexual experience in the form of rape, extra marital sexual intercourse and petting, as shown in table (33).

**Table (33) Prevalence of rape:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abdel messih et al. (1980)</b>	297 prosecuted to sexual offences.	Not mentioned.	Not mentioned.	52.86% of cases prosecuted to sexual offences are cases of rape.
<b>Mohammed (2001)</b>	30 delinquent females committed one or more sexual crime.	The Ain Shams Institute for female juvenile.	Psychiatric interview.	20% are prepubertal rape victims. 93.3% have postpubertal sexual experience in the form of rape, extra marital sexual intercourse and petting.

## **(VI) Female genital mutilation may lead to sexual dysfunctions:**

### **Female circumcision:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (see appendix 11) and they reported that 200 out of 250 (80%) wives are circumcised and 50 out of 250 (20%) are

uncircumcised (table 34). *El-Defrawy et al. (1996)* (see appendix 14) reported that the percentage of the circumcised women to the total attenders to the family planning centers of the ministry of health in Ismailia reached 75% (table 34). *Refaat et al. (1999)* studied 7128 women (see appendix 19) and they reported that 6921 out of 7128 (97.1%) women are circumcised and 207 out of 7128 (2.9%) are not circumcised (table 34). *El Fangary (2003)* studied 60 psychiatric patients with sexual dysfunction (see appendix 30) and he reported that 59 out of 60 (98.3%) patients are circumcised and one out of 60 (1.7%) patients is not circumcised, as shown in table (34).

***Table (34) Prevalence of female circumcision:***

Author/s	Sample	Site	Tools	Prevalence
<b>Lotfy &amp; El-Defrawy (1995)</b>	250 wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Gynecological examination.	80% circumcised wives.
<b>El-Defrawy et al. (1996)</b>	The total attenders.	Family planning centers of the ministry of health in Ismailia.	Gynecological examination.	95% circumcised women.
<b>Refaat et al. (1999)</b>	7128 women.	Not mentioned.	Women status questionnaire of EDHS-95.	97.1% circumcised women.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	98.3% patients are circumcised.

*Abdel Azim et al. (2000)* studied 70 circumcised and 70 uncircumcised wives (see appendix 24) and they reported that 28 out of 70 (40%) circumcised wives and 9 out of 70 (12.85%) uncircumcised wives have sexual dysfunctions. Also, they found that 13 out of 70 (18.57%) circumcised wives have disturbed resolution phase with pelvic heaviness and low backache, 2 out of 70 (2.86%) circumcised wives have excessive masturbation, 3 out of 70 (4.28%) circumcised wives have marked feeling of inadequacy of body and sex organs and 21 out of 70 (30%) circumcised wives have more than one diagnosis (table 35).

***Table (35) Prevalence of sexual dysfunction among the circumcised wives:***

Author/s	Sample	Site	Tools	Prevalence
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	40% sexual dysfunctions. 18.57% disturbed resolution phase with pelvic heaviness and low backache, 2.86% excessive masturbation, 4.28% marked feeling of inadequacy of body and sex organs, 30% more than one diagnosis.

### (1) Sexual dissatisfaction and other sexual dysfunctions:

*Abdel Azim et al. (2000)* studied the sexual satisfaction among 70 circumcised and 70 uncircumcised wives and their husbands (see appendix 24). They found that the circumcised wives and their husbands are significantly less sexually satisfied than the uncircumcised wives and their husbands, as shown in table (36).

**Table (36) Sexual satisfaction among the circumcised and uncircumcised wives and their husbands:**

Data	Circumcised	Non-circumcised	t	p
	Mean $\pm$ SD	Mean $\pm$ SD		
1- Premature ejaculation	48.38 $\pm$ 6.27	39.67 $\pm$ 5.83	6.03	<0.001
2- Non-sensuality	38.24 $\pm$ 4.71	35.51 $\pm$ 3.58	2.57	<0.005
3- Dissatisfaction (male)	54.81 $\pm$ 7.47	48.36 $\pm$ 6.23	3.93	<0.001
4- Infrequency	39.72 $\pm$ 4.96	37.01 $\pm$ 3.27	2.75	<0.005
5- Dissatisfaction (female)	57.83 $\pm$ 7.81	47.43 $\pm$ 6.45	6.12	<0.001
6- Avoidance (female)	49.34 $\pm$ 5.87	43.81 $\pm$ 4.62	4.42	<0.001
7- Non-sensuality (female)	38.91 $\pm$ 4.82	36.47 $\pm$ 3.67	4.69	<0.001
8- Vaginismus	42.32 $\pm$ 4.83	39.05 $\pm$ 3.76	3.18	<0.001
9- Anorgasmia	54.82 $\pm$ 6.13	47.16 $\pm$ 5.74	5.39	<0.001

(Abdel Azim et al., 2000)

### (2) Dysfunction of the desire phase (sexual desire disorders):

#### a) Hypoactive sexual desire disorder:

*Lotfy and El-Defrawy (1995)* studied 250 women (200 circumcised and 50 uncircumcised) (see appendix 11) and they

reported that 83 out of 200 (41.5%) circumcised women have no sexual desire, 76 out of 200 (38%) circumcised women have sexual desire and 41 out of 200 (20.5%) circumcised women sometimes have sexual desire (table 37). They found that the uncircumcised women have significantly more sexual desire than the circumcised women. *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 83 out of 200 (41.5%) circumcised wives have no sexual desire, 76 out of 200 (38%) circumcised wives have sexual desire and 41 out of 200 (20.5%) circumcised wives sometimes have sexual desire (table 37). Also, they found that the uncircumcised wives have significantly more sexual desire than the circumcised wives. *Abdel Azim et al. (2000)* (see appendix 24) reported that 3 out of 70 (4.28%) circumcised wives have lack or loss of sexual desire and 12 out of 70 (17.14%) circumcised wives have sexual aversion (table 37).

**Table (37) Prevalence of sexual desire disorder among circumcised wives:**

Author/s	Sample	Site	Tools	Prevalence
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised women.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psycho-sexual interview schedule.	41.5% have no sexual desire, 38% have sexual desire, 20.5% sometimes have sexual desire.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	The Arabic Version of (SEBA.A).	41.5% have no sexual desire, 38% have sexual desire, 20.5% sometimes have sexual desire.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	4.28% have lack or loss of sexual desire.

**b) Sexual aversion disorder and lack of sexual enjoyment:**

*Abdel Azim et al. (2000)* (see appendix 24) reported that 12 out of 70 (17.14%) circumcised wives have sexual aversion disorder and 4 out of 70 (5.71%) circumcised wives have lack of sexual enjoyment (table 38).

**Table (38) Prevalence of sexual aversion disorder and lack of sexual enjoyment among circumcised wives:**

Author/s	Sample	Site	Tools	Prevalence
Abdel Azim et al. (2000)	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	17.14% have sexual aversion disorder. 5.71% have lack of sexual enjoyment.

**(3) Dysfunction of the excitement phase (sexual arousal disorders):**

*Abdel Azim et al. (2000)* (see appendix 24) found that 4 out of 70 (5.71%) circumcised wives have failure of genital response (sexual arousal disorder) (table 39).

**Table (39) Prevalence of sexual arousal disorder among circumcised wives:**

Author/s	Sample	Site	Tools	Prevalence
Abdel Azim et al. (2000)	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	5.71% have failure of genital response (sexual arousal disorder).

#### **(4) Dysfunction of the orgasm phase (orgasmic disorders):**

*Abdel Azim et al. (2000)* (see appendix 24) reported that 14 out of 70 (20%) circumcised wives have orgasmic dysfunction (table 40).

**Table (40) Prevalence of orgasmic disorder among circumcised wives:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	20% have orgasmic dysfunction.

#### **(5) Sexual pain disorder:**

*Lotfy and El-Defrawy (1995)* studied 200 circumcised (see appendix 11) and they reported that 92 out of 200 (46%) circumcised wives have pain during intercourse, as shown in table (41). *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 83 out of 200 (41.5%) circumcised wives have pain during intercourse, as shown in table (41). Also, they found that dyspareunia is highly presented among the circumcised wives than among the uncircumcised wives. Although *Lotfy and El-Defrawy (1995)* found insignificant difference between the circumcised and the uncircumcised wives as regards dyspareunia. *Abdel Azim et al. (2000)* (see appendix 24) reported that 7 out of 70 (10%) and 12 out of 70



(17.1%) wives have non organic vaginismus and dyspareunia respectively (table 41).

**Table (41) Prevalence of sexual pain disorder among circumcised wives:**

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Prevalence</b>
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	46% have pain during intercourse.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	The Arabic Version of (SEBA.A).	41.5% have pain during intercourse.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	10% and 17.1% wives have non organic vaginismus and dyspareunia respectively.

## **(VII) Homosexuality and lesbianism:**

**Demerdash (1970)** studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he reported that 16 out of 32 (50%) Kuwaitis impotent patients, 8 out of 17 (47.1%) Palestinian impotent patients and 6 out of 13 (31.6%) Egyptian impotent patients report history of homosexuality, as shown in table (42). **Ashour\*** (1984) studied 50 male rape offenders and he reported that 25 out of 50 (50%) patients have homosexuality, as shown in table (42). **Lotaief et al. (1994)** studied 155 males and 115 females (see appendix 10) and they reported that 15 out of 155 (9.67%) males have homosexual experience and 8 out of 115 (6.95%) females have lesbian experience, as shown in table (42). **Habeeb (2000)** studied 80 general medical hospital male inpatients (see appendix 26) and he reported that one out of 80 (1.25%) patients has homosexual practice (negative partner), as shown in table (42). **Mohammed (2001)** studied 30 delinquent females aged from 12 to 20 years (see appendix 28) and he reported that 10 out of 30 (33.3%) delinquent females report history of lesbianism, as shown in table (42).

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\* Arabic Reference.

***Table (42) Prevalence of homosexuality and lesbianism:***

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Prevalence</b>
<b>Demerdash (1970)</b>	68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian).	The department of Psychiatry, Ain Shams and Cairo Faculties of medicine and The Kuwait Psychiatric Hospital.	Psychiatric interview.	50% Kuwaitis, 47.1% Palestinian and 31.6% Egyptian impotent patients report history of homosexuality.
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons.	Psycho-sexual interview.	50% have homosexuality.
<b>Lotaief et al. (1995)</b>	155 males and 115 females.	Not mentioned.	Psychiatric interview.	9.67% are homosexuals, 6.95% are lesbians.
<b>Habeeb (2000)</b>	80 general medical hospital male inpatients.	Medical and surgical departments in Cairo University Hospitals.	Sexual deviation and homo-sexuality questionnaire.	1.25% have homosexual practice (negative partner).
<b>Mohammd (2001)</b>	30 delinquent females.	The Ain Shams Institute for female juvenile.	Psychiatric interview.	33.3% report history of lesbianism.

## (VIII) Paraphilias:

*Ashour*<sup>\*</sup> (1984) studied 50 male rape offenders and he reported that 10 out of 50 (20%) male rape offenders have oral sex, as shown in table (43).

***Table (43) Prevalence of oral sex:***

Author/s	Sample	Site	Tools	Prevalence
Ashour (1984)	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	100% have violent sexual fantasies during masturbation, 20% have oral sex.

### 1) Exhibitionism:

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 male epileptic patients with sexual disorders (see appendix 5) and he reported that 3 out of 17 (17%) patients have exhibitionism, as shown in table (44). *Ashour*<sup>\*</sup> (1984) reported that 11 out of 50 (22%) male rape offenders have exhibitionism, as shown in table (2). *Bahary*<sup>\*</sup> (1987) reported that 14 out of 127 (11%) female epileptic with sexual disorders patients have exhibitionism, as shown in table (44).

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\* Arabic Reference.

***Table (44) Prevalence of exhibitionism:***

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 male epileptic patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	(1) Sexual history (Kinsey et al questionnaire (1948)). (2) Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976).	17% have exhibitionism.
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	22% have exhibitionism.
<b>Bahary (1987)</b>	127 female epileptic patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	11% have exhibitionism.

***2) Fetishism:***

*Bahary*<sup>\*</sup> (1987) studied reported that 3 out of 127 (2.4%) female epileptic patients with sexual disorders have fetishism, as shown in table (45).

***Table (45) Prevalence of fetishism:***

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 female epileptic patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	0.8% have fetishism.

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\* Arabic Reference.

**3) Sexual masochism:**

*Ashour*<sup>\*</sup> (1984) reported that 1 out of 50 (2%) male rape offenders have masochism, as shown in table (46).

**Table (46) Prevalence of sexual masochism:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	20% have masochism.

**4) Sexual sadism:**

*Ashour*<sup>\*</sup> (1984) reported that 10 out of 50 (20%) male rape offenders have sadism and 50 out of 50 (100%) male rape offenders have violent sexual fantasies during masturbation, as shown in table (47). *Bahary*<sup>\*</sup> (1987) reported that one out of 700 (0.8%) female epileptic patients with sexual disorders have sadism, as shown in table (47).

**Table (47) Prevalence of sexual sadism:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	20% have sadism, 100% have violent sexual fantasies during masturbation.
<b>Bahary (1987)</b>	127 female epileptic patients with sexual disorders.	El Hussein hospital, Bab El Shariiaa hospital and El Zahraa hospital.	Psycho-sexual interview.	0.8% have sadism.

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\* Arabic Reference.

**5) Transvesitism:**

**Bahary\*** (1987) reported that one out of 127 (0.8%) female epileptic patients with sexual disorders have transvesitism, as shown in table (48).

**Table (48) Prevalence of transvesitism:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 female epileptic patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview	0.8% have transvesitism.

**6) Voyeurism:**

**Habeeb** (2000) studied 80 general medical hospital male inpatients (see appendix 26) and he reported that one out of 80 (1.25%) patients has voyeurism, as shown in table (49). **Ashour\*** (1984) reported that 22 out of 50 (44%) male rape offenders have voyeurism, as shown in table (49).

**Table (49) Prevalence of voyeurism:**

Author/s	Sample	Site	Tools	Prevalence
<b>Habeeb (2000)</b>	80 general medical hospital male inpatients.	Medical and surgical departments in Cairo University Hospitals.	Sexual deviation and homosexuality questionnaire.	1.25% have voyeurism.
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	44% have voyeurism.

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\* Arabic Reference.

**7) Zoophilia:**

*Ashour*<sup>\*</sup> (1984) reported that 1 out of 50 (2%) male rape offenders have zoophilia (with donkey), as shown in table (50).

**Table (50) Prevalence of zoophilia:**

Author/s	Sample	Site	Tools	Prevalence
<b>Ashour (1984)</b>	50 male rape offenders.	Alexandria and Tanta prisons	Psycho-sexual interview.	20% have zoophilia (with donkey).

**(IX) Gender identity disorder:****Transsexualism:**

*Bahary*<sup>\*</sup> (1987) studied 127 female epileptic patients with sexual disorders and he reported that 2 out of 127 (1.6%) patients have transsexualism, as shown in table (51).

**Table (51) Prevalence of transsexualism:**

Author/s	Sample	Site	Tools	Prevalence
<b>Bahary (1987)</b>	127 female epileptic patients with sexual disorders.	El Hussein hospital, Bab El Shariaa hospital and El Zahraa hospital.	Psycho-sexual interview.	1.6% have transsexualism.

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<sup>\*</sup> Arabic Reference.



**(B) Age distribution:****(I) Sexual dysfunctions not caused by organic disorders:**

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 19 out of 163 (11.7%) wives are less than 20 years old, 87 out of 163 (53.4%) wives are in the age group 20 - less than 30 years old, 54 out of 163 (33.1%) wives are in the age group 30 - less than 40 years old and 3 out of 163 (1.8%) wives are in the age group 40 years old and more, as shown in table (52).

**Table (52) Age distribution among wives having sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida and Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	11.7% are less than 20 years old, 53.4% are 20 - less than 30 years old, 33.1% are 30 - less than 40 years old, 1.8% are 40 years old and more.

## **(II) Sexual assault can lead to sexual dysfunctions:**

### **a) Childhood sexual abuse (CSA):**

*Fahmy et al. (1995)* studied 54 (38 females and 16 males) psychiatric patients with history of CSA (see appendix 13) and they reported that the age of 12 out of 16 (75%) male patients and 21 out of 38 (55.3%) female patients when abused is < 10 years and 4 out of 16 (25%) male patients and 17 out of 38 (44.7%) female patients is  $\geq 10$  years, as shown in table (53).

**Table (53) Age distribution at time of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Age distribution
<b>Fahmy et al. (1995)</b>	54 (38 females and 16 males) psychiatric patients with history of CSA.	Outpatient psychiatric clinics.	Psychiatric interview.	< 10 years: 75% male and 55.3% female. $\geq 10$ years: 25% male patients and 44.7% female.

### **b) Rape:**

*Abdelmessih et al. (1980)* studied 157 rape victims (see appendix 2) and they reported that the highest incidence of rape is present among the age group from 13 to 17 years old (table 54).

**Table (54) Age distribution at time of rape:**

Age in years	Rape victims	
	N	%
0 - 4	7	4.5%
5 - 7	16	10.2%
8 - 12	24	15.3%
13 - 17	65	41.4%
18 - 25	38	24.2%
26 - 31	6	3.8%
50	1	0.6%
<b>Total</b>	<b>157</b>	<b>100%</b>

(Abdelmessih et al., 1980)

**(III) Homosexuality and lesbianism:**

*Lotaief et al. (1994)* studied 15 homosexual males and 8 lesbian females (see appendix 10) and they reported that the age of starting homosexuality tended to be younger in males than females, as shown in table (55).

**Table (55) Age distribution of starting homosexuality and lesbianism:**

Age of onset	Males		Females		p
	N	%	N	%	
< 10	1	6.7%	0	0.0%	> 0.05 (N.S)
10 - 15	8	53.3%	5	62.5%	> 0.05 (N.S)
16 - 20	6	40%	1	12.5%	> 0.05 (N.S)
20 - 30	0	0.0%	2	25%	< 0.05 (S.)
<b>Total</b>	<b>15</b>	<b>100%</b>	<b>8</b>	<b>100%</b>	<b>-</b>

(Lotaief et al., 1994)

**(C) Religion distribution:****(I) Sexual dysfunctions not caused by organic disorders:****Male erectile disorder (Impotence):**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (56) shows the religion distribution of the three groups.

**Table (56) Religion distribution of impotent patients:**

Religion	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Moslem	32	100%	16	94.1%	12	63.6%	60	88.2%
Christian	-	0.0%	1	5.9%	7	36.4%	8	11.8%

(Demerdash, 1970)

**(II) Homosexuality and lesbianism:**

*Lotaief et al. (1994)* studied 155 males (15 homosexuals and 140 controls) and 115 females (8 homosexuals and 107 controls) (see appendix 10) and they found insignificant difference between the different groups as regards religiosity except that 25% of the lesbians are religious and practice than the controls, as shown in table (57).

**Table (57) Religion distribution among homosexuals and lesbians:**

Religiosity	Males (N=155)					Females (N=115)					Compari- son between homo. and lesb. p
	Homo- sexual		Controls		p	Lesbian		Controls		p	
	N	%	N	%		N	%	N	%		
-Not reported	0	0.0%	0	0.0%	>0.05	0	0.0%	9	9.3%	>0.05	>0.05
-Religious and practice	5	33.3%	20	14.3%	>0.05	2	25%	1	1%	<0.001	>0.05
-Religious and irregular in practice	1	6.7%	11	7.9%	>0.05	1	12.5%	15	15.5%	>0.05	>0.05
-Religious but no practice	9	60%	109	77.9%	>0.05	5	62.5%	82	84.5%	>0.05	>0.05
Total	15	100%	140	100%	-	8	100%	107	100%	-	-

(Lotaief et al., 1994)

**(D) Marital status distribution:****(I) Sexual dysfunctions not caused by organic disorders:****Male erectile disorder (Impotence):**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (58) shows the marital status distribution of the three groups.

**Table (58) Marital status distribution among impotent patients:**

Marital status	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
1- Married	21	65.6%	10	58.8%	7	36.9%	38	55.9%
2- Single	9	28.1%	6	35.3%	8	42.1%	23	33.8%
3- Engaged	-	0.0%	1	5.9%	2	10.5%	3	4.4%
4- Divorced	2	6.3%	-	-	2	10.5%	4	5.9%

(Demerdash, 1970)

## **(II) Sexual assault can lead to sexual dysfunctions:**

### **Childhood sexual abuse (CSA):**

*Sayed (1998)* (see appendix 18) reported that 49 out of 60 (81.6%) history of CSA psychiatric patients are celibates, 10 out of 60 (16.6%) history of CSA psychiatric patients are married and 1 out of 60 (1.6%) history of CSA psychiatric patients is divorced, as shown in table (59). Also, he found that history of CSA psychiatric patients are significantly celibates more than non history of CSA psychiatric patients.

**Table (59) Marital status distribution of psychiatric patients having history of CSA:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	81.6% celibates, 16.6% married, 1.6% divorced.

### **(III) Homosexuality and lesbianism:**

*Lotaief et al. (1994)* studied 155 males (15 homosexuals and 140 controls) and 115 females (8 lesbians and 107 controls) (see appendix 10) and they found that homosexual males have significantly lower incidence marriage of marital status than controls and than lesbian females, as shown in table (60).

**Table (60) Marital status distribution among homosexuals and lesbians:**

Marital status	Males (N=155)					Females (N=115)					Comparison between homo. and lesb. p
	Homosexual		Controls		p	Lesbian		Controls		p	
	N	%	N	%		N	%	N	%		
Single	13	86.7%	67	47.9%	<0.01	1	12.5%	47	43.9%	>0.05	< 0.001
Married	2	13.3%	65	46.4%	<0.01	5	62.5%	48	44.9%	>0.05	< 0.01
Others	0	0.0%	8	5.7%	>0.05	2	25%	12	11.2%	>0.05	< 0.05
Total	15	100%	140	100%	-	8	100%	107	100%	-	-

(Lotaief et al., 1994)

### **(E) Residence distribution:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33

women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). Table (61) shows the residence distribution among females with sexual dysfunctions of the 3 groups.

**Table (61) Residence distribution among females with sexual dysfunctions:**

Characteristics	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33		t	P
	N	%	N	%	N	%		
<b>Residence</b>								
a- Urban	6	18.2%	8	24.2%	2	6.2%	11.34	0.0229 (Sig.)
b- Suburban	15	45.5%	22	66.6%	18	54.5%		
c- Rural	12	36.4%	3	9.2%	13	39.3%		

(Abed, 1998)

## **(II) Sexual dysfunctions in psychiatric patients:**

*El Fangary (2003)* studied 60 psychiatric female patients without sexual dysfunction and 60 psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction (see appendix 30). He found that most of the psychiatric patients with sexual dysfunction come from urban areas but without significant difference with the psychiatric patients without sexual dysfunction and with the non psychiatric patients with sexual dysfunction, as shown in table (62).



**Table (62) Residence distribution among psychiatric patients:**

Some sociodemographic data	Psychiatric patients without sexual dysfunction N=60		Psychiatric patients with sexual dysfunction N=60		Non psychiatric patients with sexual dysfunction N=30		x <sup>2</sup>	p
	N	%	N	%	N	%		
<b>Residence:</b>								
Urban	47	78.3%	42	70%	26	86.7%	3.261	0.19 (N.S.)
Rural	13	1.7%	18	30%	4	13.3%		

(El Fangary, 2003)

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **Childhood sexual abuse (CSA):**

*Sayed (1998)* (see appendix 18) reported that 52 out of 60 (86.7%) history of CSA psychiatric patients were living in urban areas and 8 out of 60 (13.3%) history of CSA psychiatric patients were living in rural areas, as shown in table (63). Also, he found that history of CSA psychiatric patients history of CSA are significantly living in urban areas more than non history of CSA psychiatric patients.

**Table (63) Residence distribution of psychiatric patients having history of CSA at time of abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	86.7% urban areas, 13.3% rural areas.

#### **(IV) Female genital mutilation may lead to sexual dysfunctions:**

##### **Female circumcision:**

*El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 63 out of 200 (31.5%) circumcised wives are from Ismailia city, 55 out of 200 (27.5%) circumcised wives are from Kassasin and 82 out of 200 (41%) circumcised wives are from El Tal El Kabir, as shown in table (64). *Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 3126 out of 6921 (45.2%) circumcised women are living in urban households and 3795 out of 6921 (54.8%) circumcised women are living in rural households, as shown in table (64). *Abdel Azim et al. (2000)* studied 70 circumcised and 70 uncircumcised (see appendix 24) and they reported that 26 out of 70 (37.14%) circumcised wives are coming from urban districts and 44 out of 70 (62.86%) circumcised wives are coming from rural areas, as shown in table (64). *El-Defrawy et al. (1996)*, *Refaat et al. (1999)* and *Abdel Azim et al. (2000)* reported that the circumcised wives are significantly more presented in the rural areas than the uncircumcised wives.

**Table (64) Residence distribution among the circumcised women:**

Author/s	Sample	Site	Tools	Results
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	31.5% Ismailia city, 27.5% Kassasin, 41% El Tal El Kabir.
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	45.2% urban households, 54.8% rural households.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview.	37.14% urban, 62.86% rural.

## **(F) Educational level distribution:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). Table (65) shows the educational level distribution among females with sexual dysfunctions of the 3 groups.

**Table (65) Educational level distribution among females with sexual dysfunctions:**

Characteristics	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33		t	P
	N	%	N	%	N	%		
<b>Education</b>								
a- Illiterate	9	27.3%	7	21.2%	12	36.3%	6.033	0.4195 (N.S.)
b- Read and write	14	42.4%	15	45.5%	15	45.5%		
c- Middle level	7	21.2%	10	30.3%	6	18.2%		
d- High level	3	9.1%	1	3%	0	0.0%		

(Abed, 1998)

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 59 out of 163 (36.2%) wives are highly educated, 38 out of 163 (23.3%) wives are preparatory and secondary educated, 12 out of 163 (7.4%) wives read and write and 54 out of 163 (33.1%) wives are illiterates, as shown in table (66).

**Table (66) Educational level distribution among wives having sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	36.2% highly educated, 23.3% preparatory and secondary educated, 7.4% read and write, 33.1% illiterates.

**Male erectile disorder (Impotence):**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (67) shows the educational level distribution of the three groups.

**Table (67) Educational level distribution among impotent patients:**

Educational level	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
1- University graduate	3	9.4%	3	17.6%	10	52.6%	16	23.5%
2- Secondary graduate	3	9.4%	8	47.1%	3	15.8%	14	20.6%
3- Intermediate graduate	11	34.4%	2	11.8%	-	0.0%	13	19.1%
4- Primary graduate	5	15.6%	4	23.5%	5	26.3%	14	20.6%
5- Read and write	7	21.9%	-	0.0%	-	0.0%	7	10.3%
6- Semi-literate	1	3.1%	-	0.0%	1	5.3%	2	2.9%
7- Illiterate	2	6.2%	-	0.0%	-	0.0%	2	2.9%

(Demerdash, 1970)

## **(II) Sexual dysfunctions in psychiatric patients:**

*El Fangary (2003)* (see appendix 30) found that most the 60 psychiatric female patients with sexual dysfunction are illiterate but without significant difference with the 60 psychiatric female patients without sexual dysfunction and with the 30 non psychiatric female patients with sexual dysfunction, as shown in table (68).

**Table (68) Educational level distribution among psychiatric patients:**

Some sociodemographic data	Psychiatric patients without sexual dysfunction N=60		Psychiatric patients with sexual dysfunction N=60		Non psychiatric patients with sexual dysfunction N=30		x <sup>2</sup>	p
	N	%	N	%	N	%		
<b>Education:</b>								
Illiterate	35	58.3%	30	50%	11	36.7%	8.402	0.21 (N.S.)
Preparatory	5	8.3%	13	21.7%	6	20%		
Secondary and high	18	30%	15	25%	10	33.3%		
University	2	3.3%	2	3.3%	3	10%		

(El Fangary, 2003)

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **Childhood sexual abuse (CSA):**

##### **a) Victim education:**

*Sayed (1998)* (see appendix 18) reported that 6 out of 60 (10%) history of CSA psychiatric patients can read and write, 9 out of 60 (15%) history of CSA psychiatric patients are primary school educated, 7 out of 60 (11.7%) history of CSA psychiatric patients are preparatory school educated, 24 out of 60 (40%) history of CSA psychiatric patients are secondary school educated, 4 out of 60 (6.7%) history of CSA psychiatric patients are technical secondary school educated, 8 out of 60

(13.3%) history of CSA psychiatric patients are academic educated and 2 out of 60 (3.3%) history of CSA psychiatric patients are post graduate educated, as shown in table (69). Also, he found no significant difference between psychiatric patients with or without history of CSA as regards level of education.

**b) Mother education:**

*Hamed (2006)* studied 1500 preparatory school students (222 students of illiterate mothers, 315 students of basic education mothers, 207 students of intermediate education mothers and 756 students of high education mothers) (see appendix 34) and he reported that 39 out of 222 (17.57%) of students of illiterate mothers are subjected to sexual abuse, 24 out of 315 (7.62%) of students of basic education mothers are subjected to sexual abuse, 3 out of 207 (1.45%) of students of intermediate education mothers are subjected to sexual abuse and 12 out of 756 (1.59%) of students of high education mothers are subjected to sexual abuse, as shown in table (69). Also, he found that students of low education mothers are significantly liable to sexual abuse than students of high education mothers.

**c) Father education:**

*Hamed (2006)* studied 1500 preparatory school students (165 students of illiterate fathers, 270 students basic education fathers, 270 students of intermediate education fathers and 795 students of high education fathers) (see appendix 34) and he reported that 33 out of 165 (20%) of students of illiterate

fathers are subjected to sexual abuse, 24 out of 270 (8.89%) of students of basic education fathers are subjected to sexual abuse, 9 out of 270 (3.33%) of students of intermediate education fathers are subjected to sexual abuse and 12 out of 795 (1.51%) of students of high education fathers are subjected to sexual abuse, as shown in table (69). Also, he found that students of low education fathers are significantly liable to sexual abuse than students of high education fathers.

**Table (69) Educational level distribution among victims of childhood sexual abuse and their parents:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	10% read and write, 15% primary school educated, 11.7% preparatory school educated, 40% secondary school educated, 6.7% technical secondary school educated, 13.3% academic educated, 3.3% post graduate educated.
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	17.57% and 20% of students of illiterate mothers and fathers respectively, 7.62% and 8.89% of students of basic education mothers and fathers respectively, 1.45% and 3.33% of students of intermediate education mothers and fathers respectively, 1.59% and 1.51% of students of high education mothers and fathers respectively are subjected to sexual abuse.



#### **(IV) Female genital mutilation may lead to sexual dysfunctions:**

##### **Female circumcision:**

##### **a) Circumcised wives:**

*El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 48 out of 200 (24%) circumcised wives are highly educated, 96 out of 200 (48%) circumcised wives are secondary educated and 56 out of 200 (28%) circumcised wives are illiterate, as shown in table (70). *Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 1996 out of 6921 (28.8%) circumcised women are more than primary educated, 1788 out of 6921 (25.8%) circumcised women are primary educated and 3136 out of 6921 (45.3%) circumcised women are not educated, as shown in table (70). *Abdel Azim et al. (2000)* studied 70 circumcised and 70 uncircumcised (see appendix 24) and they reported that 10 out of 70 (14.29%) circumcised wives are highly educated (university graduated), 18 out of 70 (25.71%) circumcised wives are secondary or technical school graduation, 20 out of 70 (28.58%) circumcised wives are just read and write and 22 out of 70 (31.42%) circumcised wives are non educated or illiterate, as shown in table (70). *El-Defrawy et al. (1996)*, *Refaat et al. (1999)* and *Abdel Azim et al. (2000)* reported that the circumcised wives are less educated than the uncircumcised wives.

**Table (70) Educational level distribution among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	24% highly educated, 48% secondary educated, 28% illiterate.
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	28.8% more than primary educated, 25.8% primary educated, 45.3% not educated.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview and gynecological examination.	14.29% highly educated, 25.71% secondary or technical, 28.58% read and write, 31.42% illiterate.

**b) Husbands of circumcised wives:**

*Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 2206 out of 6921 (31.9%) circumcised women their husbands are not educated, 1967 out of 6921 (28.4%) circumcised women their husbands are primary educated and 2748 out of 6921 (39.7%) circumcised women their husbands are more than primary educated, as shown in table (71). Also, they found that the husbands of circumcised women are significantly less educated than the husbands of uncircumcised women.

**Table (71) Educational level distribution among husbands of circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	31.9% not educated husbands , 28.4% primary educated husbands, 39.7% more than primary educated husbands.

### **(V) Homosexuality and lesbianism:**

*Lotaief et al. (1994)* studied 155 males (15 homosexuals and 140 controls) and 120 females (8 lesbians and 112 controls) (see appendix 10) and they found insignificant difference between homosexual males and controls and between lesbian females and controls and between homosexual males and lesbian females as regards the educational level, as shown in table (72).

**Table (72) Education level distribution among homosexual and lesbian:**

Educational level	Males (N=155)					Females (N=115)					Comparison between homo. and lesb. p
	Homosexual		Controls		p	Lesbian		Controls		p	
	N	%	N	%		N	%	N	%		
Illiterate	0	0.0%	6	4.3%	>0.05	0	0.0%	5	4.5%	>0.05	>0.05
Read only	1	6.7%	16	11.4%	>0.05	0	0.0%	15	13.4%	>0.05	>0.05
Read and write	0	0.0%	1	0.71%	>0.05	3	37.5%	10	8.9%	>0.05	>0.05
Primary school	3	20%	22	15.7%	>0.05	0	0.0%	20	17.9%	>0.05	>0.05
Prep. School	5	33.3%	22	15.7%	>0.05	1	12.5%	23	20.5%	>0.05	>0.05
Sec. school	2	13.3%	32	22.9%	>0.05	4	50%	39	34.8%	>0.05	>0.05
Above sec.	1	6.7%	12	8.6%	>0.05	0	0.0%	0	0.0%	>0.05	>0.05
University	3	20%	25	17.9%	>0.05	0	0.0%	0	0.0%	>0.05	>0.05
Post graduate	0	0.0%	4	2.9%	>0.05	0	0.0%	0	0.0%	>0.05	>0.05
Total	15	100%	140	100%	-	8	100%	112	100%	-	-

(Lotaief et al., 1994)

### **(G) Occupation distribution:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). Table (73) shows the occupation distribution among females with sexual dysfunctions of the 3 groups.

**Table (73) Occupation distribution among females with sexual dysfunctions:**

Characteristics	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33		t	P
	N	%	N	%	N	%		
<b>Occupation</b>								
a- House wife	25	75.8%	26	78.8%	28	84.9%	1.927	0.749 (N.S.)
b- Professional	4	12.1%	3	9.1%	1	3%		
c- Laborer	4	12.1%	4	12.1%	4	12.12%		

(Abed, 1998)

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 38 out of 163 (23.3%) wives are scientific careers, 31 out of 163 (19%) wives are clerks, 15 out of 163 (9.2%) wives are workers, 18 out of 163 (11%) wives are students and 61 out of 163 (37.4%) wives are housewives, as shown in table (74).

**Table (74) Occupation distribution among wives having sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	23.3% are scientific careers, 19% are clerks, 9.2% are workers, 11% are students, 37.4% are housewives.

**Male erectile disorder (Impotence):**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (75) shows the occupation of the three groups.

**Table (75) Occupation distribution among impotent patients:**

Occupation	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
1- Teachers	3	9.4%	3	17.6%	2	10.5%	8	11.8%
2- Students	2	6.2%	-	0.0%	-	0.0%	2	2.9%
3- Policemen	6	18.8%	-	0.0%	-	0.0%	6	8.8%
4- Officers	2	6.2%	-	0.0%	-	0.0%	2	2.9%
5- Employees	8	25%	4	23.5%	6	31.6%	18	26.5%
6- Skilled craftsmen	5	15.6%	2	11.8%	2	10.5%	9	13.2%
7- Drivers	3	9.3%	5	29.4%	-	0.0%	8	11.8%
8- Tradesmen	-	0.0%	1	5.9%	1	5.3%	2	2.9%
9- Contractors	-	0.0%	-	0.0%	2	10.5%	2	2.9%
10- Accountants	-	0.0%	1	5.9%	2	10.5%	3	4.4%
11- Professional group	1	3.1%	1	5.9%	3	15.8%	5	7.4%
12- Menial labour	1	3.1%	-	0.0%	1	5.3%	2	2.9%
13- Shepherds	1	3.1%	-	0.0%	-	0.0%	1	1.5%

(Demerdash, 1970)

## **(II) Sexual dysfunctions in psychiatric patients:**

*El Fangary (2003)* (see appendix 30) found that most of the 60 psychiatric female patients with sexual dysfunction are housewives but without significant difference with the 60 psychiatric female patients without sexual dysfunction and with the 30 non psychiatric female patients with sexual dysfunction, as shown in table (76).

**Table (76) Occupation distribution among psychiatric patients:**

Some sociodemographic data	Psychiatric patients without sexual dysfunction N=60		Psychiatric patients with sexual dysfunction N=60		Non psychiatric patients with sexual dysfunction N=30		x <sup>2</sup>	p
	N	%	N	%	N	%		
<b>Occupation</b>								
Housewives	55	91.7%	53	88.3%	25	83.3%	7.658	0.26 (N.S.)
Manual	2	3.3%	6	10%	2	6.7%		
Professional	3	5%	1	1.7%	2	6.7%		
Student	0	0.0%	0	0.0%	1	3.3%		

(El Fangary, 2003)

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **Childhood sexual abuse (CSA):**

##### **a) Victim work:**

*Sayed (1998)* (see appendix 18) reported that 22 out of 60 (36.7%) history of CSA psychiatric patients are manual workers, 4 out of 60 (6.7%) abused psychiatric patients are skilled workers, 8 out of 60 (13.3%) history of CSA psychiatric patients are professional workers, 18 out of 60 (30%) history of CSA psychiatric patients are students and 8 out of 60 (13.3%) history of CSA psychiatric patients are not working, as shown in table (77). Also, he found no significant difference between psychiatric patients with or without history of CSA as regards occupation.

##### **b) Mother work:**

*Hamed (2006)* studied 1500 preparatory school (711 students of house wife mothers and 789 students of working mothers) students (see appendix 34) and he reported that 45 out of 711 (6.33%) of students of house wife mothers are subjected to sexual abuse and 33 out of 789 (4.18%) of students of working mothers are subjected to sexual abuse, as shown in table (77). Also, he found that students of house wife mothers are significantly liable to sexual abuse than students of working mothers.



**c) Father work:**

**Hamed (2006)** studied 1500 preparatory school students (9 students of not working fathers and 1491 students of working fathers) (see appendix 34) and he reported that 6 out of 9 (66.67%) of students of not working fathers are subjected to sexual abuse and 72 out of 1491 (4.83%) of students of working fathers are subjected to sexual abuse, as shown in table (77). Also, he found that students of not working fathers are significantly liable to sexual abuse than students of working fathers.

**Table (77) Occupation distribution among victims of childhood sexual abuse and their parents:**

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Results</b>
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	36.7% manual workers, 6.7% skilled workers, 13.3% professional workers, 30% students, 13.3% not working.
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	6.33% of students of house wife mothers, 66.67% of students of not working fathers, 4.18% and 4.83% of students of working mothers and fathers respectively are subjected to sexual abuse.

## **(IV) Female genital mutilation may lead to sexual dysfunctions:**

### **Female circumcision:**

*Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 5845 out of 6921 (84.5%) circumcised women are not working and 1076 out of 6921 (15.5%) circumcised women are working, as shown in table (78). Also, they found that the circumcised women are significantly not working than the uncircumcised women. *Abdel Azim et al. (2000)* studied 70 circumcised and 70 uncircumcised (see appendix 24) and they reported that 6 out of 70 (8.57%) circumcised wives are clerk working, 22 out of 70 (31.43%) circumcised wives are workers and 42 out of 70 (60%) circumcised wives are house wives, as shown in table (78). Also, they found that the circumcised wives are mostly house wives while the uncircumcised wives are mostly clerk working.

**Table (78) Occupation distribution among the circumcised women:**

Author/s	Sample	Site	Tools	Results
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	84.5% not working, 15.5% working.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview and gynecological examination.	8.57% clerck, 31.43% worker, 60% house wife.

**(H) Social class distribution:****(I) Sexual dysfunctions not caused by organic disorders:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). Table (79) shows the social class level distribution among females with sexual dysfunctions of the 3 groups.

**Table (79) Social class distribution among females with sexual dysfunctions:**

Characteristics	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33		t	P
	N	%	N	%	N	%		
<b>Social class</b>								
a- Class I	0	0.0%	0	0%	0	0.0%	8.033	0.235 (N.S.)
b- Class II	3	9.1%	0	0%	0	0.0%		
c- Class III	6	18.2%	4	12.2%	5	15.2%		
d- Class IV	4	12.1%	8	24.2%	8	24.2%		
e- Class V	20	60.6%	21	63.6%	20	60.6%		

(Abed, 1998)

## **(II) Sexual assault can lead to sexual dysfunctions:**

### **Childhood sexual abuse (CSA):**

*Abdel Rahman and Nashed (1994)* studied 1203 primary school children (718 from low class school and 485 from high class school) (see appendix 9) and they reported that 25 out of 718 (3.42%) children of low class school are sexually abused and 3 out of 485 (0.62%) children of high class school are sexually abused, as shown in table (80). *Sayed (1998)* (see appendix 18) reported that 9 out of 60 (15%) history of CSA psychiatric patients are belonging to high social class, 22 out of 60 (37%) history of CSA psychiatric patients are belonging to middle social class, 21 out of 60 (35%) history of CSA psychiatric patients are belonging to low social class, 8 out of 60 (13%) history of CSA psychiatric patients are belonging to very low social class, as shown in table (80). Also, he found that history of CSA psychiatric patients are significantly belonging to low social class more than non history of CSA psychiatric patients. *Hamed (2006)* studied 1500 preparatory school students (900 students of governmental schools and 600 students of language schools) (see appendix 34) and he reported that 66 out of 900 (7.33%) of students of governmental schools are subjected to sexual abuse and 12 out of 600 (2%) of students of language schools are subjected to sexual abuse, as shown in table (80). Also, he found that students of governmental schools are significantly liable to sexual abuse than students of language schools.

**Table (80) Social class distribution among victims of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Abdel Rahman &amp; Nashed (1994)</b>	1203 primary school children (718 from low class school and 485 from high class school).	Two Egyptian primary schools.	Structured self-reported questionnaire.	3.42% in low class and 0.62% in high class students are sexually abused.
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	15% high social class, 37% middle social class, 35% low social class, 13% very low social class.
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	7.33% of students of governmental schools and 2% of students of language schools are subjected to sexual abuse.

### **(III) Female genital mutilation may lead to sexual dysfunctions:**

#### **Female circumcision:**

*Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 1130 out of 6921 (16.3%) circumcised

women are high/high-moderate economic level and 5791 out of 6921 (83.7%) circumcised women are moderate/low economic level, as shown in table (81). *Abdel Azim et al. (2000)* studied 70 circumcised and 70 uncircumcised wives (see appendix 24) and they reported that 8 out of 70 (11.43%) circumcised wives are of high social class, 20 out of 70 (28.57%) circumcised wives are of middle social class, 42 out of 70 (60%) circumcised wives are of low social class, as shown in table (81). *Refaat et al. (1999)* and *Abdel Azim et al. (2000)* reported that the circumcised women are significantly of low economic level than the uncircumcised women.

**Table (81) Social class distribution among the circumcised women:**

Author/s	Sample	Site	Tools	Results
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	16.3% high/high-moderate economic level , 83.7% moderate/low economic level.
<b>Abdel Azim et al. (2000)</b>	70 circumcised wives.	Gynecological outpatient clinic for family planning at Zagazig University Hospitals.	Psychiatric interview and gynecological examination.	11.43% high social class, 28.57% middle social class, 60% low social class.

**(I) Order of birth distribution:****(I) Sexual dysfunctions among medical patients:****Epilepsy:**

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) (see appendix 5) reported that 10 out of 17 (59%) epileptic male patients with sexual disorders belonged to the middle ranks of their sibship, 5 out of 17 (29%) patients belonged to the last ranks of their sibship and 2 out of 17 (12%) patients belonged to the first ranks of their sibship, as shown in table (82).

**Table(82) Order of birth distribution among a sample of male epileptics with sexual disorders:**

Author/s	Sample	Site	Tools	Results
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 epileptic male patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	Psychiatric interview.	59% middle ranks, 29% last ranks, 12% first ranks.

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\* Arabic Reference.

## **(II) Sexual assault can lead to sexual dysfunctions:**

### **Childhood sexual abuse (CSA):**

*Hamed (2006)* studied 1500 preparatory school students (498 students of youngest position in their families, 375 students of middle position in their families, 378 students of eldest position in their families and 249 students of only child in their families) (see appendix 34) and he reported that 27 out of 498 (5.42%) of students of youngest position in their families are subjected to sexual abuse, 21 out of 375 (5.6%) of students of middle position in their families are subjected to sexual abuse, 30 out of 378 (7.94%) of students of eldest position in their families are subjected to sexual abuse and no one out of 249 students of only child in their families are subjected to sexual abuse, as shown in table (83). Also, he found that students of eldest position in their families are significantly liable to sexual abuse than students of youngest position in their families.

**Table (83) Order of birth distribution in sexually abused children:**

Author/s	Sample	Site	Tools	Results
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	4.42% of students of youngest position in their families, 5.6% of students of middle position in their families, 7.94% of students of eldest position in their families and no one of students of only child in their families are subjected to sexual abuse.



**(J) Family size distribution:****(I) Sexual dysfunctions among medical patients:****Epilepsy:**

*Bahary\** (1983) and *Demerdash et al. (1986)* (see appendix 5) reported that 11 out of 17 (65%) epileptic male patients with sexual disorders came from large family size (mean = 6 or more), 4 out of 17 (23%) patients came from medium family size (mean = 5), and 2 out of 17 (12%) patients came from small family size (mean = 3-4), as shown in table (84).

**Table (84) Family size distribution among a sample of male epileptics with sexual disorders:**

Author/s	Sample	Site	Tools	Results
<b>Bahary (1983) &amp; Demerdash et al. (1986)</b>	17 epileptic male patients with sexual disorders.	The epileptic clinic in El Hussein University Hospital.	Psychiatric interview.	65% large family size, 23% medium family size, 12% small family size.

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\* Arabic Reference.

## **(II) Sexual assault can lead to sexual dysfunctions:**

### **Childhood sexual abuse (CSA):**

*Hamed (2006)* studied 1500 preparatory school students (162 students of large size family, 1062 students of medium size family and 276 students of small size family) (see appendix 34) and he reported that 43 out of 162 (26.67%) of students of large size family (more than 6 persons) are subjected to sexual abuse, 35 out of 1062 (3.3%) of students of medium size family (4-6 persons) are subjected to sexual abuse and no one of students of small size family (less than 4 persons) are subjected to sexual abuse, as shown in table (85). Also, he found that students of large size family are significantly liable to sexual abuse than students of medium and small size family.

**Table (85) Family size distribution of sexually abused children:**

Author/s	Sample	Site	Tools	Results
<b>Hamed (2006)</b>	1500 preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview.	26.67% of students of large size family, 3.3% of students of medium size family and no one of students of small size family are subjected to sexual abuse.

## **Etiology of sexual and gender identity disorders**

### **(I) Causes of sexual dysfunctions not caused by organic disorders:**

#### **(A) Causes of female sexual dysfunctions:**

##### **1) Genetic factor (family history):**

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 154 out of 163 (94.5%) wives denied the presence of a family history of sexual dysfunction and 9 out of 163 (5.5%) wives reported the presence of a family history of sexual dysfunction, as shown in table (86).

**Table (86) Family history of wives with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	94.5%      –ve family history, 5.5%      +ve family history.

##### **2) Parental emotional detachment in the families:**

*Abed (1998)* (see appendix 17) studied the parental emotional detachment in the families of females with sexual dysfunctions of the 3 groups, as shown in table (87).

**Table (87) Parental emotional detachment in the families of females with sexual dysfunctions:**

Parental emotional detachment	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33		x <sup>2</sup>	P
	N	%	N	%	N	%		
<b>1- Parental separation</b> Present	2	6.1%	1	3%	3	9.1%	1.06	0.587 (N.S.)
<b>2- Maternal</b> a- Distant or dead	16	48.5%	16	48.5%	15	45.5%	0.08	0.96 (N.S.)
b- Rejection	3	9%	6	18.2%	9	27.3%	4.32	0.115 (N.S.)
<b>3- Paternal</b> a- Distant or dead	14	42.4%	15	45.5%	13	39.4%	3.71	0.156 (N.S.)
b- Rejection	6	18.2%	4	12.1%	6	18.2%	0.08	0.71 (N.S.)

(Abed, 1998)

### **3) Paternal psychopathology:**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups as regards paternal psychopathology, as shown in table (88).

**Table (88) Paternal psychopathology of females with sexual dysfunctions:**

Paternal psychopathology	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33	
	N	%	N	%	N	%
<b>1- Violent</b>	6	18.2%	7	21.2%	4	12.1%
<b>2- Psychotic or drug abuse</b>	12	36.4%	11	33.3%	13	39.4%
<b>3- Absent</b>	15	45.5%	15	45.5%	16	48.5%

(Abed, 1998)

#### **4) Marital history:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). Table (89) shows the marital history of females with sexual dysfunctions of the 3 groups.

**Table (89) Marital history of females with sexual dysfunctions:**

Characteristics	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33		t	P
	N	%	N	%	N	%		
<b>1- Type of marriage</b>								
a- Love	15	45.5%	13	39.4%	14	42.4%	0.248	0.8833 (N.S.)
b- Arranged	18	54.5%	20	60.6%	19	57.6%		
<b>2- Duration of engagement</b> (Mean $\pm$ SD)	25.79 $\pm$ 8.01		25.79 $\pm$ 8.01		25.79 $\pm$ 8.01		0.386	0.6864 (N.S.)
<b>3- Duration of marriage</b>								
a- Less than 3 years	17	51.5%	9	27.2%	13	39.3%	9.734	0.0451 (Sig.)
b- 3 - 12 years	13	39.5%	12	36.4%	8	24.3%		
c- More than 12 years	3	9%	12	36.4%	12	36.4%		
<b>4- Previous marriage</b>								
a- No	31	93.9%	33	100%	28	84.8%	5.842	0.0539 (N.S.)
b- Yes	2	6.1%	0	0.0%	5	15.2%		
<b>5- Privacy in sexual relation</b>								
a- Available	24	72.8%	13	39.4%	17	51.5%	6.111	0.0471 (Sig.)
b- Shared room	9	27.2%	20	61.6%	16	48.5%		
<b>6- Number of children</b>								
a- No children	19	57.6%	5	15.2%	6	18.2%	21.555	< 0.01 (Sig.)
b- One child	6	18.2%	5	15.2%	6	18.2%		
c- 2 – 3 children	4	12.1%	13	39.4%	15	45.5%		
d- More than 3 children	4	12.1%	10	30.2%	6	18.2%		
<b>7- Lactation</b>								
a- Present	2	6.1%	6	18.2%	9	27.3%	5.255	0.0722 (N.S.)
b- Absent	31	93.9%	27	81.8%	24	72.7%		

(Abed, 1998)

**5) Gynecological problems:**

*Abed (1998)* (see appendix 17) studied the gynecological problems of females with sexual dysfunctions of the 3 groups, as shown in table (90).

**Table (90) Gynecological problems among females with sexual dysfunctions:**

Temporary gynecological problems	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33		x <sup>2</sup>	P
	N	%	N	%	N	%		
<b>1- Complicated abortion</b>								
a- Present and related	2	6.2%	0	0.0%	0	0.0%	-	-
b- Present and not related	0	0.0%	0	0.0%	0	0.0%		
c- Absent	31	93.9%	33	100%	33	100%		
<b>2- Unwanted pregnancy</b>							10.7	0.030 (Sig.)
a- Present and related	2	6%	6	18.2%	1	3%		
b- Present and not related	1	3%	6	18.2%	5	15.2%		
c- Absent	30	91%	21	63.6%	27	81.8%		
<b>3- Complicated pregnancy</b>							10.897	0.0278 (Sig.)
a- Present and related	2	6.1%	1	3%	0	0.0%		
b- Present and not related	2	6.1%	7	21.2%	4	12.1%		
c- Absent	29	87.8%	25	75.8%	29	87.9%		
<b>4- Gynecological operations</b>							6.124	0.19 (N.S.)
a- Present and related	3	9.1%	1	3%	0	0.0%		
b- Present and not related	1	3%	4	12.1%	5	15.1%		
c- Absent	29	86.9%	28	84.9%	28	84.9%		
<b>5- Temporary related disagreement about fertility condition</b>							5.482	0.053 (N.S.)
a- Present	3	9.1%	5	15.2%	0	0.0%		
c- Absent	30	90.9%	28	84.9%	33	100%		

(Abed, 1998)

**6) Masturbation:**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups as regards masturbation either before or after marriage, as shown in table (91).

**Table (91) Masturbation among females with sexual dysfunctions:**

Masturbation	Sexual (I) N=33		Disguised (II) N=33		Comparative (III) N=33	
	N	%	N	%	N	%
<b>1- Before marriage</b>						
a- Present	11	33.3%	8	24.2%	4	21.1%
b- Absent	22	66.7%	25	75.8%	29	87.9%
<b>2- After marriage</b>						
a- Present	7	21.2%	12	36.3%	9	27.3%
b- Absent	26	78.8%	21	63.7%	24	72.7%

(Abed, 1998)

**7) Extra marital relation:**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups as regards current extra marital relation, as shown in table (92).

**Table (92) Extra marital relation among females with sexual dysfunctions:**

Current extra marital relation	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33	
	N	%	N	%	N	%
<b>1- Present</b>	2	6.1%	0	0.0%	1	3%
<b>2- Absent</b>	31	93.9%	33	100%	32	99%

(Abed, 1998)

**8) Female genital mutilation (circumcision):**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups

as regards female genital mutilation (circumcision), as shown in table (93).

**Table (93) Female genital mutilation (circumcision) among females with sexual dysfunctions:**

Circumcision	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33	
	N	%	N	%	N	%
1- Absent	1	3%	0	0.0%	1	3%
2- Clitoridotomy	15	45.5%	16	48.4%	22	66.7%
3- Clitoridectomy	17	51.5%	17	51.6%	10	30.3%

(Abed, 1998)

**9) History of exposure to sexual trauma:**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups as regards sexual abuse but there is significant difference between the 3 groups as regards sexual trauma in the wedding night, as shown in table (94).

**Table (94) History of exposure to sexual trauma of females with sexual dysfunctions:**

Comparative exposure to sexual trauma	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33	
	N	%	N	%	N	%
1- Sexual abuse						
a- Present	8	24.2%	13	39.4%	11	33.3%
b- Absent	25	75.8%	20	60.6%	22	66.7%
2- Sexual trauma (psychological or physical) on the wedding night						
a- Present	4	12.1%	10	30.3%	3	9%
b- Absent	29	87.9%	23	69.7%	30	91%

(Abed, 1998)



**10) Sexual problems among the partner:**

*Abed (1998)* (see appendix 17) found insignificant difference between sexual, disguised and comparative groups as regards associated sexual problems among the partner, as shown in table (95).

**Table (95) Sexual problems among the partner of females with sexual dysfunctions:**

Associated sexual problems among the partner	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33	
	N	%	N	%	N	%
1- Present	4	12.1%	7	21.2%	10	30.3%
2- Absent	29	87.9%	26	78.8%	23	69.7%

(Abed, 1998)

**(B) Male erectile disorder (Impotence):****1) Genetic factor (family history):**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he reported that 3 out of 32 (9.4%) Kuwaitis patients, 1 out of 19 (5.3%) Egyptian impotent patients and no one of Palestinian impotent patients have family history of impotence.

**2) Age of puberty:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found insignificant difference between cases having early onset and cases having late onset of impotence within each ethnic group as regards age of puberty, as shown in table (96).

**Table (96) Age of puberty among impotent patients:**

Age of puberty	Kuwaitis N=32		Palestinian N=17		Egyptian N=19	
	Onset of impotence		Onset of impotence		Onset of impotence	
	Early	Late	Early	Late	Early	Late
Mean (SD) years	15.1 (4.3)	14.5 (1.2)	15.2 (1.17)	14.5 (1.2)	15.2 (1.17)	15 (1.3)

(Demerdash, 1970)

### **3) Feelings towards parents:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found insignificant difference between the 3 groups as regards feelings towards parents, as shown in table (97).

**Table (97) Feelings towards parents among impotent patients:**

Feelings towards Parents	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
<b>Feelings towards father</b>								
Negative	21	65.6%	8	47.1%	9	47.4%	38	55.9%
Positive	11	34.4%	9	52.9%	10	52.6%	30	44.1%
<b>Feelings towards mother</b>								
Negative	7	21.9%	1	5.9%	2	10.5%	10	14.7%
Positive	25	78.1%	16	94.1%	17	89.5%	58	85.3%

(Demerdash, 1970)

#### **4) Attitude towards religion:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (98) shows the attitude towards religion of the three groups.

**Table (98) Attitude towards religion among impotent patients:**

Attitude towards religion	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Active	20	62.5%	6	35.3%	7	36.4%	33	48.5%
Inactive	12	37.5%	11	64.7%	12	63.6%	35	51.5%

(Demerdash, 1970)

#### **5) Psychogenic precipitating factors:**

*Demerdash (1970)* studied 68 impotent patients (34 patients having early onset who experienced impotence from the first attempt of heterosexual coitus and 34 patients having late onset who experienced impotence after a period of normal heterosexual coitus) (see appendix 1). He found that cases having early onset has significantly psychogenic precipitating factors more than cases having late onset of impotence, as shown in table (99). Also, he found that the most common precipitating factor is honeymoon (1<sup>st</sup> intercourse stress) (67.4%; 29 out of 43 impotent patients having psychogenic stress).

**Table (99) Psychogenic precipitating factors among impotent patients:**

Psychogenic precipitating factors	Early onset group N=34		Late onset group N=34		Total N=68	
	N	%	N	%	N	%
Positive	26	76.5%	17	50%	43	63.2%
Negative	8	23.5%	17	50%	25	36.8%

(Demerdash, 1970)

**6) Pre-pubertal sexuality:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found that Kuwaitis impotent patients have significantly admitted pre-pubertal sexuality more than impotent Egyptian and Palestinian patients, as shown in table (100).

**Table (100) Pre-pubertal sexuality among impotent patients:**

Pre-pubertal sexuality	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Admitted	26	81.3%	7	41.2%	6	31.6%	39	57.4%
Denied	6	18.7%	10	58.8%	13	68.4%	29	42.6%

(Demerdash, 1970)

Also, he found insignificant difference between cases having early onset and cases having late onset of impotence within each ethnic group as regards the age of onset of pre-pubertal sexuality, as shown in table (101).

**Table (101) Age of onset of pre-pubertal sexuality impotent patients:**

Age of onset of pre- pubertal sexuality	Kuwaitis N=32		Palestinian N=17		Egyptian N=19	
	Onset of impotence		Onset of impotence		Onset of impotence	
	Early	Late	Early	Late	Early	Late
Mean (SD) years	10.33 (1.72)	9 (1.33)	8.4 (1.6)	9.3 (1.7)	7.33 (0.52)	9 (1)

(Demerdash, 1970)

**7) Pre-marital heterosexual petting:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found that Kuwaitis impotent patients have significantly admitted pre-marital heterosexual petting less than Egyptian and Palestinian impotent patients, as shown in table (102).

**Table (102) Pre-marital heterosexual petting among impotent patients:**

Pre-marital heterosexual petting	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Admitted	13	40.6%	12	70.6%	14	73.7%	39	57.4%
Denied	19	59.4%	5	29.4%	5	26.3%	29	42.6%

(Demerdash, 1970)

Also, he found insignificant difference between cases having early onset and cases having late onset of impotence within each ethnic group as regards the age of onset of pre-marital petting, as shown in table (103).

**Table (103) Age of onset of pre-marital petting among impotent patients:**

Age of onset of pre-marital petting	Kuwaitis N=32		Palestinian N=17		Egyptian N=19	
	Onset of impotence		Onset of impotence		Onset of impotence	
	Early	Late	Early	Late	Early	Late
Mean (SD) years	18.67 (3.07)	16.43 (2.05)	19 (3.53)	18.38 (3.87)	18.2 (1.6)	17.69 (2.9)

(Demerdash, 1970)

**8) Pre-marital coitus:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found insignificant difference between the three groups as regards pre-marital coitus, as shown in table (104).

**Table (104) Pre-marital coitus among impotent patients:**

Pre-marital coitus	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Admitted	23	71.9%	12	70.6%	13	68.4%	39	57.4%
Denied	9	28.1%	5	29.4%	6	31.6%	29	42.6%

(Demerdash, 1970)

Also, he found insignificant difference between cases having early onset and cases having late onset of impotence within each ethnic group as regards age of onset of pre-marital coitus, as shown in table (105).

**Table (105) Age of onset of pre-marital coitus among impotent patients:**

Age of onset of pre-marital coitus	Kuwaitis N=32		Palestinian N=17		Egyptian N=19	
	Onset of impotence		Onset of impotence		Onset of impotence	
	Early	Late	Early	Late	Early	Late
Mean (SD) years	21.43 (4.07)	19 (1.97)	21.75 (2.32)	19.5 (1.12)	20.43 (1.42)	18.33 (3.01)

(Demerdash, 1970)

**9) Age of onset of masturbation:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found insignificant difference between cases having early onset and cases having late onset of impotence within each ethnic group as regards age of onset of masturbation, as shown in table (106).

**Table (106) Age of onset of masturbation among impotent patients:**

Age of onset of masturbation	Kuwaitis N=32		Palestinian N=17		Egyptian N=19	
	Onset of impotence		Onset of impotence		Onset of impotence	
	Early	Late	Early	Late	Early	Late
Mean (SD) years	16.3 (1.87)	15.9 (2.3)	15.1 (1.01)	15.8 (1.6)	15.25 (1.83)	15.33 (2.6)

(Demerdash, 1970)

**10) Source of learning about masturbation:**

*Demerdash (1970)* studied 60 impotent patients (26 Kuwaitis, 16 Palestinian and 18 Egyptian) (see appendix 1). Table (107) shows the source of learning about masturbation of the three groups.

**Table (107) Source of learning about masturbation among impotent patients:**

Source of learning about masturbation	Kuwaitis N=26		Palestinian N=16		Egyptian N=18		Total N=60	
	N	%	N	%	N	%	N	%
1- Conversation and reading	3	11.5%	1	6.3%	8	44.4%	12	20%
2- Observation	11	42.3%	8	50%	2	11.2%	21	35%
3- Homosexual participation	-	0.0%	2	12.5%	-	0.0%	2	3.3%
4- Self discovery	12	46.2%	5	31.2%	8	44.4%	25	41.7%

(Demerdash, 1970)

**11) Age of marriage:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found that Kuwaitis impotent patients significantly marry earlier than the Palestinians and Egyptian patients, as shown in table (108).

**Table (108) Age of marriage among impotent patients:**

Age of marriage	Kuwaitis N=32	Palestinian N=17	Egyptian N=19
Mean (SD) years	21.63 (3.25)	25 (3.68)	24.11 (3.9)

(Demerdash, 1970)



**12) Smoking:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) compared with 17 Kuwaitis healthy controls, 24 Palestinian healthy controls and 17 Egyptian healthy controls (see appendix 1) and he found that the incidence of smokers among impotent patients of the 3 groups is significantly less than in healthy control subjects, as shown in table (109).

**Table (109) Smoking among impotent patients:**

Smoking	Kuwaitis				Palestinian				Egyptian			
	Patients N=32		Controls N=17		Patients N=17		Controls N=24		Patients N=19		Controls N=17	
	N	%	N	%	N	%	N	%	N	%	N	%
Smoker	12	37.5%	2	70.6%	7	41.2%	18	75%	5	26.3%	10	58.8%
Non-smoker	20	62.5%	5	29.4%	10	58.8%	6	25%	14	73.7%	7	41.2%

(Demerdash, 1970)

**(II) Cause of sexual dysfunctions in psychiatric patients:**

**(A) Causes of female sexual dysfunctions among psychiatric patients:**

**1) Personality disorders:**

*El Fangary (2003)* studied 60 psychiatric patients with sexual dysfunction and 30 non psychiatric patients with sexual

dysfunction (see appendix 30). He found that psychiatric patients with sexual dysfunction have significantly more frequent personality disorder in all types of personalities than non psychiatric patients with sexual dysfunction except antisocial, avoidant, dependent and narcissistic personalities which show insignificant difference between both groups (table 110).

**Table (110) Distribution of personality disorders among female psychiatric and non psychiatric patients with sexual dysfunction:**

Psychiatric diagnosis	Psychiatric patients with sexual dysfunction N=60		Non-psychiatric patients with sexual dysfunction N=30		x <sup>2</sup>	p
	N	%	N	%		
1- Paranoid personality	60	100%	28	93.3%	4.091	< 0.05
2- Schizoid personality	42	70%	7	23.3%	17.561	< 0.0001
3- Schizotypal personality	41	68.3%	14	46.7%	3.951	< 0.05
4- Histrionic personality	32	53.3%	7	23.3%	7.33	< 0.0001
5- Aantisocial personality	22	36.7%	5	16.7%	3.81	0.06
6- Borderline personality	41	68.3%	12	40%	6.632	0.01
7- Avoidant personality	58	96.7%	26	86.7%	3.214	0.07
8- Dependent personality	56	93.3	24	80%	3.6	0.06
9- Obsessive personality	55	91.7%	17	56.7%	15.313	< 0.0001
10- Narcissistic personality	57	95%	25	83.3%	3.361	0.07
11- Passive aggressive personality	51	85%	13	43.3%	16.902	< 0.0001

(El Fangary, 2003)

**2) Age of puberty:**

*El Fangary (2003)* studied 60 psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction (see appendix 30). He reported that mean age of puberty of psychiatric female patients with sexual dysfunction is  $12.75 \pm 0.91$  (table 111) with insignificant difference with non psychiatric female patients with sexual dysfunction.

**3) Age of first sexual intercourse:**

*El Fangary (2003)* (see appendix 30) reported that mean age of first sexual experience among 60 psychiatric female patients with sexual dysfunction is  $18.58 \pm 3.16$  (table 111) which is significantly younger than 30 non psychiatric female patients with sexual dysfunction.

**4) Masturbation:**

*El Fangary (2003)* (see appendix 30) found that 3/60 (5%) psychiatric female patients with sexual dysfunction have history of masturbation (table 111) and there is insignificant difference by comparing with 30 non psychiatric female patients with sexual dysfunction.

**Table (111) Sexual history among psychiatric female patients with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	Mean age of puberty is ( $12.75 \pm 0.91$ ), mean age of first sexual experience is ( $18.58 \pm 3.16$ ), 5% have history of masturbation.

**5) Type of defloration:**

*El Fangary (2003)* (see appendix 30) reported that 31 out of 60 (51.7%) psychiatric female patients with sexual dysfunction have defloration through intercourse and 29 out of 60 (48.3%) patients have manual defloration, as shown in table (112). Also, he found insignificant difference between psychiatric and non psychiatric female patients with sexual dysfunction as regards type of defloration.

**Table (112) Types of defloration among psychiatric female patients with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	51.7% patients have defloration through intercourse, 48.3% patients have manual defloration.

**6) Family influence:**

*El Fangary (2003)* (see appendix 30) reported that 26 out of 60 (43.3%) psychiatric female patients with sexual dysfunction have discriminative family influence in favor of males, as shown in table (113). Also, he found that 60 psychiatric female patients with sexual dysfunction have significantly higher discriminative family influence in favour of males than 30 non psychiatric female patients with sexual dysfunction.

**Table (113) Family influence among psychiatric female patients with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	43.3% have discriminative family influence in favour of males.

**7) Gender satisfaction:**

*El Fangary (2003)* (see appendix 30) reported that 8 out of 60 (13.3%) psychiatric female patients with sexual dysfunction have gender dissatisfaction, as shown in table (114). Also, he found that these patients have significantly higher gender dissatisfaction than 30 non psychiatric female patients with sexual dysfunction.

**Table (114) Gender satisfaction among psychiatric female patients with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	13.3% have gender dissatisfaction.

### **8) Sex hormones:**

*El Fangary (2003)* found insignificant difference between 60 psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction as regards sex hormones ( $9.045 \pm 6.33$  L.H.,  $3.988 \pm 2.26$  F.S.H.,  $9.543 \pm 5.53$  prolactin,  $0.4267 \pm 0.1812$  testosterone).

### **(B) Causes of male sexual dysfunctions among depressed patients:**

#### **1) Substance abuse:**

*Ahmed and Ezz El-Din (1992)* studied 46 male patients diagnosed as major depression (DSM III R); 27 patients with sexual dysfunction and 19 patients without sexual dysfunction (see appendix 6) and they reported that 6 out of 27 (22.22%) depressed patients with sexual dysfunction have past history of drug abuse (table 115), which is significantly higher than the prevalence of drug abuse among the depressed patients without sexual dysfunction.

**2) Recurrent attack of illness:**

*Ahmed and Ezz El-Din (1992)* (see appendix 6) reported that 12 out of 27 (44.44%) depressed male patients with sexual dysfunction have past history of recurrent attack of illness (table 115), which is significantly higher than the prevalence of recurrent attack of illness among the 19 depressed male patients without sexual dysfunction.

**3) Marital conflict:**

*Ahmed and Ezz El-Din (1992)* (see appendix 6) reported that 15 out of 27 (55.56%) depressed male patients with sexual dysfunction have past history of marital conflict (table 115). This prevalence is significantly higher than the prevalence among the 19 depressed male patients without sexual dysfunction.

**Table (115) Causes of sexual dysfunction in depressed male patients with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Ahmed &amp; Ezz El-Din (1992)</b>	27 depressed male patients with sexual dysfunction.	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Psychiatric interview.	22.22% have history of drug abuse, 44.44% have history of recurrent attack of illness and 55.56% have history of marital conflict.

#### **4) Sex hormones:**

*Ahmed and Ezz El-Din (1992)* studied 46 male major depressed patients. After taking tricyclic antidepressant 75 mg to 100 mg/day for six months, the sex hormones are reassessed (see appendix 6) and they concluded that there is significant increase in the level of prolactin and significant decrease in the level of testosterone in whole depressed patients (either with or without sexual dysfunction), and there is no significant difference between those who improved sexually and those who don't improve sexually.

#### **(C) Causes of sexual dysfunctions among schizophrenic patients:**

##### **1) Age of schizophrenic patients:**

*Abdel Azim et al. (2007)* studied 120 chronic schizophrenics (68 males and 52 females) (see appendix 35) and they reported that as age increase, sexual function worsen including erection and ejaculatory dysfunction but sexual desire and libido doesn't diminish with age. By studying 30 male non-paranoid schizophrenics, *Mohammed (2005)* (see appendix 32) and *Hashem et al. (2006)* (see appendix 33) reported that there is insignificant difference between the age of those being sexually functioning and those being sexually dysfunctioning (table 116) and by studying 30 male paranoid schizophrenics *Mohammed (2005)* (see appendix 32) and *Hashem et al. (2006)* (see appendix 33) found insignificant difference between the age of those being sexually dysfunctioning and those being sexually functioning except in



the frequency of masturbation, the sexual excitement, the achieve erection and the orgasm where the age is more older among those have sexual dysfunction than among those have sexual functioning (table 117).

***Table (116) Age of male non-paranoid schizophrenics with sexually functioning and sexually dysfunctioning:***

		Age (years)		t	P
		Mean	SD		
<b>Q1- Sexual desire</b>	F (n=16)	41.5	±9.67	0.517	0.609 (N.S.)
	D (n=14)	43.5	±11.51		
<b>Q2- Frequency of intercourses/week</b>	F (n=6)	42.33	±9.65	0.026	0.532 (N.S.)
	D (n=24)	42.46	±10.82		
<b>Q3- Frequency of masturbation/week</b>	F (n=11)	41.72	±11.75	0.357	0.724 (N.S.)
	D (n=15)	42.87	±10.89		
<b>Q4- Excitement</b>	F (n=16)	40.75	±9.96	1.078	0.291 (N.S.)
	D (n=12)	45.17	±11.69		
<b>Q5- Enjoyment</b>	F (n=20)	43.65	±8.79	0.777	0.444 (N.S.)
	D (n=8)	40.13	±15.07		
<b>Q6- Sexual satisfaction</b>	F (n=13)	45.69	±7.58	1.422	0.167 (N.S.)
	D (n=15)	40.00	±12.57		
<b>Q7- Achieve erection</b>	F (n=18)	42.39	±9.04	0.165	0.871 (N.S.)
	D (n=10)	43.10	±13.88		
<b>Q8- Maintain erection</b>	F (n=19)	41.79	±10.70	0.602	0.552 (N.S.)
	D (n=9)	44.44	±11.31		
<b>Q9- Delayed ejaculation</b>	F (n=21)	41.81	±10.63	0.703	0.488 (N.S.)
	D (n=7)	45.14	±11.60		
<b>Q10- Premature ejaculation</b>	F (n=20)	44.20	±10.53	1.222	0.233 (N.S.)
	D (n=8)	38.75	±11.03		
<b>Q11- Orgasm</b>	F (n=15)	41.93	±8.46	0.369	0.715 (N.S.)
	D (n=13)	43.46	±13.26		
<b>Overall</b>	F (n=4)	41.25	±0.96	0.240	0.812 (N.S.)
	D (n=26)	42.62	±11.22		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

**Table (117) Age (in years) of sexually functioning and sexually dysfunctioning male paranoid schizophrenics:**

		Age (years)		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=19)	35.89	±8.99	1.497	0.146 (N.S.)
	D (n=11)	41.45	±11.12		
<b>Q2-</b> Frequency of intercourses/week	F (n=12)	37.17	±8.02	0.337	0.738 (N.S.)
	D (n=18)	38.44	±11.34		
<b>Q3-</b> Frequency of masturbation/week	F (n=12)	33.58	±7.97	2.165	0.043 (Sign.)
	D (n=10)	41.90	±10.06		
<b>Q4-</b> Excitement	F (n=21)	35.05	±8.29	2.651	0.013 (Sign.)
	D (n=9)	44.67	±10.90		
<b>Q5-</b> Enjoyment	F (n=22)	35.91	±8.15	1.920	0.065 (N.S.)
	D (n=8)	43.50	±12.94		
<b>Q6-</b> Sexual satisfaction	F (n=18)	36.11	±8.00	1.132	0.273 (N.S.)
	D (n=12)	40.67	±12.31		
<b>Q7-</b> Achieve erection	F (n=24)	35.58	±8.75	2.876	0.008 (Sign.)
	D (n=6)	47.33	±9.81		
<b>Q8-</b> Maintain erection	F (n=19)	36.32	±7.65	1.171	0.252 (N.S.)
	D (n=11)	40.73	±13.11		
<b>Q9-</b> Delayed ejaculation	F (n=26)	38.00	±10.44	0.785	0.439 (N.S.)
	D (n=4)	34.25	±6.24		
<b>Q10-</b> Premature ejaculation	F (n=17)	40.53	±9.09	1.647	0.105 (N.S.)
	D (n=13)	34.54	±10.49		
<b>Q11-</b> Orgasm	F (n=24)	36.00	±9.39	2.261	0.032 (Sign.)
	D (n=6)	45.67	±9.27		
<b>Overall</b>	F (n=6)	38.00	±8.74	0.018	0.986 (N.S.)
	D (n=24)	37.90	±10.48		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

## **2) Schizophrenic symptoms:**

*Abdel Azim et al. (2007)* studied 68 chronic male schizophrenics and 52 chronic female schizophrenics (see appendix 35) and they found that there is no significant association between any area of sexual dysfunction and

PANSS total and subscale scores of male schizophrenics, while in female schizophrenics those reported problems with enjoyment during sex have significantly higher negative symptoms scores (mean  $\pm$  SD is  $16.2 \pm 7.8$ ), general psychopathology (mean  $\pm$  SD is  $31.3 \pm 4.5$ ) and total scores (mean  $\pm$  SD is  $62.0 \pm 12.6$ ) of PANSS.

### **3) Secondary depression among schizophrenics:**

*Abdel Azim et al. (2007)* (see appendix 35) found that in chronic male schizophrenics, depression is significantly correlated with poor libido, erectile dysfunction and orgasmic dysfunction but there is no association between depression and ejaculatory function; while in chronic female schizophrenics, depression is significantly correlated with poor libido, reduced physical arousal and orgasmic problems, as shown in table (118).

**Table (118) Sexual dysfunction among chronic schizophrenics with secondary depression:**

	Male schizophrenics (N=68)			Female schizophrenics (N=52)		
Type of sexual dysfunction	Reduced libido	Erectile dysfunction	Ejaculatory dysfunction	Reduced libido	Arousal dysfunction	Orgasmic dysfunction
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Depressed patients	47 (77%)	41 (69%)	35 (49%)	35 (68%)	34 (67%)	36 (71%)
Non depressed patients	23 (33%)	22 (33%)	28 (41%)	11 (22%)	12 (23%)	10 (21%)
<b>r</b>	0.37	0.34	0.181	0.41	0.59	0.064
<b>p</b>	0.001 (Sign.)	0.001 (Sign.)	0.781 (N.S.)	0.03 (Sign.)	0.001 (Sign.)	0.001 (Sign.)

(Abdel Azim et al., 2007)

### **4) Age of onset of schizophrenic disorder:**

*Mohammed (2005)* (see appendix 32) and *Hashem et al. (2006)* (see appendix 33) studied 30 male chronic paranoid schizophrenics and 30 male chronic non paranoid

schizophrenics. Table (119) shows insignificant difference between the sexually functioning and sexually dysfunctioning male paranoid schizophrenics except the frequency of intercourses/week and the frequency of masturbation/week. Table (120) shows insignificant difference between the sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics except the sexual satisfaction.

**Table (119) Age at onset of paranoid schizophrenia in male sexual function and sexual dysfunction:**

		Age at onset (yrs) of schizophrenia		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=19)	25.68	±7.50	0.480	0.635 (N.S.)
	D (n=11)	24.27	±8.21		
<b>Q2-</b> Frequency of intercourses/week	F (n=12)	28.58	±5.43	2.288	0.030 (Sign.)
	D (n=18)	22.89	±8.20		
<b>Q3-</b> Frequency of masturbation/week	F (n=12)	19.67	±4.145	3.520	0.002 (Sign.)
	D (n=10)	28.80	±7.79		
<b>Q4-</b> Excitement	F (n=21)	24.86	±7.30	0.333	0.742 (N.S.)
	D (n=9)	25.89	±8.85		
<b>Q5-</b> Enjoyment	F (n=22)	24.05	±6.86	1.349	0.188 (N.S.)
	D (n=8)	28.25	±9.33		
<b>Q6-</b> Sexual satisfaction	F (n=18)	24.89	±7.13	0.239	0.813 (N.S.)
	D (n=12)	25.58	±8.70		
<b>Q7-</b> Achieve erection	F (n=24)	24.33	±7.44	1.201	0.240 (N.S.)
	D (n=6)	28.50	±8.29		
<b>Q8-</b> Maintain erection	F (n=19)	24.47	±6.48	0.645	0.524 (N.S.)
	D (n=11)	26.36	±9.58		
<b>Q9-</b> Delayed ejaculation	F (n=26)	25.96	±7.44	1.479	0.150 (N.S.)
	D (n=4)	20.00	±8.04		
<b>Q10-</b> Premature ejaculation	F (n=17)	26.47	±7.39	1.069	0.294 (N.S.)
	D (n=13)	23.46	±7.95		
<b>Q11-</b> Orgasm	F (n=24)	24.70	±8.32	0.961	0.350 (N.S.)
	D (n=6)	27.00	±4.10		
<b>Overall</b>	F (n=6)	28.17	±6.05	1.076	0.291 (N.S.)
	D (n=24)	24.42	±7.94		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

***Table (120) Age at onset of non-paranoid schizophrenia in male sexual function and sexual dysfunction:***

		Age at onset (yrs) of schizophrenia		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=16)	24.25	±8.01	0.758	0.445 (N.S.)
	D (n=14)	22.36	±5.12		
<b>Q2-</b> Frequency of intercourses/week	F (n=6)	27.00	±8.00	1.500	0.145 (N.S.)
	D (n=24)	22.46	±6.30		
<b>Q3-</b> Frequency of masturbation/week	F (n=11)	22.36	±4.88	0.143	0.888 (N.S.)
	D (n=15)	22.7	±5.47		
<b>Q4-</b> Excitement	F (n=16)	24.69	±8.15	1.069	0.295 (N.S.)
	D (n=12)	21.83	±5.00		
<b>Q5-</b> Enjoyment	F (n=20)	25.00	±7.50	1.922	0.066 (N.S.)
	D (n=8)	19.63	±3.66		
<b>Q6-</b> Sexual satisfaction	F (n=13)	26.30	±6.84	2.124	0.043 (Sign.)
	D (n=15)	21.00	±6.38		
<b>Q7-</b> Achieve erection	F (n=18)	24.61	±7.76	1.169	0.253 (N.S.)
	D (n=10)	21.40	±5.13		
<b>Q8-</b> Maintain erection	F (n=19)	24.26	±6.67	0.872	0.391 (N.S.)
	D (n=9)	21.78	±7.82		
<b>Q9-</b> Delayed ejaculation	F (n=21)	23.80	±7.60	0.445	0.660 (N.S.)
	D (n=7)	22.42	±5.16		
<b>Q10-</b> Premature ejaculation	F (n=20)	23.05	±6.05	0.487	0.630 (N.S.)
	D (n=8)	24.50	±9.41		
<b>Q11-</b> Orgasm	F (n=15)	23.13	±5.93	0.264	0.794 (N.S.)
	D (n=13)	23.85	±8.33		
<b>Overall</b>	F (n=4)	27.00	±9.02	1.159	0.256 (N.S.)
	D (n=26)	22.81	±6.41		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

### ***5) Duration of schizophrenic disorder:***

*Mohammed (2005)* (see appendix 32) and *Hashem et al. (2006)* (see appendix 33) studied 30 male chronic paranoid schizophrenics and 30 male chronic non paranoid schizophrenics. Table (121) shows insignificant difference

between the sexually functioning and sexually dysfunctioning male paranoid schizophrenics except the sexual desire, frequency of intercourses/week, excitement, achieve erection and orgasm. Table (122) shows insignificant difference between the sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics.

**Table (121) Duration of schizophrenia of sexually functioning and sexually dysfunctioning male paranoid schizophrenics:**

		Duration of illness (years)		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=19)	10.05	±8.54	2.414	0.023 (Sign.)
	D (n=11)	17.64	±8.38		
<b>Q2-</b> Frequency of intercourses/week	F (n=12)	8.33	±7.19	2.430	0.022 (Sign.)
	D (n=18)	15.83	±8.92		
<b>Q3-</b> Frequency of masturbation/week	F (n=12)	13.92	±7.95	0.078	0.939 (N.S.)
	D (n=10)	13.60	±11.13		
<b>Q4-</b> Excitement	F (n=21)	10.05	±7.83	2.921	0.007 (Sign.)
	D (n=9)	19.33	±8.35		
<b>Q5-</b> Enjoyment	F (n=22)	11.73	±7.96	1.127	0.269 (N.S.)
	D (n=8)	15.88	±11.31		
<b>Q6-</b> Sexual satisfaction	F (n=18)	11.06	±7.94	1.350	0.188 (N.S.)
	D (n=12)	15.50	±10.05		
<b>Q7-</b> Achieve erection	F (n=24)	11.13	±7.89	2.228	0.034 (Sign.)
	D (n=6)	19.67	±10.44		
<b>Q8-</b> Maintain erection	F (n=19)	11.68	±7.90	0.921	0.365 (N.S.)
	D (n=11)	14.82	±10.65		
<b>Q9-</b> Delayed ejaculation	F (n=26)	12.62	±8.88	0.335	0.740 (N.S.)
	D (n=4)	14.25	±10.75		
<b>Q10-</b> Premature ejaculation	F (n=17)	14.18	±10.13	0.937	0.357 (N.S.)
	D (n=13)	11.08	±7.16		
<b>Q11-</b> Orgasm	F (n=24)	11.17	±8.35	2.164	0.039 (Sign.)
	D (n=6)	19.50	±8.80		
<b>Overall</b>	F (n=6)	9.33	±10.05	1.073	0.292 (N.S.)
	D (n=24)	13.71	±8.67		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

**Table (122) Duration of schizophrenia of sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics:**

		Duration of illness (years)		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=16)	17.19	±8.55	1.120	0.272 (N.S.)
	D (n=14)	21.29	±11.45		
<b>Q2-</b> Frequency of intercourses/week	F (n=6)	15.33	±9.93	1.028	0.313 (N.S.)
	D (n=24)	20.04	±10.06		
<b>Q3-</b> Frequency of masturbation/week	F (n=11)	18.82	±9.90	0.522	0.606 (N.S.)
	D (n=15)	20.93	±10.42		
<b>Q4-</b> Excitement	F (n=16)	16.13	±10.07	1.905	0.068 (N.S.)
	D (n=12)	23.33	±9.69		
<b>Q5-</b> Enjoyment	F (n=20)	18.70	±9.14	0.408	0.687 (N.S.)
	D (n=8)	20.50	±13.65		
<b>Q6-</b> Sexual satisfaction	F (n=13)	19.62	±9.54	0.187	0.853 (N.S.)
	D (n=15)	18.87	±11.38		
<b>Q7-</b> Achieve erection	F (n=18)	17.78	±9.31	0.982	0.335 (N.S.)
	D (n=10)	21.80	±12.16		
<b>Q8-</b> Maintain erection	F (n=19)	17.63	±9.84	1.181	0.248 (N.S.)
	D (n=9)	22.56	±11.28		
<b>Q9-</b> Delayed ejaculation	F (n=21)	18.10	±10.52	0.988	0.332 (N.S.)
	D (n=7)	22.57	±9.91		
<b>Q10-</b> Premature ejaculation	F (n=20)	21.10	±10.13	1.560	0.131 (N.S.)
	D (n=8)	14.50	±10.09		
<b>Q11-</b> Orgasm	F (n=15)	18.67	±8.88	0.295	0.771 (N.S.)
	D (n=13)	19.85	±12.23		
<b>Overall</b>	F (n=4)	14.25	±8.50	1.039	0.308 (N.S.)
	D (n=26)	19.85	±10.20		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

### **6) Duration of hospitalization of schizophrenic patients:**

**Mohammed (2005)** (see appendix 32) **and Hashem et al. (2006)** (see appendix 33) studied 30 male chronic paranoid schizophrenics and 30 male chronic non paranoid schizophrenics. Table (123) shows insignificant difference

between the sexually functioning and sexually dysfunctioning male paranoid schizophrenics except the excitement and delayed ejaculation. Table (124) shows insignificant difference between the sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics.

**Table (123) Duration of hospitalization of sexually functioning and sexually dysfunctioning male paranoid schizophrenics:**

		Duration (weeks) of hospitalization		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=19)	58.05	±120.4	0.975	0.338 (N.S.)
	D (n=11)	107.73	±156.7		
<b>Q2-</b> Frequency of intercourses/week	F (n=12)	29.08	±85.97	1.613	0.118 (N.S.)
	D (n=18)	107.2	±152.98		
<b>Q3-</b> Frequency of masturbation/week	F (n=12)	109.92	±171.49	0.249	0.771 (N.S.)
	D (n=10)	90.6	±127.44		
<b>Q4-</b> Excitement	F (n=21)	43.67	±107.61	2.153	0.040 (Sign.)
	D (n=9)	152.33	±164.96		
<b>Q5-</b> Enjoyment	F (n=22)	75.41	±143.89	0.057	0.955 (N.S.)
	D (n=8)	78.61	±112.66		
<b>Q6-</b> Sexual satisfaction	F (n=18)	79.56	±138.75	0.161	0.873 (N.S.)
	D (n=12)	71.33	±133.46		
<b>Q7-</b> Achieve erection	F (n=24)	69.5	±138.95	0.545	0.590 (N.S.)
	D (n=6)	103.33	±121.79		
<b>Q8-</b> Maintain erection	F (n=19)	63.63	±126	0.670	0.508 (N.S.)
	D (n=11)	98.09	±151.53		
<b>Q9-</b> Delayed ejaculation	F (n=26)	56.38	±106.9	2.198	0.036 (Sign.)
	D (n=4)	205.5	±231.56		
<b>Q10-</b> Premature ejaculation	F (n=17)	94.65	±159.42	0.853	0.401 (N.S.)
	D (n=13)	52.23	±93		
<b>Q11-</b> Orgasm	F (n=24)	90.83	±146	1.196	0.242 (N.S.)
	D (n=6)	18	±16.54		
<b>Overall</b>	F (n=6)	64.83	±148.53	0.229	0.820 (N.S.)
	D (n=24)	79.13	±133.91		

F = Functioning

(Mohammed, 2005 and Hashem et al., 2006)

D

=

Dysfunctioning



**Table (124) Duration of hospitalization of sexually functioning and sexually dysfunctional male non-paranoid schizophrenics:**

		Duration of hospitalization (weeks)		t	P
		Mean	SD		
<b>Q1-</b> Sexual desire	F (n=16)	133.56	±231	0.905	0.373 (N.S.)
	D (n=14)	73	±99		
<b>Q2-</b> Frequency of intercourses/week	F (n=6)	20.71	±29.32	1.3	0.206 (N.S.)
	D (n=24)	126.63	±198.14		
<b>Q3-</b> Frequency of masturbation/week	F (n=11)	127.1	±230.62	0.232	0.819 (N.S.)
	D (n=15)	109	±168.13		
<b>Q4-</b> Excitement	F (n=16)	103.94	±208.08	0.197	0.845 (N.S.)
	D (n=12)	118.33	±165.23		
<b>Q5-</b> Enjoyment	F (n=20)	112.1	±211.8	0.087	0.931 (N.S.)
	D (n=8)	105.13	±122.13		
<b>Q6-</b> Sexual satisfaction	F (n=13)	178.77	±251.24	1.885	0.071 (N.S.)
	D (n=15)	50.6	±75.28		
<b>Q7-</b> Achieve erection	F (n=18)	134.17	±222.6	0.907	0.373 (N.S.)
	D (n=10)	66.8	±94.07		
<b>Q8-</b> Maintain erection	F (n=19)	116.53	±216.02	0.258	0.798 (N.S.)
	D (n=9)	96.56	±116.6		
<b>Q9-</b> Delayed ejaculation	F (n=21)	116.86	±206.84	0.324	0.748 (N.S.)
	D (n=7)	89.86	±123.66		
<b>Q10-</b> Premature ejaculation	F (n=20)	93.2	±146.64	0.747	0.461 (N.S.)
	D (n=8)	152.38	±273.24		
<b>Q11-</b> Orgasm	F (n=15)	150.2	±241.19	1.225	0.231 (N.S.)
	D (n=13)	63.85	±84.08		
<b>Overall</b>	F (n=4)	9.00	±6.58	1.142	0.263 (N.S.)
	D (n=26)	120.15	±191.70		

F = Functioning (Mohammed, 2005 and Hashem et al., 2006)

D = Dysfunctioning

## **7) Antipsychotic drugs:**

### **a) Type of antipsychotics (typical or atypical):**

*Abdel Azim et al. (2007)* studied 120 chronic schizophrenics (68 males and 52 females) (see appendix 35) and they reported that there is insignificant difference between the type of antipsychotics either typical or atypical and the overall means of Sexual Functioning Questionnaire (SFQ) in either males or females.

### **b) The autonomic side effects of the antipsychotics for the males:**

By studying 68 male chronic schizophrenics (see appendix 35), *Abdel Azim et al. (2007)* reported that the autonomic side effects of the antipsychotics have significant correlation with the male sexual dysfunction such as anti-cholinergic side effects which are particularly associated with erectile dysfunction ( $r = 0.32$  ,  $p = 0.041$ ) and anti-adrenergic side effects which are associated with abnormal ejaculation as retarded ejaculation or reduced volume ( $r = 0.43$  ,  $p = 0.006$ ).

## **8) Smoking:**

*Abdel Azim et al. (2007)* studied 68 male chronic schizophrenics and 52 female chronic schizophrenics (see appendix 35) and they found no significant relation between smoking and any type of sexual dysfunction in either males or females except in the males who don't smoke they have less desire for sexual intercourse than the males who smoke.

**9) Sex hormones:**

***Mohammed (2005)*** (see appendix 32) ***and Hashem et al. (2006)*** (see appendix 33) studied 60 male schizophrenics (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia). Table (125) shows the distribution of serum prolactin level among the sexually functioning and sexually dysfunctioning male paranoid schizophrenics. Table (126) shows the distribution of serum prolactin level among the sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics.

**Table (125) Serum prolactin level in sexually functioning and sexually dysfunctioning male paranoid schizophrenics:**

		Number of patients having		c	P
		Normoprolactinaemia	Hyperprolactinaemia		
<b>Q1- Sexual desire</b>	Functioning	17	2	0.212	0.236 (N.S.)
	Dysfunctioning	8	3		
<b>Q2- Frequency of intercourses/week</b>	Functioning	12	-	0.343	0.046 (Sign.)
	Dysfunctioning	13	5		
<b>Q3- Frequency of masturbation/week</b>	Functioning	9	3	0.059	0.781 (N.S.)
	Dysfunctioning	8	2		
<b>Q4- Excitement</b>	Functioning	17	4	0.097	0.593 (N.S.)
	Dysfunctioning	8	1		
<b>Q5- Enjoyment</b>	Functioning	19	3	0.134	0.460 (N.S.)
	Dysfunctioning	6	2		
<b>Q6- Sexual satisfaction</b>	Functioning	17	1	0.343	0.046 (Sign.)
	Dysfunctioning	8	4		
<b>Q7- Achieve erection</b>	Functioning	21	3	0.218	0.221 (N.S.)
	Dysfunctioning	4	2		
<b>Q8- Maintain erection</b>	Functioning	16	3	0.031	0.865 (N.S.)
	Dysfunctioning	9	2		
<b>Q9- Delayed ejaculation</b>	Functioning	21	5	0.173	0.337 (N.S.)
	Dysfunctioning	4	-		
<b>Q10- Premature ejaculation</b>	Functioning	14	3	0.030	0.869 (N.S.)
	Dysfunctioning	11	2		
<b>Q11- Orgasm</b>	Functioning	20	4	0.000	1 (N.S.)
	Dysfunctioning	5	1		
<b>Overall</b>	Functioning	6	-	0.218	0.221 (N.S.)
	Dysfunctioning	19	5		

**(Mohammed, 2005 and Hashem et al., 2006)**

**Table (126) Serum prolactin level in sexually functioning and sexually dysfunctioning male non-paranoid schizophrenics:**

		Number of patients having		c	P
		Normoprolactinaemia	Hyperprolactinaemia		
<b>Q1-</b> Sexual desire	Functioning	15	1	0.345	0.044 (Sign.)
	Dysfunctioning	9	5		
<b>Q2-</b> Frequency of intercourses/week	Functioning	5	1	0.042	0.819 (N.S.)
	Dysfunctioning	19	5		
<b>Q3-</b> Frequency of masturbation/week	Functioning	9	2	0.099	0.612 (N.S.)
	Dysfunctioning	11	4		
<b>Q4-</b> Excitement	Functioning	12	4	0.100	0.595 (N.S.)
	Dysfunctioning	10	2		
<b>Q5-</b> Enjoyment	Functioning	18	2	0.403	0.02 (Sign.)
	Dysfunctioning	4	4		
<b>Q6-</b> Sexual satisfaction	Functioning	12	1	0.298	0.099 (N.S.)
	Dysfunctioning	10	5		
<b>Q7-</b> Achieve erection	Functioning	15	3	0.154	0.410 (N.S.)
	Dysfunctioning	7	3		
<b>Q8-</b> Maintain erection	Functioning	15	4	0.013	0.944 (N.S.)
	Dysfunctioning	7	2		
<b>Q9-</b> Delayed ejaculation	Functioning	16	5	0.100	0.595 (N.S.)
	Dysfunctioning	6	1		
<b>Q10-</b> Premature ejaculation	Functioning	16	4	0.055	0.771 (N.S.)
	Dysfunctioning	6	2		
<b>Q11-</b> Orgasm	Functioning	14	1	0.360	0.041 (Sign.)
	Dysfunctioning	8	5		
<b>Overall</b>	Functioning	4	-	0.192	0.283 (N.S.)
	Dysfunctioning	20	6		

**(Mohammed, 2005 and Hashem et al., 2006)**

*Abdel Azim et al. (2007)* studied 120 chronic schizophrenics (68 males and 52 females) (see appendix 35). Table (127) show the level of prolactin hormone related to results of sexual dysfunction; which revealed that prolactin level for male patients were in the high normal range and 34%

being hyperprolactinaemic (> 480 IU/L), while 75% of female patients with high prolactin level (> 480 IU/L).

**Table (127) Level of prolactin hormone related to results of sexual dysfunction:**

	Males (34% high prolactin)			Females (75% high prolactin)		
Type of sexual dysfunction	Reduced libido	Erectile dysfunction	Ejaculatory dysfunction	Reduced libido	Arousal dysfunction	Orgasmic dysfunction
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Depressed patients	51 (78%)	56 (85%)	55 (84%)	37 (74%)	36 (71%)	34 (68%)
Non depressed patients	17 (27%)	24 (37%)	20 (31%)	11 (21%)	12 (24%)	10 (19%)
<b>r</b>	0.41	0.562	0.56	0.46	0.43	0.52
<b>p</b>	0.02 (Sign.)	0.023 (Sign.)	0.023 (N.S.)	0.03 (Sign.)	0.02 (Sign.)	0.02 (Sign.)

(Abdel Azim et al., 2007)

### **(III) Causes of sexual dysfunctions among male heroin abusers:**

#### **(1) Serum testosterone level:**

*Hashem and El-Orabi (1993)* studied 17 male chronic heroin abusers (see appendix 8) and they reported that 8 out of 17 (47%) patients have below normal serum testosterone level and 9 out of 17 (53%) patients have normal serum testosterone level, as shown in table (128). Also, they found that male chronic heroin abusers have significantly below normal serum testosterone level more than the controls.

**Table (128) Serum testosterone level among male chronic heroin abusers:**

Author/s	Sample	Site	Tools	Results
<b>Hashem &amp; El-Orabi (1993)</b>	17 male chronic heroin abusers.	Al-Salama Hospital in Jeddah, Kingdom of Saudi Arabia.	Laboratory investigation.	47% below normal, 53% within normal serum testosterone.

**(2) Serum FSH level:**

*Hashem and El-Orabi (1993)* studied 17 male chronic heroin abusers (see appendix 8) and they reported that all patients have normal serum FSH level and the mean (SD) serum FSH level among all patients is 2.66 (1.11) U/L, as shown in table (129). Also, they found that male chronic heroin abusers have significantly decreased mean serum FSH level than the controls.

**(3) Serum prolactine level:**

*Hashem and El-Orabi (1993)* studied 17 male chronic heroin abusers (see appendix 8) and they reported that 3 out of 17 (17.6%) patients have above normal serum prolactine level, 14 out of 17 (82.4%) patients have normal serum prolactine level and the mean (SD) serum prolactine level among all patients is 15.39 (13.21) ng/ml, as shown in table (129). Also, they found that there is relative increase in the mean (SD) serum prolactine level in male chronic heroin abusers compared to the controls, but the difference didn't reach statistical significance.

**(4) Serum LH level:**

*Hashem and El-Orabi (1993)* studied 17 male chronic heroin abusers (see appendix 8) and they reported that all patients have normal serum LH level and the mean (SD) serum LH level among all patients is 3.99 (1.83) U/L, as shown in table (129). Also, they found that there is relative increase in the mean (SD) serum LH level in male chronic heroin abusers compared to the controls, but the difference didn't reach statistical significance.

**Table (129) Serum FSH, prolactine and LH level among male chronic heroin abusers:**

Author/s	Sample	Site	Tools	Results
<b>Hashem and El-Orabi (1993)</b>	17 male chronic heroin abusers.	Al-Salama Hospital in Jeddah, Kingdom of Saudi Arabia.	Laboratory investigation.	Serum FSH level ( $2.66 \pm 1.11$ ). serum prolactine level ( $15.39 \pm 13.21$ ). serum LH level ( $3.99 \pm 1.83$ ).

**(IV) Causes of sexual dysfunctions among medical patients:**

**(A) Causes of sexual dysfunction in epileptic patients:**

**1) Fits follow sexual arousal:**

*Bahary\* (1983) and Demerdash et al. (1986)* studied 17 epileptic male patients with sexual disorders (see appendix 5)

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\* Arabic Reference.

and they report that 2 out of 17 (11.5%) patients reported sexual events (sexual arousal) as precipitating factors to their seizures, so they can not complete the sexual act.

## **2) Fits at night:**

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 epileptic male patients with sexual disorders (see appendix 5) and they reported that 13 out of 17 (76%) patients had their fits at night. This finding helps to explain the occurrence of sexual inadequacy in the sample in view of the fact that sexual activity usually takes place at the end of the working day.

## **3) Long duration of epilepsy:**

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 male epileptic patients with sexual disorders (see appendix 5) and they reported that 12 out of 17 (71%) patients suffered from epilepsy for more than one year and 5 out of 17 (29%) patients suffered from epilepsy for less than one year. So, they concluded that seizures of moderate and long duration could develop sexual abnormality.

## **4) Temporal lobe epilepsy:**

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 epileptic male patients with sexual disorders (see appendix 5) and they reported that 12 out of 17 (71%) patients have temporal lobe epilepsy. So, sexual disorders are more common presented in temporal lobe epilepsy. *Awny* (1997) studied 32 epileptic male patients (20 patients with temporal lobe epilepsy

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<sup>\*</sup> Arabic Reference.



and 12 patients with generalized tonic clonic seizure) (see appendix 16) and he reported that 12 out of 20 (60%) patients with temporal lobe epilepsy have sexual dysfunctions, as shown in table (130). Also, he found that patients with temporal lobe epilepsy have significantly sexual dysfunctions more than patients with generalized tonic clonic seizure (one out of 12 (8.3%)).

***Table (130) Effect of type of epilepsy on sexual dysfunction pattern:***

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Results</b>
<b>Awny (1997)</b>	32 male epileptic patients (20 patients with temporal lobe epilepsy and 12 patients with generalized tonic clonic seizure).	The epilepsy clinic at Al-Hussein University Hospital.	Psychiatric interview.	60% patients with temporal lobe epilepsy, 8.3% patients with generalized tonic clonic seizure have sexual dysfunctions

***Mourad (2009)*** studied 48 male epileptic patients with sexual dysfunction (18 patients on monotherapy (11 patients with TLE and 7 patients with generalized epilepsy) and 30 patients on polytherapy (16 patients with temporal lobe epilepsy (TLE), 5 patients with generalized epilepsy and 9 patients with frontal lobe epilepsy (FLE) (see appendix 37) and he found no significant difference between TLE and generalized epilepsy groups on monotherapy as regards different sex functions. Also, he found that the mean rank of orgasmic function are significantly lower in FLE than in both TLE and generalized epilepsy groups on polytherapy, but no

significant difference between TLE, generalized epilepsy and FLE groups on polytherapy as regards different sex functions other than orgasmic function, as shown in table (131).

***Table (131) Effect of type of epilepsy with monotherapy and polytherapy on sexual dysfunction pattern:***

Sexual function	Monotherapy N=18			Polytherapy N=30			
	Generalized N=7	TLE N=11	P	Generalized N=5	TLE N=16	FLE N=9	P
1- Mean rank of erectile function	9.07	9.77	0.791	14	15.88	15.67	0.72
2- Mean rank of orgasmic function	8.36	10.23	0.479	22	17.31	8.67	0.003
3- Mean rank of sexual desire function	10.71	8.73	0.479	16.5	14.63	16.5	0.404
4- Mean rank of intercourse satisfaction	9.5	9.5	1	15.5	15.5	15.5	1

(Mourad, 2009)

### ***5) High frequency of fits:***

*Bahary* <sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 male epileptic patients with sexual disorders (see appendix 5) and they reported that 8 out of 17 (47%) patients have one or more fits daily, 7 out of 17 (41%) patients have their fits weekly and 2 out of 17 (12%) patients have their fits monthly. Such high frequency of fits leads to sexual disturbance as a part of the affective and cognitive disorders resulting from the high fit frequency.

*Mourad* (2009) studied 49 male epileptic patients with sexual dysfunction (19 patients on monotherapy (Group a: 5

<sup>\*</sup> Arabic Reference.

patients have frequency of seizures more than 4 months, Group b: 10 patients have frequency of seizures from 1-3 months and Group c: 4 patients have frequency of seizures of fit free one year or more) and 30 patients on polytherapy (Group a: 16 patients had frequency of seizures more than 4 months, Group b: 5 patients had frequency of seizures from 1-3 months and Group c: 9 patients had frequency of seizures of fit free one year or more)) (see appendix 37) and he found no significant difference between seizure frequency groups on monotherapy as regards different sex functions. Also, he found that mean rank of orgasmic function of Group (c) patients on polytherapy is significantly lower than mean rank of orgasmic function of Group (a) and (b) patients on polytherapy denoting that the least seizure frequencies affected orgasmic function than higher frequencies supporting the poor role of frequency on sexual dysfunction, as shown in table (132).

***Table (132) Effect of frequency of seizures with monotherapy and polytherapy on sexual dysfunction pattern:***

Sexual function	Monotherapy N=19				Polytherapy N=30			
	Group(a) months>4 N=5	Group(b) 1-3 months N=10	Group(c) ≥1 year N=4	P	Group(a) months>4 N=16	Group(b) 1-3 months N=5	Group(c) ≥1 year N=9	P
1- Mean rank of erectile function	7	10.8	11.75	0.213	15.88	14	15.67	0.72
2- Mean rank of orgasmic function	10.2	9.25	11.63	0.703	17.31	22	8.67	0.003
3- Mean rank of sexual desire function	12.5	9.65	7.75	0.24	14.63	16.5	16.5	0.404
4- Mean rank of intercourse satisfaction	10	10	10	1	15.5	15.5	15.5	1

(Mourad, 2009)

**6) Polypharmacy of antiepileptic drugs:**

*Mourad (2009)* studied 50 male epileptic patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy) (see appendix 37) and he found insignificant difference between epileptic patients on monotherapy and polytherapy as regards different sex functions, as shown in table (133).

**Table (133) Effect of antiepileptics on sexual dysfunction pattern:**

Sexual function	Monotherapy N=20	Polytherapy N=30	P
1- Mean rank of erectile function	28.5	23.5	0.074 (N.S.)
2- Mean rank of orgasmic function	25.25	25.67	0.908 (N.S.)
3- Mean rank of sexual desire function	22.75	27.33	0.07 (N.S.)
4- Mean rank of intercourse satisfaction	25.5	25.5	1 (N.S.)

(Mourad, 2009)

**(B) Causes of sexual dysfunction in 1ry ESRD patients under regular haemodialysis:**

*Ibrahim et al. (1995)* studied 60 1ry ESRD patients under regular haemodialysis (48 males and 12 females) (see appendix 12) and they concluded that sexual dysfunction is common in haemodialysis patients, but neither KT/V nor PCR estimation can help in prediction of these disorders (there is no correlation between KT/V or PCR and the sexual difference before and after dialysis [ $r = -0.03$ ,  $p > 0.05$ ]).

**(C) Causes of male sexual dysfunction in various medical diseases patients:**

**Precipitating factors of erectile dysfunction among various medical patients:**

**1) Old age:**

*Habeeb (2000)* studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) and he reported that the scores of International Index of Erectile Function (IIEF) are negatively correlated to age ( $r = -0.5369$  and  $P < 0.001$ ).

**2) Deep Venous Thrombosis (DVT):**

*Habeeb (2000)* studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) reported that patients having D.V.T. have significantly the worst sexual function and patients having minor anal surgical problem have significantly the best sexual function, as shown in table (134).

**Table (134) International Index of Erectile Function (IIEF) of various medical and surgical patients:**

Diagnosis	Patients N=80		Mean of IIEF
	N	%	
1- Minor anal surgical problem	19	23.75%	49.57
2- Ischemic heart diseases	7	8.75%	44.60
3- Inguinal hernia	6	7.5%	41.50
4- Connective tissue disease	6	7.5%	40.75
5- Swelling for excisional biopsy	8	10%	37.17
6- Bilharzial hepatosplenomegally, portal hypertension	15	18.75%	35.17
7- Multiple fracture	6	7.5%	34.00
8- L.L. ischemia	8	10%	30.40
9- D.V.T.	5	6.25%	30.00

(Habeeb, 2000)

**3) Diabetes mellitus (D.M.):**

**Habeeb (2000)** studied 42 male inpatients (19 patients have minor anal surgical problem, 8 patients have L.L. ischemia and 15 patients have bilharzial hepatosplenomegally, portal hypertension) (six of the 42 inpatients have D.M.) (see appendix 26). He found that six patients have D.M. with low erectile function, as shown in table (135).

**Table (135) The effect of D.M. on erectile function:**

Medical disease	With D.M. N=6	
	N	Mean IIEF
1- Minor anal surgical problem	1	40.18
2- L.L. ischemia	3	26.17
3- Bilharzial hepatosplenomegally, portal hypertension	2	29.65

**(Habeeb, 2000)**

**4) Religious attitude:**

**Habeeb (2000)** studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) and he reported that patients who usually pray and fast have significantly lower erectile function than patients who sometimes pray and fast and who neither pray nor fast, as shown in table (136).

**Table (136) The impact of religious attitude on erectile function:**

Characteristics	Patients N=80		Mean of IIEF	f	P
	N	%			
<b>Religious attitude</b>					
a- Neither prays nor fasts	10	12.5%	46.83		
b- Some times pray and fast	41	51.25%	43.73	2.90	0.05
c- Usually pray and fast	29	36.25%	35.50		

(Habeeb, 2000)

### **5) Psychiatric disorders:**

**Habeeb (2000)** studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) and he found significantly negative correlation between erectile function and somatization, anxiety and interpersonal sensitivity, while there is a significant positive correlation between erectile function and O.C.D. and he reported that dysthymic patients have sexual function worse than patients with adjustment disorder. Non psychiatric patients have the best erectile function, but without significant difference, as shown in table (137).

### **6) Manual work:**

**Habeeb (2000)** studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) and he reported that patients of manual work have slightly worse sexual function than patients of mental work, but without significant difference, as shown in table (137).

**7) Low social support:**

*Habeeb (2000)* studied 80 male inpatients in medical and surgical departments in Cairo university hospital (see appendix 26) and he reported that patients of low social support have slightly worse sexual function than patients of high social support, but without significant difference, as shown in table (137).

**Table (137) The impact of occupation, social support and psychiatric disorder on erectile function:**

Characteristics	Patients N=80		Mean of IIEF	f	P
	N	%			
<b>1- Occupation</b>					
a- Manual work	68	85%	40.85	0.3436	0.36
b- Mental work	12	15%	42.62		
<b>2- Social support</b>					
a- High	61	76.25%	39.00	0.15	0.85
b- Low	19	23.75%	41.48		
<b>3- Psychiatric disorders</b>					
a- Dysthymia	1	1.25%	32.66	1.565	0.21
b- Adjustment disorder	19	23.75%	36.44		
c- Patients with no psychiatric disorders	60	75%	42.92		

(Habeeb, 2000)

**(V) Causes of homosexuality and lesbianism:**

**1) Crowding (number of rooms):**

*Lotaief et al. (1994)* studied 155 males (15 homosexuals and 140 controls) and 115 females (8 lesbians and 107



controls) (see appendix 10) and they found insignificant difference between homosexual males and females and controls as regards number of rooms (crowding).

## **2) Parental attitude:**

**Lotaief et al. (1994)** (see appendix 10) found insignificant difference between homosexual males and controls and between lesbian females and controls and between homosexual males and lesbian females as regards parental attitude, as shown in table (138).

**Table (138) Parental attitude of homosexual males and lesbian females:**

Social upbringing	Males (N=155)					Females (N=115)					Comparison between homo. and lesb. p
	Homosexual		Controls		p	Lesbian		Controls		p	
	N	%	N	%		N	%	N	%		
Restrictive	4	26.7%	42	30%	>0.05	2	25%	31	29%	>0.05	> 0.05
Average	8	53.3%	56	40%	>0.05	3	37.5%	42	39.2%	>0.05	> 0.05
Permissive	3	20%	42	30%	>0.05	3	37.5%	34	31.8%	>0.05	> 0.05
Total	15	100%	140	100%	-	8	100%	107	100%	-	-

(Lotaief et al., 1994)

## **3) Other causes:**

**Demerdash (1970)** studied 30 impotent patients with past history of homosexuality (16 Kuwaitis, 8 Palestinian and 6 Egyptian) (see appendix 1). Table (139) shows the causes of the first homosexual experience of the three groups.

**Table (139) Causes of the first homosexual experience of impotent patients:**

Causes of the first homosexual experience	Kuwaitis N=16		Palestinian N=8		Egyptian N=6		Total N=30	
	N	%	N	%	N	%	N	%
1- Seduction	2	12.5%	3	37.5%	2	33.3%	7	23.3%
2- Imitation	-	0.0%	3	37.5%	1	16.7%	4	13.3%
3- Opposite sex unavailable or inaccessible	9	56.3%	-	0.0%	2	33.3%	11	36.7%
4- Spontaneous desire	5	31.2%	2	25 %	1	16.7%	8	26.7%

(Demerdash, 1970)

## **Clinical description of sexual and gender identity disorders:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

#### **(A) Female sexual dysfunction:**

##### **1) Age:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17) and he reported the mean age of women of sexual group ( $25.79 \pm 8.01$ ) is significantly lower than that of women of disguised group ( $31.03 \pm 8.01$ ) and women of comparative group ( $29.64 \pm 7.9$ ), as shown in table (140).

**Table (140) Age of females with sexual dysfunctions:**

Author/s	Sample	Site	Tools	Prevalence
<b>Abed (1998)</b>	99 women (sexual group: 33 women, disguised group: 33 women and comparative group: 33 women).	Gynecologica l outpatient clinic of Al-Zahraa University hospital.	Psychiatric interview.	Mean age of women of sexual group is $25.79 \pm 8.01$ , Mean age of women of disguised group is $31.03 \pm 8.01$ , Mean age of women of comparative group is $29.64 \pm 7.9$ . ( $P = 0.0236$ , Sign.)

## **2) Sexual complaints:**

**Owida and Amin (1999)** studied 163 wives with sexual dysfunction (see appendix 20) and they found that 49 out of 163 (30.1%) wives came to the clinic complaining directly of manifestations of sexual dysfunction and 114 out of 163 (69.9%) wives came to the clinic complaining indirectly of manifestations of sexual dysfunction. Also, they found that 25 out of 163 (15.3%) female patients came to the clinic complaining from pain during intercourse, 24 out of 163 (14.7%) wives complained from inaccessible intercourse, 63 out of 163 (38.7%) wives complained from pelvic heaviness, 47 out of 163 (28.8%) wives complained from low back pain and 4 out of 163 (2.5%) wives complained from vague sexual complaint, as shown in table (141).

**Table (141) Sexual complaint among wives with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview and gynecological examination.	30.1% complaining directly, 69.9% complaining indirectly. 15.3% pain during intercourse, 14.7% inaccessible intercourse, 38.7% pelvic heaviness, 28.8% low back pain, 2.5% vague sexual complaint.

**(B) Male erectile disorder (Impotence):****1) Age:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (142) shows the mean age of the three groups.

**Table (142) The mean age among impotent patients:**

	Kuwaitis	Palestinian	Egyptian
Number of patients	32	17	19
Age (Mean $\pm$ SD)	28.75 $\pm$ 6.84	30.49 $\pm$ 11.6	33.78 $\pm$ 4.08

(Demerdash, 1970)

**2) Mode of onset:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and he found insignificant difference between the three groups as regards the mode of onset, as shown in table (143).

**Table (143) Mode of onset of impotent patients:**

Mode of onset	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Sudden	13	40.6%	5	29.4%	9	47.4%	27	39.7%
Insidious	19	59.4%	12	71.6%	10	52.6%	41	60.3%

(Demerdash, 1970)

**3) Duration of impotence:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1) and

he found that the greater majority of cases reported a duration of more than one year, as shown in table (144).

**Table (144) Duration of impotence:**

Duration of impotence	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
-Less than one year	5	15.6%	3	17.6%	3	15.8%	13	19.1%
-One year	3	9.3%	2	11.8%	2	10.5%	7	10.3%
-More than one year	24	75.1%	12	70.6%	14	73.7%	48	70.6%

(Demerdash, 1970)

## **(II) Sexual dysfunctions in psychiatric patients:**

### **(A) Female psychiatric patients:**

#### **1) Afraid at the onset of menstruation:**

*El Fangary (2003)* studied 60 female psychiatric patients with sexual dysfunction and 30 female non psychiatric patients with sexual dysfunction (see appendix 30) and he reported that 45/60 (75%) female psychiatric patients with sexual dysfunction were afraid at the onset of menstruation (menarche) (see table 145) but there is insignificant difference between the female psychiatric patients with sexual dysfunction and the female non psychiatric patients with sexual dysfunction.

#### **2) Scoring of sexual functions:**

By studying the sexual functioning questionnaire (see appendix 30), *El Fangary (2003)* reported the scoring of the

sexual functions of 60 female psychiatric patients with sexual dysfunction (see table 145). Also, he found that the female psychiatric patients with sexual dysfunction have significantly lower scores of pleasure, desire frequency, orgasm and total sexual functioning than the female non psychiatric patients with sexual dysfunction but there is insignificant difference between both groups as regards desire interest and arousal.

### **3) Marital satisfaction:**

*El Fangary (2003)* (see appendix 30) reported that the mean (SD) of the marital satisfaction among 60 psychiatric patients with sexual dysfunction is  $(23.7 \pm 13.02)$ , as shown in table (145). Also, he found significant more marital dissatisfaction among those patients than among 30 non psychiatric patients with sexual dysfunction.

### **4) Sexual behaviours:**

According to Derogatis sexual functioning inventory (Clayton et al, 1997) (see appendix 30), *El Fangary (2003)* reported the sexual behaviours of 60 psychiatric patients with sexual dysfunction, as shown in table (145). Also, he found that the female psychiatric patients with sexual dysfunction have significantly lower scores of general sexual information, drive, attitude and sexual satisfaction than the female non psychiatric patients with sexual dysfunction but there is insignificant difference between both groups as regards body image.

**Table (145) Various findings of the psychiatric female patients with sexual dysfunction:**

<b>1- Afraid at the onset of menstruation</b>	<b>N (%)</b>
Present	45 (75%)
Absent	15 (25%)
<b>2- Sexual function</b>	<b>Mean <math>\pm</math> SD</b>
Sexual pleasure	1.3 $\pm$ 0.54
Sexual desire frequency	3.5 $\pm$ 1.4
Sexual desire interest	4.8 $\pm$ 1.9
Sexual arousal	6.5 $\pm$ 1.64
Sexual orgasm	4.67 $\pm$ 1.4
Total sexual function	28.03 $\pm$ 4.67
<b>3- Marital satisfaction</b>	<b>23.7 <math>\pm</math> 13.02</b>
<b>4- Sexual behaviours</b>	<b>Mean <math>\pm</math> SD</b>
General sexual information	4.77 $\pm$ 1.77
Sexual drive	9.08 $\pm$ 2.91
Sexual attitude	0.2 $\pm$ 1.79
Sexual satisfaction	3.017 $\pm$ 1.49
Body image	8.52 $\pm$ 2.74

**El Fangary (2003)**

**B) Male psychiatric patients:**

**Severity of depression:**

*Ahmed and Ezz El-Din (1992)* found that the means of Taylor's Questionnaire for depression ( $32.62 \pm 2.61$ ), E.P.Q. on neuroticism ( $16.4 \pm 4.31$ ), extraversion ( $4.54 \pm 2.21$ ) and criminality ( $9.53 \pm 3.32$ ) subscales are significantly more in 27 depressed male patients with sexual dysfunction than 19 depressed male patients without sexual dysfunction.



### **(III) Sexual dysfunctions among medical patients:**

#### **(A) Epilepsy:**

##### **1) Sexual behaviour:**

*Bahary*<sup>\*</sup> (1983) and *Demerdash et al.* (1986) studied 17 epileptic male patients with sexual disorders and comparing with 20 healthy controls by using the Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976) (see appendix 5). They found significant difference in the following dimensions: (1) the epileptics have low scores on the pornography; this reflects reluctance to practice an activity, (2) the epileptics are more shy and inhibited as regards sex, (3) the high scores of epileptics on prudishness reflect avoidance of any expression of spontaneous sexual feelings, (4) the high scores on sexual disgust may be considered as an expression of frustration with sex and (5) the low scores of epileptics on sexual excitement reflect impaired libido, as shown in table (146).

**Table (146) Sexual behaviour of male epileptics with sexual disorders:**

Author/s	Sample	Site	Tools	Results
<b>Bahary (1983) and Demerdash et al. (1986)</b>	17 male epileptics with sexual disorders and 20 healthy controls.	The epileptic and dental clinics in El Hussein University Hospital.	Eysenck and Wilson questionnaire of sexual behaviour and attitudes (1976).	Significantly low scores in pornography and sexual excitement. Significantly high scores in shyness prudishness and sexual disgust.

<sup>\*</sup> Arabic Reference.

**2) Duration of sexual dysfunction:**

**Mourad (2009)** studied 50 epileptic male patients with sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy) (see appendix 37) and he reported that the duration of sexual dysfunction among the monotherapy epileptic patients is  $10.3 \pm 8.75$  months and among the polytherapy epileptic patients is  $20.83 \pm 4.99$  months with significant difference between them, as shown in table (147).

**Table (147) Duration of sexual dysfunction among male epileptic patients:**

Author/s	Sample	Site	Tools	Results
<b>Mourad (2009)</b>	50 epileptic male patients with sexual dysfunction (30 patients on polytherapy and 20 patients on monotherapy).	Kasr El-Aini Epilepsy Outpatient Clinic.	Psychiatric interview.	The duration of sexual dysfunction among the monotherapy epileptic patients is $10.3 \pm 8.75$ months and among the polytherapy epileptic patients is $20.83 \pm 4.99$ months.

**(B) Infertility:**

**Mohammed\* (1989)** studied 30 infertile women (the cause is Fallobian tube obstruction) and 15 healthy controls and he reported that 14 out of 30 (46.7%) infertile women report sexual fantasies during coitus and 16 out of 30 (53.3%) infertile women report no sexual fantasies during coitus, as shown in table (148). Also, he found that the coitus is associated with sexual fantasies in infertile women more than

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\* Arabic Reference.

the healthy controls. Sexual fantasies in infertile women are related to desire of pregnancy but in healthy controls are related to orgasm during coitus.

**Table (148) Sexual fantasies during coitus of infertile women:**

Author/s	Sample	Site	Tools	Results
<b>Mohammed (1989)</b>	30 infertile women.	The psychiatric and gynecological departments in El Hussein University Hospital.	The DSFI (Derogatis sexual functioning inventory).	46.7% report sexual fantasies during coitus and 53.3% report no sexual fantasies during coitus.

#### **(IV) Sexual assault can lead to sexual dysfunctions:**

##### **(A) Childhood sexual abuse (CSA):**

##### **1) Age at time of abuse:**

*Sayed (1998)* studied 60 psychiatric patients with history of CSA (see appendix 18) and he reported that the mean age of history of CSA psychiatric patients when abuse occurred is 8.6 years, as shown in table (149).

**Table (149) Age of victims of CSA at time of abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	Mean age of abused psychiatric patients when abuse occurred is 8.6 years.

**2) Gender of the perpetrator:**

*Sayed (1998)* studied 60 psychiatric patients with history of CSA (see appendix 18) and he reported that the perpetrators of 51 out of 60 (85%) history of CSA psychiatric patients are males, the perpetrators of 4 out of 60 (6.6%) history of CSA psychiatric patients are females and the perpetrators of 5 out of 60 (8.3%) history of CSA psychiatric patients are both males and females, as shown in table (150).

**Table (150) Gender of the perpetrator of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	85% males, 6.7% females, 8.3% both males and females.

**3) Relationship to the perpetrator:**

*Fahmy et al. (1995)* studied 54 (38 females and 16 males) psychiatric patients with history of CSA (see appendix 13) and they reported that the perpetrator of CSA of 4 out of 16 (25%) male patients and 22 out of 38 (57.9%) female patients is relative, 11 out of 16 (68.7%) male patients and 14 out of 38 (36.8%) female patients is well known and one out of 16 (6.3%) male patients and 2 out of 38 (5.2%) female patients is foreigner, as shown in table (151). *Sayed (1998)* (see appendix 18) reported that the perpetrator of 6 out of 60 (10%) history of CSA psychiatric patients is member of the nuclear family, the perpetrator of 17 out of 60 (28.3%) history of CSA psychiatric

patients is member of the extended family, the perpetrator of 8 out of 60 (13.3%) history of CSA psychiatric patients is stranger and the perpetrator of 29 out of 60 (48.3%) history of CSA psychiatric patients is acquaintance, as shown in table (151). **Soliman et al. (1999)** studied 35 depressed women with history of CSA (see appendix 21) and they reported that 19 out of 35 (54.3%) women report intra-familial abuse and 16 out of 35 (45.7%) women report extra-familial abuse, as shown in table (151).

**Table (151) Relationship to the perpetrator of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Fahmy et al. (1995)</b>	54 (38 females and 16 males) psychiatric patients with history of CSA.	Outpatient psychiatric clinics.	Psychiatric interview.	The perpetrator of CSA of 25% male patients and 57.9% female patients is relative, of 68.7% male patients and 36.8% female patients is well known and of 6.3% male patients 5.2% female patients is foreigner.
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	10% member of the nuclear family, 28.3% member of the extended family, 13.3% stranger, 48.3% acquaintance.
<b>Soliman et al. (1999)</b>	35 depressed women with history of CSA.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Psychiatric interview.	54.3% intra-familial, 45.7% extra-familial.

**4) Type of childhood sexual abuse (CSA):**

**Sayed (1998)** (see appendix 18) reported that highest level of sexual activity in 6 out of 60 (10%) history of CSA psychiatric patients is touching of non genitals in a sexual way, 9 out of 60 (15%) history of CSA psychiatric patients is touching of genitals, 12 out of 60 (20%) history of CSA psychiatric patients is oral sex, 4 out of 60 (6.7%) history of CSA psychiatric patients is attempted intercourse, 3 out of 60 (5%) history of CSA psychiatric patients is penetration with object or finger and 26 out of 60 (43.3%) history of CSA psychiatric patients is completed intercourse, as shown in table (152). **Soliman et al. (1999)** (see appendix 21) reported that 7 out of 35 (20%) history of CSA depressed women report sexual abuse not involving genitalia, 13 out of 78 (37.1%) history of CSA depressed women report sexual abuse involving genitalia without penetration and 15 out of 78 (42.9%) history of CSA depressed women report sexual abuse involving genitalia with penetration, as shown in table (152).

**Table (152) Types of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	10% touching of non genitals in a sexual way, 15% touching of genitals, 20% oral sex, 6.7% attempted intercourse, 5% penetration with object or finger, 43.3% completed intercourse.
<b>Soliman et al. (1999)</b>	35 depressed women with history of CSA.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Psychiatric interview.	20% not involving genitalia, 37.1% involving genitalia without penetration, 42.9% involving genitalia with penetration.

**5) Level of force:**

*Sayed (1998)* (see appendix 18) reported that the level of force in 32 out of 60 (53.3%) history of CSA psychiatric patients is threatening, 16 out of 60 (26.7%) history of CSA psychiatric patients is very much physical force and 12 out of 60 (20%) history of CSA psychiatric patients have no force at all, as shown in table (153). *Soliman et al. (1999)* (see appendix 21) reported that 25 out of 35 (71.4%) history of CSA depressed women report used or threatened violence and 10 out of 35 (28.6%) history of CSA depressed women do not report used or threatened violence, as shown in table (153).

**Table (153) Level of force of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	53.3% threatening, 26.7% very much physical force, 20% not at all.
<b>Soliman et al. (1999)</b>	35 depressed women with history of CSA.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Psychiatric interview.	71.4% with threatened violence, 28.6% without threatened violence.

**6) Frequency of childhood sexual abuse (CSA):**

*Fahmy et al. (1995)* (see appendix 13) reported that 6 out of 16 (37.5%) history of CSA male psychiatric patients and 5 out of 38 (13.1%) history of CSA female psychiatric patients have abused once and 10 out of 16 (62.5%) history of CSA male psychiatric patients and 33 out of 38 (86.9%) history of CSA female psychiatric patients have frequent abuse, as shown in table (154). *Sayed (1998)* (see appendix 18) reported that 11 out of 60 (18.3%) history of CSA psychiatric patients have abused once, 32 out of 60 (53.3%) history of CSA psychiatric patients have abused 2-5 times, 15 out of 60 (25%) history of CSA psychiatric patients have abused 6-10 times and 2 out of 60 (3.3%) history of CSA psychiatric patients have abused more than 10 times, as shown in table (154).

**Table (154) Frequency of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Fahmy et al. (1995)</b>	54 (38 females and 16 males) psychiatric patients with history of CSA.	Outpatient psychiatric clinics.	Psychiatric interview.	37.5% male patients and 13.1% female patients have abused once, 62.5% male patients and 86.9% female patients have frequent abuse.
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	18.3% once, 53.3% 2-5 times, 25% 6-10 times, 3.3% more than 10 times.



**7) Duration of childhood sexual abuse (CSA):**

*Sayed (1998)* (see appendix 18) reported that duration of sexual abuse among 12 out of 60 (20%) history of CSA psychiatric patients is one day, 16 out of 60 (26.7%) history of CSA psychiatric patients is less than one month, 19 out of 60 (31.7%) history of CSA psychiatric patients is one month to one year, 11 out of 60 (18.3%) history of CSA psychiatric patients is one year to 5 years and 2 out of 60 (3.3%) history of CSA psychiatric patients is more than 5 years, as shown in table (155).

**Table (155) Duration of childhood sexual abuse:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	20% one day, 26.7% less than one month, 31.7% one month to one year, 18.3% one year to 5 years, 3.3% more than 5 years.

**8) Disclosure during the abuse:**

*Soliman et al. (1999)* (see appendix 21) reported that 29 out of 35 (82.91%) history of CSA depressed women could not disclose the abuse for years after the abuse had stopped and 6 out of 35 (17.1%) history of CSA depressed women disclose the abuse, as shown in table (156).

**Table (156) Disclosure during the abuse:**

Author/s	Sample	Site	Tools	Results
<b>Soliman et al. (1999)</b>	35 depressed women with history of CSA.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Psychiatric interview.	17.1% disclose the abuse, 82.91% couldn't disclose the abuse.

**9) Other characteristics of childhood sexual abuse (CSA):**

*Fahmy et al. (1995)* (see appendix 11) reported the characteristics of childhood sexual abuse of females and males psychiatric patients in the following table.

**Table (157) Characteristics of childhood sexual abuse:**

Characteristics of CSA	Psychiatric patients with history of CSA		z	P
	16 Males N (%)	38 Females N (%)		
<b>1- Number of abusers</b>				
a- One person	13 (81.25%)	29 (76.32%)	0.398	> 0.05 (N.S)
b- Multiple	3 (18.75%)	9 (23.68%)	0.398	> 0.05 (N.S)
<b>2- Kind of assault</b>				
a- Molestation	13 (81.25%)	34 (89.47%)	0.822	> 0.05 (N.S)
b- Other	3 (18.75%)	4 (10.53%)	0.822	> 0.05 (N.S)
<b>3- Family knowledge</b>				
a- At beginning	4 (25%)	3 (7.89%)	1.709	< 0.05 (Sig.)
b- Later on	0 (0.0%)	10 (26.32%)	2.273	< 0.05 (Sig.)
c- Not known	12 (75%)	25 (65.79%)	0.665	> 0.05 (N.S)
<b>4- Family reaction</b>				
a- Active	4 (25%)	11 (28.95%)	0.296	> 0.05 (N.S)
b- Passive	12 (75%)	27 (71.05%)	0.935	> 0.05 (N.S)

(Fahmy et al., 1995)

**(B) Rape:****1) Assailant:**

*Abdelmessih et al. (1980)* studied 157 rape victims (see appendix 2) and they reported that the assailant of 96 out of 157 (61.2%) rape victims is a stranger, as shown in table (158).

**Table (158) Relationship between victim and assailant in rape:**

Type of relationship	Rape victims	
	N	%
- Strangers	96	61.2%
- Casual acquaintance	17	10.8%
- Neighbour	14	8.9%
- Close friend	3	1.9%
- Family friend	6	3.8%
- Family relative	2	1.3%
- Paid servants in the ravisher's house	19	12.1%
<b>Total</b>	<b>157</b>	<b>100%</b>

(Abdelmessih et al., 1980)

**2) Place of rape:**

*Abdelmessih et al. (1980)* (see appendix 2) reported that 109 out of 157 (69.4%) rape victims are raped in a participant's place, as shown in table (159).

**Table (159) Place of rape:**

Place of rape	Rape victims	
	N	%
- Participant's place	109	69.4%
- Place of work	23	14.7%
- Roof tops and uninhabited buildings	17	10.8%
- Open spaces	5	3.2%
- Cars	3	1.9%
<b>Total</b>	<b>157</b>	<b>100%</b>

(Abdelmessih et al., 1980)

**3) Type of assault in rape:**

*Abdelmessih et al. (1980)* (see appendix 2) reported that 141 out of 157 (89.8%) rape victims are raped by a single assailant, as shown in table (160).

**Table (160) Type of assault in rape:**

Type of rape	Rape victims	
	N	%
- Single	141	89.8%
- Pair	7	4.5%
- Group	9	5.7%
<b>Total</b>	<b>157</b>	<b>100%</b>

(Abdelmessih et al., 1980)

**4) Condition of hymen and accompanying signs of rape:**

*Abdelmessih et al. (1980)* (see appendix 2) reported that 40 out of 157 (25.5%) rape victims have ruptured hymen, 2 out of 157 (1.3%) rape victims have perineal tears, 15 out of 157 (9.5%) rape victims have signs of local and general violence, 14 out of 157 (8.9%) rape victims have human spermatozoa and 11 out of 157 (7%) rape victims have signs of pregnancy, as shown in table (161).

**Table (161) Condition of hymen and accompanying signs among rape victims:**

Author/s	Sample	Site	Tools	Results
<b>Abdelmessih et al. (1980)</b>	157 rape victims	Not mentioned.	Not mentioned.	25.5% have ruptured hymen, 1.3% have perineal tears, 9.5% have signs of local and general violence, 8.9% have human spermatozoa, 7% have signs of pregnancy.

**5) Seasonal incidence of rape:**

*Abdelmessih et al. (1980)* (see appendix 2) reported that 9 out of 157 (5.7%) rape victims are raped in January, 6 out of 157 (3.8%) rape victims are raped in February, 19 out of 157 (12.1%) rape victims are raped in March, 23 out of 157 (14.7%) rape victims are raped in April, 16 out of 157 (10.2%) rape victims are raped in May, 10 out of 157 (6.4%) rape victims are raped in June, 13 out of 157 (8.3%) rape victims are raped in July, 8 out of 157 (5.1%) rape victims are raped in August, 19 out of 157 (12.1%) rape victims are raped in September, 13 out of 157 (8.3%) rape victims are raped in October, 12 out of 157 (7.6%) rape victims are raped in November and 9 out of 157 (5.7%) rape victims are raped in December, as shown in table (162). Also, they found that the incidence of rape is high in spring and autumn, and lower in summer and winter.

**Table (162) Seasonal incidence of rape:**

Author/s	Sample	Site	Tools	Results
<b>Abdelmessih et al. (1980)</b>	157 rape victims.	Not mentioned.	Not mentioned.	5.7% January, 3.8% February, 12.1% March, 14.7% April, 10.2% May, 6.4% June, 8.3% July, 5.1% August, 12.1% September, 8.3% October, 7.6% November, 5.7% December.

## **(V) Female genital mutilation may lead to sexual dysfunctions:**

### **Female circumcision:**

#### **1) Age at time of female circumcision:**

*Lotfy and El-Defrawy (1995)* studied 200 circumcised wives (see appendix 11) and they reported that 152 out of 200 (76%) circumcised wives had undergone this procedure between ages 8 and 12 years, 14 out of 200 (7%) circumcised wives had circumcised before age 8 years and 34 out of 200 (17%) circumcised wives had circumcised after age 12 years, as shown in table (163). *El-Defrawy et al. (1996)* studied 200 circumcised wives (see appendix 14) and they reported that 123 out of 200 (61.5%) circumcised wives had undergone this procedure between ages 8 and 12 years, 43 out of 200 (21.5%) circumcised wives had circumcised before age 8 years and 34 out of 200 (17%) circumcised wives had circumcised after age 12 years (table 163). *El Fangary (2003)* studied 60 psychiatric patients with sexual dysfunction (see appendix 30) and he reported that mean age of circumcision of the patients is ( $7.87 \pm 1.95$ ), as shown in table (163).

**Table (163) Age at time of female circumcision:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	7% before age 8 years, 76% between ages 8 and 12 years, 17% after age 12 years.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	21.5% before age 8 years, 61.5% between ages 8 and 12 years, 17% after age 12 years.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	Mean age of circumcision is (7.87 $\pm$ 1.95).

**2) Places of doing the female circumcision:**

*Lotfy and El-Defrawy (1995)* studied 200 circumcised wives (see appendix 11) and they reported that 117 out of 200 (58.5%) circumcised wives had circumcised at home, 69 out of 200 (34.5%) circumcised wives had circumcised in medical clinic, 14 out of 200 (7%) circumcised wives had circumcised at daya home, as shown in table (164). *El-Defrawy et al. (1996)* studied 200 circumcised wives (see appendix 14) and they reported that 115 out of 200 (57.5%) circumcised wives had circumcised at home, 67 out of 200 (33.5%) circumcised wives had circumcised in medical clinic, 9 out of 200 (4.5%) circumcised wives had circumcised at daya's home, 7 out of

200 (3.5%) circumcised wives had circumcised at barber's places and 2 out of 200 (1%) circumcised wives had circumcised in governmental hospitals, as shown in table (164).

***Table (164) Places of doing the female circumcision:***

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	58.5% at home, 34.5% medical clinic, 7% at daya home.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	57.5% at home, 33.5% medical clinic, 4.5% at daya's home, 3.5% barber, 1% governmental hospital.

### ***3) Female circumcision's operators:***

*Lotfy and El-Defrawy (1995)* studied 200 circumcised wives (see appendix 11) and they reported that 97 out of 200 (48.5%) circumcised wives had circumcised by dayas, 73 out of 200 (36.5%) circumcised wives had circumcised by physicians, 17 out of 200 (8.5%) circumcised wives had circumcised by barbers and 13 out of 200 (6.5%) circumcised wives did not know, as shown in table (165). *El-Defrawy et al. (1996)* studied 200 circumcised wives (see appendix 14) and they reported that 97 out of 200 (48.5%) circumcised wives



had circumcised by dayas, 73 out of 200 (36.5%) circumcised wives had circumcised by physicians, 19 out of 200 (9.5%) circumcised wives had circumcised by barbers and 11 out of 200 (5.5%) circumcised wives do not know, as shown in table (165).

***Table (165) Female circumcision's operators:***

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	48.5% by daya, 36.5% by physician, 8.5% by barber, 6.5% unknown.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	48.5% by daya, 36.5% by physician, 9.5% by barber, 5.5% unknown.

#### ***4) Type of female circumcision:***

*Lotfy and El-Defrawy (1995)* studied 200 circumcised wives (see appendix 11) and they reported that 101 out of 200 (50.5%) circumcised wives had circumcised with injury of the clitoris, 73 out of 200 (36.5%) circumcised wives had circumcised with excision of the clitoris and 26 out of 200 (13%) circumcised wives had circumcised with excision of the clitoris and surrounding parts, as shown in table (166). *EL-*

*Defrawy et al. (1996)* studied 200 circumcised wives (see appendix 14) and they reported that 76 out of 200 (38%) circumcised wives had circumcised with injury of the clitoris, 109 out of 200 (54.5%) circumcised wives had circumcised with excision of the clitoris and 15 out of 200 (7.5%) circumcised wives had circumcised with excision of the clitoris and surrounding parts, as shown in table (166).

***Table (166) Types of female circumcision:***

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	50.5% with injury of the clitoris, 36.5% with excision of the clitoris, 13% with excision of the clitoris and surrounding parts.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	38% with injury of the clitoris, 54.5% with excision of the clitoris, 7.5% with excision of the clitoris and surrounding parts.

**5) Complications of female circumcision:**

**Lotfy and El-Defrawy (1995)** studied 200 circumcised wives (see appendix 11) and they reported that 93 out of 200 (46.5%) circumcised wives have recalled no complications following the procedures and 107 out of 200 (53.5%) circumcised wives have recalled complications following the procedures as pain 58 out of 200 (29%), bleeding 21 out of 200 (10.5%), infection (U.T.) 24 out of 200 (12%) and clitoris swelling 4 out of 200 (2%) circumcised wives), as shown in table (167). **El-Defrawy et al. (1996)** studied 200 circumcised wives (see appendix 14) and they reported that the circumcised wives have recalled complications following the procedures as pain among 103 out of 200 (51.5%), bleeding among 33 out of 200 (16.5%), infection among 86 out of 200 (43%), external deformation among 19 out of 200 (9.5%) circumcised wives and also urinary tract infections are included, as shown in table (167).

**Table (167) Complications of female circumcision:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	46.5% no complications, 53.5% complications with 29% pain, 10.5% bleeding, 12% infection (U.T.), 2% clitoris swelling.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	51.5% pain, 16.5% bleeding, 43% infection, 9.5% external deformation.

## **(VI) Homosexuality and lesbianism:**

### **1) Distribution of age of onset:**

*Demerdash (1970)* studied 30 impotent patients with past history of homosexuality (16 Kuwaitis, 8 Palestinian and 6 Egyptian) (see appendix 1) and he found insignificant difference between the 3 groups as regards the age of onset of homosexuality, as shown in table (168).

**Table (168) Age of onset of homosexuality among impotent patients:**

Age of onset of homosexuality	Kuwaitis N=16	Palestinian N=8	Egyptian N=6
Mean (SD) years	15.67 (4.47)	12.88 (4.15)	15 (6.71)

(Demerdash, 1970)

**2) Duration of homosexual experience:**

*Demerdash (1970)* studied 30 impotent patients with past history of homosexuality (16 Kuwaitis, 8 Palestinian and 6 Egyptian) (see appendix 1) and he found insignificant difference between the 3 groups as regards the duration of homosexual experience, as shown in table (169).

**Table (169) Duration of homosexual experience among impotent patients:**

Duration of homosexual experience	Kuwaitis N=16		Palestinian N=8		Egyptian N=6		Total N=30	
	N	%	N	%	N	%	N	%
- Less than one year	5	31.3%	6	75%	3	50%	14	46.7%
- One year	1	6.2%	1	12.5%	2	33.3%	4	13.3%
- More than one year	10	62.5%	1	12.5%	1	16.7%	12	40%

(Demerdash, 1970)

**3) Distribution of the age of the other partner on first homosexual experience :**

*Lotaief et al. (1994)* studied 15 homosexuals and 8 lesbians (see appendix 10) and they found insignificant difference between the homosexual males and the lesbian females as regards the age of the other partner on first experience, as shown in table (170).

**Table (170) Distribution of the age of the other partner during first homosexual experience:**

Age of the other partner	Males		Females		p
	N	%	N	%	
< 15	5	33.3%	2	25%	> 0.05 (N.S)
16 - 30	6	40%	2	25%	> 0.05 (N.S)
31 - 50	3	20%	4	50%	> 0.05 (N.S)
Over 50	1	1.7%	0	0.0%	> 0.05 (N.S)
<b>Total</b>	15	100%	8	100%	-

(Lotaief et al., 1994)

**4) Relation of homosexual males with the other partner:**

*Lotaief et al. (1994)* studied 15 homosexual males (see appendix 10). Table (171) shows the relation between homosexual males and the other partner.

**Table (171) Relation of homosexual males with the other partner:**

Relation with the other partner	Males	
	N	%
Friend	1	6.7%
Comrade	2	13.3%
Neighbour	3	19.9%
2nd degree relative	1	6.7%
Other relation	6	40%
Not reported	2	13.3%
<b>Total</b>	15	100%

(Lotaief et al., 1994)

**5) Marital state of the other partner of homosexuals and lesbians:**

*Lotaief et al. (1994)* (see appendix 10) found insignificant difference between the homosexual males and the lesbian females as regards the marital state of the other partner, as shown in table (172).

**Table (172) Distribution of the marital state of the other partner of homosexuals and lesbians:**

Marital state of the other partner	Males		Females		p
	N	%	N	%	
Single	7	46.7%	4	50%	> 0.05 (N.S)
Married	2	13.3%	1	12.5%	> 0.05 (N.S)
Widow	1	6.7%	0	0%	> 0.05 (N.S)
Children	5	33.3%	3	37.5%	< 0.05 (N.S)
<b>Total</b>	15	100%	8	100%	-

(Lotaief et al., 1994)

## **Management of sexual and gender identity disorders:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

#### **Male erectile disorder (Impotence):**

*Soliman*<sup>\*</sup> (1981) studied 30 impotent patients: 14 patients accepted to undergo psychotherapy for 15 sessions, 15 minutes each (group I) and 16 patients treated by vitamins and prostatic massage (group II) and he found that 4 out of 14 (28.6%) patients of group I and 3 out of 16 (18.8%) patients of group II show great improvement, 9 out of 14 (64.3%) patients of group I and 8 out of 16 (50%) patients of group II show moderate improvement and one out of 14 (7.1%) patients of group I and 5 out of 16 (31.2%) patients of group II show no improvement (table 173). *El-Akabawi and Idarous (1982)* studied 30 patients presenting with a complaint of impotence (see appendix 3) and they reported that two models of therapy were used : A classical drug therapy regime (each patient was prescribed polyvitamin tabs., a depot testosterone 100 mg I.M. injection once weekly (7) and prostatic massage course once weekly for 15 sessions) and a talk therapy model (patients were seen for 15 brief psychotherapeutic sessions twice weekly in which Masters and Johnson's pleasuring instructions were given to them combining a behavioral and non directive

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<sup>\*</sup> Arabic Reference.



expressive psychotherapeutic interventions). They found that 13 out of 14 (92.9%) impotent patients improved without drug therapy (with talk therapy) and 11 out of 16 (68.8%) impotent patients improved with drug therapy, as shown in table (173).

***Table (173) Management of impotence:***

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Results</b>
<b>Soliman (1981)</b>	30 impotent patients: 14 treated with psychotherapy (group I) and 16 treated with drug therapy (group II).	The outpatient department of the Venereal and Skin Diseases, Al Hussein University Hospital in Cairo.	1) Psychotherapy. 2) Drug therapy.	28.6% patients of group I and 18.8% patients of group II show great improvement, 64.3% patients of group I and 50% patients of group II show moderate improvement and 7.1% patients of group I and 31.2% patients of group II show no improvement.
<b>El - Akabawi &amp; Idarous (1982)</b>	30 impotent patients: 14 treated with non-drug therapy and 16 treated with drug therapy.	The outpatient department of the Venereal and Skin Diseases, Al Hussein University Hospital in Cairo.	1) Drug therapy regime. 2) Talk therapy model. Master and Johnson instructions and non-directive expressive intervention.	92.9% impotent patients improved with talk therapy. 68.8% impotent patients improved with drug therapy.

## **(II) Sexual dysfunctions in depressed patients:**

*Ahmed and Ezz El-Din (1992)* studied 46 male major depressed patients 27 patients with sexual dysfunction and 19 patients without sexual dysfunction. Patients received tricyclic antidepressant 75 mg to 100 mg/day for six months then they were reassessed (see appendix 6). They found that 20 out of 27 (74.08%) of patients with sexual dysfunction show sexual dysfunction improvement and 7 out of 19 (36.84%) of patients without sexual dysfunction show decrease in sexual performance, as shown in table (174).

**Table (174) Management of sexual dysfunction in patients with major depression:**

Author/s	Sample	Site	Tools	Results
<b>Ahmed &amp; El-Din (1992)</b>	27 depressed patients with sexual dysfunction (Group A) and 19 depressed patients without sexual dysfunction (Group B).	The outpatient psychiatric clinic of a private hospital in Saudi Arabia.	Tricyclic antidepressant in the doses of 75 mg to 100 mg/day for six months.	74.08% of patients of {group A} showed improvement in their sexual dysfunction and 36.84% of patients of {group B} showed decrease in sexual performance after treatment.

## **Outcome of sexual and gender identity disorders:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

#### **1) Marital satisfaction:**

*Abed (1998)* studied 99 women: 33 women presented with a sexual complaint (sexual group), 33 women reveal their sexual problem after screening (disguised group) and 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group) (see appendix 17). He found no significant difference between sexual, disguised and comparative groups as regards marital satisfaction, as shown in table (175).

**Table (175) Marital satisfaction among females with sexual dysfunctions:**

Marital satisfaction	Sexual (I) N=33		Disguised (II) N=33		Comparative(III) N=33	
	N	%	N	%	N	%
1- Satisfied	21	63.6%	20	60.6%	27	81.8%
2- Dissatisfied	9	27.3%	7	21.2%	5	15.2%
3- Tend to divorce	3	9.1%	6	18.2%	1	3%

(Abed, 1998)

## 2) Having children:

*Owida and Amin (1999)* studied 163 wives with sexual dysfunction (see appendix 20) and they found that 116 out of 163 (71.2%) wives have children and 47 out of 163 (28.8%) wives have no children, as shown in table (176).

**Table (176) Having children among wives with sexual dysfunction:**

Author/s	Sample	Site	Tools	Results
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	71.2% have children, 28.8% have no children.

## 3) Change in sexual functioning after onset of psychiatric illness:

*El Fangary (2003)* studied 60 psychiatric female patients with sexual dysfunction. He reported that 23 out of 60 (38.3%) patients become worse in sexual functioning after onset of psychiatric illness and 37 out of 60 (61.7%) patients show no change in sexual functioning after onset of psychiatric illness, as shown in table (177).

**Table (177) Distribution of psychiatric female patients with sexual dysfunction according to change in sexual functioning after onset of psychiatric illness:**

Author/s	Sample	Site	Tools	Results
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview and sexual functioning questionnaire.	38.3% patients become worse in sexual functioning after onset of psychiatric illness, 61.7% patients show no change in sexual functioning after onset of psychiatric illness.

**(4) Psychiatric diagnoses:**

*El Fangary (2003)* studied 60 psychiatric female patients with sexual dysfunction and 60 psychiatric female patients without sexual dysfunction (see appendix 30). He found insignificant difference between both groups as regards psychiatric disorders, as shown in table (178).

**Table (178) Distribution of psychiatric diagnoses among female patients with and without sexual dysfunction:**

Psychiatric diagnosis	Psychiatric patients			
	With sexual dysfunction N=60		Without sexual dysfunction N=60	
	N	%	N	%
1- Mood disorder	20	33.3%	17	28.3%
2- Anxiety disorder	15	25%	20	33.3%
3- Somatoform disorder	12	20%	7	11.7%
4- Adjustment disorder	11	18.3%	12	20%
5- Others	2	3.3%	4	6.7%

(El Fangary, 2003)

## **(II) Sexual dysfunctions among medical patients:**

**Epilepsy:**

*Bahary\* (1983) and Demerdash et al. (1986)* studied 17 male epileptic patients with sexual disorders (see appendix 5) and they reported that 6 out of 17 (35%) patients have no psychiatric disorders and 11 out of 17 (65%) patients have

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\* Arabic Reference.

psychiatric disorders in the form of neurotic depression (82%) and anxiety neurosis (18%). These psychiatric disorders may be due to the sexual disorders itself and / or due to the epilepsy.

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **Childhood sexual abuse (CSA):**

##### **1) Low self esteem:**

*Hamed (2006)* studied 1500 preparatory school students (78 sexually abused and 1422 not sexually abused) (see appendix 34) and he reported that 75 out of 78 (96.15%) sexually abused students have low self esteem, 3 out of 78 (3.85%) sexually abused students have average self esteem and no one of sexually abused students have high self esteem, as shown in table (179). Also, he found that students subjected to sexual abuse are significantly liable to low self esteem than students not subjected to sexual abuse.

**Table (179) Self esteem of sexually abused children:**

Author/s	Sample	Site	Tools	Results
<b>Hamed (2006)</b>	78 sexually abused preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview and Copper smith Self-Esteem Inventory.	96.15% have low self esteem, 3.85% have average self esteem, no one have high self esteem.

##### **2) Unsatisfactory adult sexual functioning:**

*Sayed (1998)* (see appendix 18) reported that 17 out of 60 (28.3%) psychiatric patients with history of CSA have

satisfactory sexual functioning and 43 out of 60 (71.6%) psychiatric patients with history of CSA have unsatisfactory sexual functioning, as shown in table (180). Also, he found that psychiatric patients with history of CSA have significantly unsatisfactory sexual functioning more than psychiatric patients without history of CSA (18 out of 60 (30%)).

**Table (180) Distribution of psychiatric patients with childhood sexual abuse according to adult sexual functioning:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of childhood sexual abuse.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview and adult sexual functioning.	28.3% have satisfactory sexual functioning, 71.6% have unsatisfactory sexual functioning.

### **3) Less social adjustment:**

*Soliman and Effat (2000)* studied 35 depressed women with history of CSA and 40 depressed women without history of CSA and followed up for 24 months (see appendix 22). Table (181) shows the scores of Social Adjustment Scale at one and two years among the sexually abused and non- abused depressed women. They concluded that the depressed women with history of CSA are less socially adjusted particularly to marital roles and work.

**Table (181) Social Adjustment Scale Scores of depressed women with and without history of CSA:**

Variable	One year				P	Two year				P
	Abused		Not abused			Abused		Not abused		
	N	Mean ±SD	N	Mean± SD		N	Mean± SD	N	Mean ±SD	
1- Work	35	20.8±6.5	40	16.2±5.9	0.000	35	20.3±6.9	40	15.9±6	0.002
2- Leisure activities	35	28.7±5.6	40	27.1±4.9	0.139	35	27.8±5.4	40	26.6±4.9	0.251
3- Relationship with extended family	35	23.7±3.3	40	22.7±4	0.000	35	23.9±3.6	40	22.5±4.1	0.271
4- Marital roles as spouse	24	31.0±5.1	33	23±4.2	0.000	24	30.8±5.3	33	22.6±4.2	0.000
5- Marital role as parent	26	11.9±2.8	33	9.3±2	0.000	26	11±2.7	33	9.6±2	0.004
6- Marital role as member of family unit	26	7.1±1.4	33	4.9±0.9	0.000	26	6.6±1.5	33	4.6±0.8	0.000
7- Overall score	36	20.7±3.1	40	17.9±3.9	0.000	36	20.3±3.2	40	17.5±3.8	0.000

(Soliman and Effat, 2000)

#### **4) Depression:**

*Hamed (2006)* studied 1500 preparatory school students (78 sexually abused and 1422 not sexually abused) (see appendix 34) and he reported that 48 out of 78 (61.54%) sexually abused students have major depressive episode, as shown in table (182). Also, he found that students subjected to sexual abuse are significantly liable to a major depressive episode than students not subjected to sexual abuse.



**Table (182) Major depressive episode of sexually abused children:**

Author/s	Sample	Site	Tools	Results
<b>Hamed (2006)</b>	78 sexually abused preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview and The Mini International Neuropsychiatric Interview for children and adolescents (MINI).	61.54% of sexually abused students have major depressive episode.

*Soliman et al. (1999)* studied 35 depressed women with history of CSA and 43 depressed women without history of CSA (see appendix 21) and they found that the depression is more severe among the depressed women with history of CSA. Also, *Soliman and Effat (2000)* (see appendix 22) found that the depression is more severe among the depressed women with history of CSA (N = 35) than among the depressed women without history of CSA (N = 40), as shown in table (183).

**Table (183) Depressed women with and without history of CSA:**

Variable	Depressed women		Mann-Whitney U test	P
	35 with history of CSA	43 without history of CSA		
1- Age of onset of depression	21.5±6.8	33.4±6.6	171.00	<0.0001(S.)
2- Number of depressive episodes	4.5±2.7	2.1±1.2	298.00	<0.0001(S.)
3- Length of stay in hospital	63.9±44	33.6±24.8	367.00	<0.001(S.)
4- Days per annum spent in hospital	73.1±48.6	38.3±31.3	366.00	<0.001(S.)
5- Ability to trust men	5.1±2.1	7.4±1.3	219.00	<0.0001(S.)
6- Quality of relationship with partner	5.5±2.2	7.4±1.3	321.50	<0.0001(S.)
7- Quality of sex life	4.3±2.5	7.1±1.5	246.50	<0.0001(S.)
8- Number of times of antidepressant change during last 6 months	0.8±1	0.3±0.5	550.00	<0.05(S.)
9- Number of suicide attempts	6±5	0.3±0.6	85.00	<0.0001(S.)

(Soliman et al., 1999)

	35 with history of CSA	40 without history of CSA		P
10- Number of suicide attempts	1.9±1.2	0.4±0.6	-	0.000 (S.)
11- BDI score (one year)	23.3±9.4	13.9±8.9	-	0.000 (S.)
12- BDI score (two year)	24.2±10.3	15.6±10.2	-	0.000 (S.)
13- Frequency of readmission	1.4±1	0.8±0.7	-	0.003 (S.)
14- Use of emergency/crisis services	1.9±1	1.2±0.8	-	0.004 (S.)
15- Use of other mental health services	17.3±15.7	9.2±12.4	-	0.023 (S.)

(Soliman and Effat, 2000)

**Severity of depression:****a) Intrafamilial CSA:**

*Soliman et al. (1999)* studied 35 depressed women with history of CSA (19 with intra-familial CSA and 16 with extra-familial CSA) (see appendix 21) and they found that the depression is more severe among the depressed women with history of intra-familial CSA, as shown in table (184).

**Table (184) Depressed women with history of intra-familial and extra-familial CSA:**

Variable	35 depressed women with CSA		Mann-Whitney U test	P
	19 Intra-familial Mean± SD	16 Extra-familial Mean± SD		
1- Age of onset of depression	18.7±4.6	24.7±7.6	75.50	<0.05 (S.)
2- Number of depressive episodes	5.79±2.6	3±1.9	55.50	<0.001(S.)
3- Number of suicide attempts	7.1±4	4.8±5.9	84.00	<0.05(S.)
4- Days per annum spent in hospital	89.5±54.4	53.6±27.9	90.50	<0.05 (S.)
5- Ability to trust men	4.3±2	6±1.8	74.50	<0.01(S.)
6- Quality of sex life	3.5±1.9	5.1±2.8	92.50	<0.05 (S.)
7- Number of times of antidepressant change during last 6 months	1.3±1.1	0.2±0.4	64.50	<0.01(S.)

(Soliman et al., 1999)

**b) Type of CSA:**

*Soliman et al. (1999)* studied 78 depressed women (43 depressed women without history of CSA, 7 depressed women with history of CSA without genital contact, 13 depressed women with history of CSA with genital contact without penetration and 15 depressed women with history of CSA with genital penetration) (see appendix 21) and they found that the depression is more severe among the depressed women with history of CSA with genital penetration, as shown in table (185).

**Table (185) Depressed women with history of different types of CSA:**

Variable	78 depressed women			
	43 without history of CSA Mean± SD	35 with history of CSA		
		7 without genital contact Mean± SD	13 with genital contact Mean± SD	15 with genital penetration Mean± SD
1- Age of onset of depression	33.4±6.6	27.4±4.5	23.4±8	17.1±2.6
2- Number of depressive episodes	2.1±1.2	2.7±1.4	4.3±3.1	5.5±2.3
3- Number of suicide attempts	0.3±0.6	1.6±1.3	5.5±5.3	8.5±4.4
4- Length of stay in hospital	33.6±24.8	43.9±26.4	54.9±28.1	81.1±56
5- Days per annum spent in hospital	38.3±31.3	50.4±36.8	62.5±27.1	92.9±61.1
6- Ability to trust men	7.4±1.1	7±0.8	5.9±1.4	3.5±1.7
7- Quality of relationship with partner	7.4±1.3	7.4±1	6.2±2	4±1.9
8- Quality of sex life	7.1±1.5	6.4±1.3	5.1±2.5	2.5±1.6
9- Number of times of antidepressant change during last 6 months	0.3±0.5	0.3±0.5	0.4±0.7	1.3±1.2

(Soliman et al., 1999)

**5) Psychological and behavioral disorders:**

*Fahmy et al. (1995)* studied 145 (28 sexually abused and 117 non sexually abused) psychiatric patients with adult personality and behavioral disorders (see appendix 13) and they reported that 7 out of 28 (25%) sexually abused patients have psychological and behavioral disorders associated with sexual development and orientation. Also, they found that sexually abused patients have significantly psychological and behavioral disorders associated with sexual development and orientation more than non sexually abused patients.

**6) Other Psychiatric disorders:**

*Fahmy et al. (1995)* studied 627 psychiatric patients (54 with history of CSA and 573 without history of CSA) (see appendix 13). They found that sexually abused patients have significantly disorders of adult personality and behavior, mental and behavioral disorder due to psychoactive substance use and behavioral syndromes more than non sexually abused patients, as shown in table (186).

**Table (186) Psychiatric disorders among psychiatric patients with and without history of CSA:**

Psychiatric disorder	Psychiatric patients				Total N=627	
	54 with history of CSA		573 without history of CSA			
	N	%	N	%	N	%
1- Disorders of adult personality and behaviour	28	51.9%	117	20.4%	145	23.1%
2- Mental and behavioural disorder due to psychoactive substance abuse	11	20.4%	52	9.1%	63	10.1%
3- Behavioural syndromes	5	9.3%	21	3.7%	26	4.2%

**(Fahmy et al., 1995)**

**Sayed (1998)** studied 60 psychiatric patients with history of CSA compared with 60 psychiatric patients without history of CSA (see appendix 18). Table (187) shows psychiatric diagnoses among psychiatric patients with and without CSA.

***Table (187) Psychiatric disorders among psychiatric patients with and without history of CSA:***

Psychiatric diagnoses	Psychiatric patients			
	60 with history of CSA		60 without history of CSA	
	N	%	N	%
1- Psychoactive substance use disorders	2	3.3%	2	6.6%
2- Mood (affective) disorders				
a- Manic episodes without psychotic symptoms	1	1.6%	5	8.3%
b- Depressive disorders without psychotic symptoms	7	11.6%	4	6.6%
c- Bipolar affective disorders without psychotic symptoms	2	3.3%	7	11.6%
d- Dysthymia	6	10%	4	6.6%
3- Neurotic disorders	4	6.6%	8	13.3%
4- Obsessive compulsive disorders	4	6.6%	7	11.6%
5- Stress-related disorders	-	-	4	6.6%
6- Adjustment disorders	4	6.6%	1	1.6%
7- Dissociative (conversion) disorders	2	3.3%	3	5%
8- Somatoform disorders	8	13.3%	4	6.6%
9- Sexual dysfunction	5	8.3%	2	3.3%
10- Personality disorders	3	5%	6	10%
11- Trichotillomania	1	1.3%	-	-
12- Gender identity disorder	1	1.3%	1	1.6%
13- Disorders of sexual preference	1	1.3%	-	-
14- Homosexuality	9	15%	-	-

(Sayed, 1998)

*Hamed (2006)* studied 1500 preparatory school students (78 sexually abused and 1422 not sexually abused) (see appendix 34) and he reported that 6 out of 78 (7.69%) of

sexually abused students have conduct disorder, 30 out of 78 (38.46%) of sexually abused students have anxiety withdrawal, 12 out of 78 (15.38%) of sexually abused students have attention problems, 18 out of 78 (23.08%) of sexually abused students have socialized aggression and 12 out of 78 (15.38%) of sexually abused students have motor excess, as shown in table (188). Also, he found a significant association between sexual abuse and anxiety withdrawal, attention problems, socialized aggression and motor excess but there is no significant association between sexual abuse and conduct disorder.

**Table (188) Psychiatric problems of sexually abused children:**

Author/s	Sample	Site	Tools	Results
<b>Hamed (2006)</b>	78 sexually abused preparatory school students.	6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.	Psychiatric interview and Revised Behaviour Problem Checklist (RBPC).	7.69% have conduct disorder, 38.46% have anxiety withdrawal, 15.38% have attention problems, 23.08% have socialized aggression 15.38% have motor excess.

**Age of onset of adult psychiatric illness:**

*Sayed (1998)* studied 120 psychiatric patients (60 patients with history of CSA and 60 patients without history of CSA) (see appendix 18) and he reported that the mean age of onset of psychiatric disorder in 60 psychiatric patients with history of CSA is 17.14 years (table 189) and in the psychiatric



patients without history of CSA is 25 years with significant difference between them. Also, *Soliman et al. (1999)* (see appendix 21) found that the mean age of onset of depression is significantly lower among the depressed women with history of CSA ( $21.49 \pm 6.78$ ) than among the depressed women without history of CSA ( $33.42 \pm 6.58$ ) as shown in table (189).

**Table (189) Distribution of psychiatric patients with childhood sexual abuse according to age of onset of adult psychiatric illness:**

Author/s	Sample	Site	Tools	Results
<b>Sayed (1998)</b>	60 psychiatric patients with history of CSA.	Psychiatric outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	Mean age of onset of psychiatric disorder in psychiatric patients with history of CSA is 17.14 years.
<b>Soliman et al. (1999)</b>	35 depressed women with history of CSA.	Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.	Semi-structured psychiatric interview.	Mean age of onset of depression in depressed women with history of CSA is $21.49 \pm 6.78$ .

#### **(IV) Female genital mutilation may lead to sexual dysfunctions:**

##### **Female circumcision:**

##### **1) Age of menarche:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that the age of menarche of 4 out of 200 (2%) circumcised wives is between ages 9 and 11 years, the age of menarche of 162 out of 200 (81%) circumcised wives is

between ages 12 and 14 years and the age of menarche of 34 out of 200 (17%) circumcised wives is of ages 15 and more, as shown in table (190). *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that the age of menarche of 16 out of 200 (8%) circumcised wives is between ages 9 and 11 years, the age of menarche of 151 out of 200 (75.5%) circumcised wives is between ages 12 and 14 years and the age of menarche of 33 out of 200 (16.5%) circumcised wives is of ages 15 and more, as shown in table (190). *Lotfy and El-Defrawy (1995) and El-Defrawy et al. (1996)* reported insignificant difference between the circumcised and the uncircumcised wives as regards the age of menarche.

***Table (190) Age of menarche among the circumcised wives:***

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	2% between 9 and 11 years, 81% between 12 and 14 years, 17% 15 and more years.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	8% between 9 and 11 years, 75.5% between 12 and 14 years, 16.5% 15 and more years.

## **2) Less initiation of sexual relationship with husband:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 76 out of 200 (38%) circumcised wives reports that husband always initiates the sexual relationship, 102 out of 200 (51%) circumcised wives reports that husband sometimes initiates sexual relationship and 22 out of 200 (11%) circumcised wives reports that wife always initiates the sexual relationship, as shown in table (191). Also, they found that the circumcised wives have significantly less initiation of sexual relationship with husband than the uncircumcised wives.

**Table (191) Initiation of sex with husband among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	38% husband always, 51% husband sometimes, 11% wife always initiates the sexual relationship.

## **3) Foreplay before sexual relation:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 103 out of 200 (51.5%) circumcised wives do not foreplay before sex and 97 out of 200 (48.5%) circumcised wives foreplay before sex, as shown in table (192). Also, they found insignificant difference between the circumcised and the uncircumcised wives as regards foreplay before sex.

**Table (192) Foreplay before sex among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	51.5% no foreplay before sex, 48.5% foreplay before sex.

#### **4) Enjoyment of sexual relation:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 88 out of 200 (44%) circumcised wives do not enjoy the sexual relation, 64 out of 200 (32%) circumcised wives enjoy the sexual relation and 48 out of 200 (24%) circumcised wives sometimes enjoy the sexual relation, as shown in table (193). *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 88 out of 200 (44%) circumcised wives do not enjoy by sex, 64 out of 200 (32%) circumcised wives enjoy by sex and 48 out of 200 (24%) circumcised wives sometimes enjoy by sex, as shown in table (193). *Lotfy and El-Defrawy (1995) and El-Defrawy et al. (1996)* reported that the enjoyment of sexual life among the circumcised wives is significantly less than among the uncircumcised wives.

**Table (193) Enjoyment of sexual relation among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	44% not enjoy the sexual relation, 24% sometimes enjoy the sexual relation, 32% enjoy the sexual relation.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	The Arabic Version of (SEBA.A)	44% not enjoy by sex, 24% sometimes enjoy by sex, 32% enjoy by sex.

### **5) Less achieving the orgasm:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 86 out of 200 (43%) circumcised wives do not achieve orgasm, 58 out of 200 (29%) circumcised wives achieve orgasm and 56 out of 200 (28%) circumcised wives sometimes achieve orgasm, as shown in table (194). *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 83 out of 200 (41.5%) circumcised wives do not achieve orgasm, 67 out of 200 (33.5%) circumcised wives achieve orgasm and 50 out of 200 (25%) circumcised wives sometimes achieve orgasm, as shown in table (194). *Lotfy and El-Defrawy (1995) and El-Defrawy et al. (1996)* reported that the circumcised wives reach the orgasm significantly less than the uncircumcised wives.

**Table (194) Achieving the orgasm among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	43% not achieve orgasm, 29% achieve orgasm, 28% sometimes achieve orgasm.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	The Arabic Version of (SEBA.A).	41.5% not achieve orgasm, 33.5% achieve orgasm, 25% sometimes achieve orgasm.

**6) Difficulty in time of orgasm among the circumcised wives:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 42 out of 200 (21%) circumcised wives have orgasm before husband, 37 out of 200 (18.5%) circumcised wives have orgasm with husband and 121 out of 200 (60.5%) have not timed orgasm with husband at all, as shown in table (195). Also, they found that the circumcised wives have significantly difficulty to time orgasm with husband than the uncircumcised wives.

**Table (195) Time of orgasm among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	21% orgasm before husband, 18.5% orgasm with husband, 60.5% not at all.

**7) Dryness during intercourse:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 97 out of 200 (48.5%) circumcised wives have dryness during intercourse and 103 out of 200 (51.5%) circumcised wives have no dryness during intercourse, as shown in table (196). Also, they found that the circumcised wives have significantly dryness during intercourse than the uncircumcised wives.

**Table (196) Dryness during intercourse among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	48.5% dryness during intercourse, 51.5% no dryness during intercourse.

**8) Dysmenorrhea:**

*Lotfy and El-Defrawy (1995)* studied 250 wives (200 circumcised and 50 uncircumcised) (see appendix 11) and they reported that 161 out of 200 (80.5%) circumcised wives have painful menstrual cycle and 39 out of 200 (19.5%) circumcised wives have not painful menstrual cycle, as shown in table (197). *El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 173 out of 200 (86.5%) circumcised wives have painful menstrual cycle and 27 out of 200 (13.5%) circumcised wives haven't painful menstrual cycle, as shown in table (197). *Lotfy and El-Defrawy (1995) and El-Defrawy et al. (1996)* reported that dysmenorrhea is highly presented among the circumcised wives than among the uncircumcised wives with significant difference between them.

**Table (197) Dysmenorrhea among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psychosexual interview schedule.	80.5% painful menstrual cycle, 19.5% no painful menstrual cycle.
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	The Arabic Version of (SEBA.A).	86.5% painful menstrual cycle, 13.5% no painful menstrual cycle.



**9) Fertility:**

*El-Defrawy et al. (1996)* studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 142 out of 200 (71%) circumcised wives are fertile, 21 out of 200 (10.5%) circumcised wives have 1ry infertility and 37 out of 200 (18.5%) circumcised wives have 2ry infertility, as shown in table (198). Also, they found insignificant difference between the circumcised and the uncircumcised wives as regards the fertility.

**Table (198) Fertility among the circumcised wives:**

Author/s	Sample	Site	Tools	Results
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview and gynecological examination.	71% fertile, 10.5% 1ry infertility, 18.5% 2ry infertility.

**10) Husband beating status:**

*Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 2481 out of 6921 (35.8%) circumcised women are ever beating and 4440 out of 6921 (64.2%) circumcised women are never beating, as shown in table (199). Also, they found that the circumcised women are significantly ever beating than the uncircumcised women.

**Table (199) Husband beating status among the circumcised women:**

Author/s	Sample	Site	Tools	Results
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	35.8% ever husband beating, 64.2% never husband beating.

**11) Acceptance of husband beating:**

*Refaat et al. (1999)* studied 7128 women (6921 circumcised and 207 uncircumcised) (see appendix 19) and they reported that 6059 out of 6921 (87.5%) circumcised women accept husband beating and 862 out of 6921 (12.5%) circumcised women do not accept husband beating, as shown in table (200). Also, they found that the circumcised women are significantly accepting husband beating more than the uncircumcised women. By using the multivariate analysis, they reported that circumcised wives are more likely to accept husband beating 7.5 times than those not circumcised and even 3 times after controlling for education, work, economic and rural residence.

**Table (200) Acceptance of husband beating among the circumcised women:**

Author/s	Sample	Site	Tools	Results
<b>Refaat et al. (1999)</b>	6921 circumcised women.	Not mentioned.	Women status questionnaire of EDHS-95.	87.5% accept husband beating, 12.5% do not accept husband beating.

## **Knowledge and opinion about human sexuality:**

### **(I) The difference between males and females as regards the sexual knowledge:**

#### **1) Knowledge about sexuality:**

*Nagia et al. (2001)* studied 170 males and 286 females of first year university students (see appendix 27). They found that the mean scores of knowledge about sexuality of males are significantly higher than females, as shown in table (201).

**Table (201) Knowledge about sexuality:**

Items	Male	Female	t	P
	Mean $\pm$ SD	Mean $\pm$ SD		
1-Female genital anatomy	19.3 $\pm$ 19	12.9 $\pm$ 16	3.9	< 0.05 (S.)
2-Female sexual development	38.2 $\pm$ 30.9	34.1 $\pm$ 28.6	1.4	>0.05(N.S)
3-Male genital anatomy	21.5 $\pm$ 23.6	6.2 $\pm$ 14.4	8.6	< 0.05(S.)
4-Male sexual development	43 $\pm$ 30.8	20.4 $\pm$ 27.6	8.1	< 0.05(S.)
5-Wet dreams	46.5 $\pm$ 47.1	10.3 $\pm$ 28.3	10.2	< 0.05(S.)
6-Masturbation	35.5 $\pm$ 42.9	13.9 $\pm$ 33.1	6	< 0.05(S.)
7-Heterosexual relations	65.6 $\pm$ 44.3	53.7 $\pm$ 48	2.6	< 0.05(S.)
8-Homosexuality	39.6 $\pm$ 30.8	20 $\pm$ 27.8	7	< 0.05(S.)
9-Average	38.7 $\pm$ 20.8	21.4 $\pm$ 17.7	9.34	< 0.05(S.)

(Nagia et al., 2001)

## **2) Knowledge about sexually transmitted diseases (STDs):**

*Nagia et al. (2001)* (see appendix 27) found that the mean scores of knowledge about STDs including AIDs are significantly higher among males than females, as shown in table (202).

**Table (202) Knowledge about STDs:**

Items	Male	Female	t	P
	Mean $\pm$ SD	Mean $\pm$ SD		
1- Gonorrhea	26.2 $\pm$ 24.5	9.9 $\pm$ 16.2	8.5	< 0.05(S.)
2- Syphilis	18.8 $\pm$ 21.3	10.6 $\pm$ 16.7	4.5	< 0.05(S.)
3- Viral hepatitis	8 $\pm$ 14.3	6.1 $\pm$ 13.3	1.4	>0.05(N.S)
4- AIDs	48.1 $\pm$ 23.8	44.9 $\pm$ 20.9	1.5	>0.05(N.S)
5- Average	25.3 $\pm$ 15.5	17.9 $\pm$ 11.7	5.7	< 0.05(S.)

(Nagia et al., 2001)

## **3) Feelings associated with masturbation:**

*Nagia et al. (2001)* (see appendix 27) found significant difference between 170 males and 286 females of first year university students as regards feelings associated with masturbation, as shown in table (203).

**Table (203) Feelings associated with masturbation:**

Feeling	Male N=170		Female N=286		Total N=456		x <sup>2</sup>	P
	N	%	N	%	N	%		
<b>1- Induce comfort</b>								
a- Yes	45	26.5%	44	15.4%	89	19.5%	121	< 0.05 (S.)
b- No	90	52.9%	37	12.9%	127	27.9%		
c- Do not know	35	20.6%	205	71.7%	240	52.6%		
<b>2- Self-admiration</b>								
a- Yes	13	7.7%	12	4.2%	25	5.4%	128	< 0.05 (S.)
b- No	125	73.5%	65	22.7%	190	41.7%		
c- Do not know	32	18.8%	209	73.1%	241	52.9%		
<b>3- Guilt feeling</b>								
a- Yes	115	67.7%	54	18.9%	169	37.1%	127	< 0.05 (S.)
b- No	24	14.1%	30	10.5%	54	11.8%		
c- Do not know	31	18.2%	202	70.6%	233	51.1%		
<b>4- Disgust</b>								
a- Yes	71	41.8%	40	14%	111	24.4%	107	< 0.05 (S.)
b- No	59	34.7%	36	12.6%	95	20.8%		
c- Do not know	40	23.5%	210	73.4%	250	54.8%		

(Nagia et al., 2001)

#### **4) Methods of coping with sexual needs:**

*Nagia et al. (2001)* (see appendix 27) found significant difference between 170 males and 286 females of first year university students as regards methods of coping with sexual needs, as shown in table (204).

**Table (204) Methods of coping with sexual needs:**

Coping method	Male N=170		Female N=286		Total N=456		x <sup>2</sup>	P
	N	%	N	%	N	%		
<b>1- Sports</b>								
a- Yes	136	80%	132	46.2%	268	58.8%	18	< 0.05 (S.)
b- No	18	10.6%	72	25.2%	90	19.7%		
c- Do not know	16	9.4%	82	28.7%	98	21.5%		
<b>2- Fasting</b>								
a- Yes	136	80%	155	54.2%	291	63.8%	11	< 0.05 (S.)
b- No	19	11.2%	61	21.3%	80	17.5%		
c- Do not know	15	8.8%	70	24.5%	85	18.6%		
<b>3-Masturbation</b>								
a- Yes	12	7.1%	20	7%	32	7%	11	< 0.05 (S.)
b- No	136	80%	163	57%	299	65.6%		
c- Do not know	22	12.9%	103	36%	125	27.4%		
<b>4- Pornography</b>								
a- Yes	11	6.5%	18	6.3%	29	6.4%	9.5	< 0.05 (S.)
b- No	144	84.7%	182	63.6%	326	71.5%		
c- Do not know	15	8.8%	86	30.1%	101	22.1%		
<b>5- Marriage</b>								
a- Yes	18	10.6%	41	14.3%	59	12.9%	0.3	> 0.05 (S.)
b- No	152	89.6%	245	85.7%	397	87.1%		
c- Do not know	0	0.0%	0	0.0%	0	0.0%		

(Nagia et al., 2001)

## **(II) Sexual knowledge of the wives:**

### **1) Definition of marital relation:**

By studying 137 educated employed wives (see appendix 4), *Loutfi et al. (1984)* found that 68 out of 137 (49.6%) educated employed wives defined marital relation as

being both family and sexual relation, 66 out of 137 (48.2%) defined it as a family relation and 3 out of 137 (2.2%) viewed it as a sexual relation, as shown in table (205).

**Table (205) The different definitions of marital relation among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	49.6% family and sexual relation. 48.2% family relation only. 2.2% sexual relation only.

## **2) Source of sexual informations:**

**Loutfi et al. (1984)** (see appendix 4) found that 40 out of 137 (29.2%) educated employed wives reported friends as being the main source of sexual informations, 29 out of 137 (21.2%) reported books, 24 out of 137 (17.5%) reported parents mainly mothers, 9 out of 137 (6.6%) reported relatives, 6 out of 137 (4.4%) reported sisters and 5 out of 137 (3.6%) reported school as being the source of sexual informations, as shown in table (206). **Owida and Amin (1999)** studied 163 wives with sexual dysfunction (see appendix 20) and they found that 97 out of 163 (59.5%) wives reported that their mothers represented their main source of sex information and 66 out of 163 (40.5%) wives reported that sources other than maternal represented their source of sex information, as shown in table (206). **El Fangary (2003)** studied 60 psychiatric female patients with sexual dysfunction (see appendix 30). He

reported that the source of sexual informations of 49 out of 60 (81.7%) patients is family, 6 out of 60 (10%) patients is friends and 5 out of 60 (8.3%) patients is other sources (table 206). Also, he found insignificant difference between those psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction as regards the source of sexual informations.

***Table (206) Source of sexual informations:***

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Results</b>
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	29.2% friends, 21.2% books, 14.6% mother, 2.9% father, 6.6% relatives, 4.4% sisters, 3.6% school, 17.5% no answer.
<b>Owida &amp; Amin (1999)</b>	163 wives with sexual dysfunction.	Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.	Psychiatric interview.	59.5% maternal source of sex information, 40.5% other sources.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	81.7% family, 10% friends, 8.3% other sources.

### ***3) Resources of more informations about sex:***

*Loutfi et al. (1984)* (see appendix 4) found that 50 out of 137 (36.5%) educated employed wives will resort to books



to increase their knowledge about sex, 23 out of 137 (16.8%) will seek medical advice and 19 out of 137 (13.9%) a friend will be the resource person. The husband was reported by 12 out of 137 (8.8%) and the relatives by 5 out of 137 (3.6%). The rest 28 (20.4%) are either satisfied with their present knowledge or do not know what to do, as shown in table (207).

**Table (207) Resources of more informations about sex among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	36.5% books, 16.8% doctors, 13.9% friends, 8.8% husband, 3.6% relatives, 20.4% don't know.

**4) Time of acquiring informations about human sexuality:**

*Loutfi et al. (1984)* (see appendix 4) found that 58 out of 137 (42.3%) educated employed wives reported that they acquired information about human sexuality after marriage, 51 out of 137 (37.2%) did so immediately before marriage, 16 out of 137 (11.7%) acquired their information during school education and 12 out of 137 (8.8%) did not receive any information, as shown in table (208).

**Table (208) Time of acquiring informations about human sexuality among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	42.3% after marriage, 37.2% immediately before marriage, 11.7% during education, 8.8% was not informed.

### **(III) Sexual rights of the wives:**

#### **1) The importance of female orgasm:**

*Loutfi et al. (1984)* (see appendix 4) found that 77 out of 137 (56.2%) educated employed wives reported that female orgasm is essential, 39 out of 137 (28.5%) denied this right and 21 out of 137 (15.3%) did not know, as shown in table (209).

**Table (209) The importance of wife sexual pleasure (orgasm) among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	56.2% orgasm is essential, 28.5% orgasm is not essential, 15.3% do not know.

#### **2) The right of wife to initiate sexual relation:**

*Loutfi et al. (1984)* (see appendix 4) found that 37 out of 137 (27%) educated employed wives denied the right of

wife to initiate sexual relation, 70 out of 137 (51.1%) reported that she sometimes has this right and 30 out of 137 (21.9%) gave her the full right, as shown in table (210).

**Table (210) The right of wife to initiate sexual relation among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	21.9% yes, 51.1% sometimes, 27% no.

**3) The right of wife to refuse sexual relation:**

*Loutfi et al. (1984)* (see appendix 4) found that 2 out of 137 (1.4%) educated employed wives reported that the wife has the right to refuse intercourse, 42 out of 137 (30.7%) refused this right absolutely, 60 out of 137 (43.8%) said that the matter could be discussed with the husband and 33 out of 137 (24.1%) did not know, as shown in table (211).

**Table (211) The right of wife to refuse sexual relation among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	43.8% discuss with the husband, 30.7% should respond, 1.4% refuse, 24.1% do not know.

**4) The right of wife to discuss her sexual problems:**

*Loutfi et al. (1984)* (see appendix 4) found that 64 out of 137 (46.7%) educated employed wives agreed to discuss her sexual problems, 37 out of 137 (27%) did not agree to discuss her sexual problems and 36 out of 137 (26.3%) did not know, as shown in table (212).

**Table (212) The right of wife to discuss her sexual problems among wives:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Adminstration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	46.7% agree, 27% do not agree, 26.3% do not know.

**5) The seek for medical treatment for the sexual problems:**

*Loutfi et al. (1984)* (see appendix 4) found that 53 out of 137 (38.7%) educated employed wives reported that both husband and wife should seek medical treatment for sexual problems, 32 out of 137 (23.4%) reported husband only, 30 out of 137 (21.9%) reported the wife only and 22 out of 137 (16%) did not know, as shown in table (213).

**Table (213) The seek for medical treatment for the sexual problems:**

Author/s	Sample	Site	Tools	Results
<b>Loutfi et al. (1984)</b>	137 educated employed wives.	The Alexandria University Administration and the Egyptian copper factory in Alexandria.	Questionnaire sheet.	38.7% husband and wife, 23.4% husband only, 21.9% wife only, 16% do not know.

**6) The effect of age on the opinion of wife about her sexual rights:**

By studying 137 educated employed wives (87.4% were between 25 to < 40 years of age) (see appendix 4), **Loutfi et al. (1984)** concluded that there is significant difference between the various age groups as regards the opinion of wives on (the importance of female orgasm). But, there is insignificant difference between the various age groups as regards the opinion of wives on (1) the right of wife to initiate sexual relation, (2) the right of wife to refuse sexual relation and (3) the right of wife to discuss her sexual problems.

**(IV) Knowledge about impotence among the males:**

**1) The cause of impotence (by the patients themselves):**

**Demerdash (1970)** studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) (see appendix 1). Table (214) shows the cause of impotence by the patients themselves.

**Table (214) The cause of impotence (by the impotent patients themselves):**

Explanation of impotence by patients themselves	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
1- Small organ and/or small testes	7	21.9%	1	5.9%	2	10.5%	10	14.7%
2- Disease of genitalia	10	31.3%	4	23.5%	7	36.4%	21	30.9%
3- Supernatural causes	7	21.9%	-	0.0%	1	5.3%	8	11.8%
4- Inexperience	-	0.0%	1	5.9%	2	10.5%	3	4.4%
5- Mental strain	1	3.1%	2	11.8%	1	5.3%	4	5.9%
6- Uncooperative spouse	1	3.1%	0	0.0%	-	0.0%	1	1.5%
7- Masturbation	2	6.2%	6	35.3%	3	15.8%	11	16.2%
8- Don't know	4	12.4%	3	17.6%	3	15.8%	10	14.7%

(Demerdash, 1970)

**2) Attitude towards consulting a psychiatrist:**

*Demerdash (1970)* studied 68 impotent patients (32 Kuwaitis, 17 Palestinian and 19 Egyptian) referred mostly by venereologists and also by psychiatrists and neurologists (see appendix 1) and he found that Egyptian impotent patients have significantly willing towards consulting a psychiatrist more than impotent Kuwaitis and Palestinians patients, as shown in table (215).

**Table (215) Attitude towards consulting a psychiatrist among impotent patients:**

Attitude towards consulting a psychiatrist	Kuwaitis N=32		Palestinian N=17		Egyptian N=19		Total N=68	
	N	%	N	%	N	%	N	%
Willing	13	40.6%	6	35.3%	17	89.5%	36	52.9%
Unwilling	19	59.4%	11	64.7%	2	10.5%	32	47.1%

(Demerdash, 1970)

## **(V) Knowledge and attitude about sexuality among male substance users:**

### **1) Definite relation between substance use and sexual activities:**

*Ismail and Hafez (2000)* studied 14 male substance users (see appendix 25) and they reported that when the patients are asked to comment on “most people use drugs in order to do good sex”, all patients say that this is true.

### **2) Unsafe sex:**

*Ismail and Hafez (2000)* (see appendix 25) reported that when the 14 male substance users are asked if any one of them uses condoms on practicing sex, no one of them raises the issue of importance of wearing the condom on practicing sex.

### **3) Attitude of substance users towards curing from STDs:**

*Ismail and Hafez (2000)* (see appendix 25) reported that when the 14 male substance users are asked if any one of them performs serological testing for sexually transmitted diseases,

no one of them cares about regular screen for the possible infection of one of sexually transmitted diseases.

## **(VI) Knowledge about childhood sexual abuse (CSA) among the child care providers:**

*El-Defrawi et al. (1993)* studied 453 child care providers (see appendix 7) and they found that 349 out of 453 (77%) child care providers report child sexual abuse is an important risk factor for psychiatric problems and further child abuse.

## **(VII) Knowledge about circumcision among the females:**

### **1) Opinion on circumcision:**

*Lotfy and El-Defrawy (1995)* studied 200 circumcised women (see appendix 11) and they reported that 138 out of 200 (69%) circumcised women perceive circumcision operation as painful and 62 out of 200 (31%) circumcised women perceive circumcision operation as beneficial, as shown in table (216). *El Fangary (2003)* (see appendix 30) reported that 47 out of 60 (78.3%) psychiatric female patients with sexual dysfunction agree on circumcision and 13 out of 60 (21.7%) psychiatric female patients with sexual dysfunction disagree on circumcision (table 216). Also, he found insignificant difference between those psychiatric female patients with sexual dysfunction and 30 non psychiatric female patients with sexual dysfunction as regards opinion on circumcision.



**Table (216) Opinion on circumcision:**

Author/s	Sample	Site	Tools	Results
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised women.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psycho-sexual interview schedule.	69% painful operation 31% beneficial operation.
<b>El Fangary (2003)</b>	60 psychiatric female patients with sexual dysfunction.	Psychiatric and gynecological outpatient clinic in Kasr el Aini hospital.	Psychiatric interview.	78.3% agree on circumcision, 21.7% disagree on circumcision.

**2) Attitude towards daughter's circumcision:**

**Lotfy and El-Defrawy (1995)** (see appendix 11) reported that 77 out of 200 (38.5%) circumcised wives do not intend to circumcise their daughters and 123 out of 200 (61.5%) circumcised wives intend to circumcise their daughters (for religious tradition (31%), family tradition (18.5%) or hygienic tradition (12%)), as shown in table (217). **El-Defrawy et al. (1996)** studied 300 wives (200 circumcised and 100 uncircumcised) (see appendix 14) and they reported that 118 out of 200 (59%) circumcised wives do not intend to circumcise their daughters and 82 out of 200 (41%) circumcised wives intend to circumcise their daughters (table 217). Also, they reported that 41% of the circumcised wives and 22% of the uncircumcised wives intend to circumcise their daughters with significant difference between them.

**Table (217) Attitude of circumcised wives towards their daughter's circumcision:**

<b>Author/s</b>	<b>Sample</b>	<b>Site</b>	<b>Tools</b>	<b>Results</b>
<b>Lotfy &amp; El-Defrawy (1995)</b>	200 circumcised wives.	Family planning center located in Maternal and Childhood Center in Ismailia.	Psycho-sexual interview schedule.	38.5% will not circumcise their daughters, 61.5% will circumcise their daughters (for religious tradition (31%), family tradition (18.5%) or hygienic tradition (12%)).
<b>El-Defrawy et al. (1996)</b>	200 circumcised wives.	Family planning centers of the ministry of health in Ismailia.	Psychiatric interview.	59% will not circumcise their daughters, 41% will circumcise their daughters.

**Jones (2002)** put several standardized appraisal questions which should be asked for all research papers. The standardized appraisal questions are the following:

- 1) Was the aim of the study clearly stated?
- 2) Was there an explanation why the study was carried out (need for the study)?
- 3) What is the study design? Is it appropriate to the aim of the study?
- 4) Was the study preceded by a pilot study to justify the proper?
- 5) What is the sample size? Was it mentioned? Was it statistically calculated (power of the study)?
- 6) Was the sample representative?
- 7) How were cases selected?
- 8) What were the characters of the sample?
- 9) What were the methods of assessment and measurements? Were they mentioned and referenced? Are they valid and reliable?
- 10) What were the statistical methods used? Were they discussed?
- 11) Were results presented in a clear way (tables, figures, etc.)?
- 12) Were results compared with other researches whether supporting the same findings or establishing other findings with explanation of different findings?
- 13) What were the limitations of the study?
- 14) Were significant recommendations generated?

## **Critical Appraisal**

### **1- Subject: A psycho-social study of cases of psychogenic impotence (Demerdash, 1970).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a comparative cross-sectional study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is mentioned, but it is not clear.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated, it is small sample.
- 9) **Tools:** The tools are mentioned but not referenced.
- 10) **Statistical methods:** are described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are mentioned and discussed, but (1) the researcher mentions in the methodology that 95% of patients are referred by venereologists; this is considered as a result, (2) there is a mistake in table 12 page 92 as the number of Palestinian patients is 17, but it is not equal 17 in the table. (3) there is also a mistake in page 103 as the researcher mentions that " 9 patients couldn't offer an explanation of their complaint" but actually they are 10 patients.

- 14) **Summary and conclusion:** The number of pages of summary is 1/2 page which is too small, whereas the conclusion is 6 pages.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is not bad, it contains about 270 pages.

## **2- Subject: A psychological and forensic study of rape in Cairo (Abdelmessih et al., 1980).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** Cross-sectional study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** Adequate sample size although it is not calculated.
- 9) **Tools:** Methods of assessment are not mentioned.
- 10) **Statistical methods:** It is descriptive study without any statistics.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are mentioned and discussed.

- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned with conclusion.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is not good, as there is no aim of the work or methods. It is formed of 18 pages.

**3- Subject: Sex therapy compared with placebo in the treatment of impotence (El Akabawi and Idarous, 1982).**

- 1) **Title:** Not expressive; according to the content it is a comparison between drug therapy and talk therapy.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** It is not mentioned in the study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is clearly mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** Small sample not calculated. So, we can not generalize the results.
- 9) **Tools:** It is not clearly mentioned.
- 10) **Statistical methods:** are mentioned, but not have results.
- 11) **Consent:** It is taken from the patients.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The tables of the results do not mention any statistical analysis.

- 14) **Abstract:** It is mentioned.
- 15) **Recommendations:** It is mentioned within conclusion.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 12 pages.

**4- Subject: Knowledge and opinion of educated females about human sexuality (Loutfi et al., 1984).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly stated giving an explanation for why the study was carried out.
- 3) **Study design:** It is not mentioned.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** The method of assessment is a questionnaire but it is not referenced.
- 10) **Statistical methods:** are mentioned.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are mentioned and discussed, but the researchers did not mention all the quantitative results. Also, many results are in percentage without mention the real number and they comment about some statistically differences between some topics without

- mention what are the differences. Also, some results are different from that of table (1).
- 14) **Abstract:** It is clearly mentioned.
  - 15) **Recommendations:** It is not mentioned.
  - 16) **Limitations of the study:** are not discussed by the researcher.
  - 17) **The general appearance of the paper:** is good, it is formed of 13 pages.

**5- Subject: The sexual behaviour of a sample of male Egyptian epileptics (Demerdash et al., 1986).**

- 1) **Title:** Not expressive as they study the types of sexual disorders among a selected sample of male epileptic patients with sexual disorders.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is clearly mentioned.
- 6) **Study population:** It is not clearly mentioned.
- 7) **Sample design:** It is not described.
- 8) **Sample size:** The sample is composed of seventeen cases only which is small size (not adequate sample size).
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are not well described.
- 11) **Consent:** It is not taken.



- 12) **Pilot study:** There is no a pilot study but we can consider the study as a preliminary study.
- 13) **Results and discussion:** They are mentioned together under one title (findings and discussion).
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is fair, it is formed of 22 pages.

**6- Subject: Sexual dysfunction in patients with major depression (Ahmed and Ezz El-Din, 1992).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly stated giving an explanation for why the study was carried out.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control longitudinal study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated, but we can consider it as a preliminary study.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.

- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are mentioned and discussed, but there are some contradicting results: (a) in page 184, the researchers mentioned that the group with sexual dysfunction was significantly older in age, but in page 185, they mentioned that there was no significant difference between the age of both groups and (b) in table 5, the researchers mentioned that the number of patients of group A showed improvement in their sexual dysfunction after treatment was 20 patients, but in table 6 they are 15 patients only.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 18 pages.

**7- Subject: Assessment of knowledge of child abuse in Seuz Canal Area (El- Defrawi et al., 1993).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is mentioned.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.

- 7) **Sample design:** Multistage cluster sample.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned with discussion.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 11 pages.

**8- Subject: Effect of heroin abuse on pituitary-gonadal axis in male subjects (El Sheikh and El Fouly, 1993).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not clearly mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned or described.

- 8) **Sample size:** Small sample size and it is not calculated, but we can consider it as a preliminary study.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but the statistical results are not present below the tables.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, but there is no aim of the work. It is formed of 7 pages.

**9- Subject: Psychiatric aspects of child abuse in Egypt (Abdel Rahman and Nashed, 1994).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not clearly mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is not clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned or described.

- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from parents before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, but there is no aim of the work. It is formed of 9 pages.

**10- Subject: A socio-demographic study of homosexuality in an Egyptian sample (Lotaief et al., 1994).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is not mentioned. The researchers didn't mention the presence of control subjects in methods but mentioned it in results.

- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are mentioned and discussed but (1) the titles of tables are not clear, (2) the number of the female controls is 107, but there are mistakes in this number in tables c,d,e and f, (3) there are 10 references only and (4) the researchers mentioned the references at the end of the paper only, not in the content.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned within discussion.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, although there are no references in the content. It is formed of 8 pages.

**11- Subject: Psychosexual impact of female circumcision (Lotfy and El- Defrawy, 1995).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.

- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** Adequate sample size although it is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 9 pages.

**12- Subject: Sexual dysfunction in relation to dialysis adequacy in haemodialysis patients (Ibrahim et al., 1995).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly stated giving an explanation for why the study was carried out.

- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 9 pages.

**13- Subject: Remote psychiatric sequelae of sexual abuse in childhood (Fahmy et al., 1995).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.



- 4) **Setting of the study:** It is not definite; the researcher mentioned only outpatient psychiatric clinics.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** (1) Results and discussion are mentioned together. (2) There is a result mentioned in subjects and methods. (3) There is a mistake in table 4 in number 1 of personality disorders.
- 14) **Abstract and conclusion:** are clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is not good. It is formed of 9 pages.

**14- Subject: Female circumcision in Ismailia. A descriptive study (El-Defrawy et al., 1996).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not mentioned.

- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated but the sample size appears to be adequate.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed but there are some controversial results as in page 139 (table 2), page 140 (table 4), page 141 (table 10) and page 142 (table 15) as P Value refers to significant results but the researcher mentions it as insignificant and vice versa.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 9 pages.

**15- Subject: ECT and sexual activity in males with major depressive illness (El Sheikh and El Fouly, 1997).**

- 1) **Title**: Clear and to the point.
- 2) **Aim of the study**: It is clearly stated giving an explanation for why the study was carried out.
- 3) **Study design**: It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study**: It is not mentioned.
- 5) **Time of the study**: It is not mentioned.
- 6) **Study population**: It is mentioned.
- 7) **Sample design**: It is not mentioned or described.
- 8) **Sample size**: It is not calculated and the sample is composed of 15 cases only which is small size (not adequate sample size), but we can consider it as a preliminary study.
- 9) **Tools**: Methods of assessment are mentioned and referenced.
- 10) **Statistical methods**: are well described.
- 11) **Consent**: It is not taken.
- 12) **Pilot study**: The study is not preceded by a pilot study.
- 13) **Results and discussion**: The results are mentioned and discussed.
- 14) **Abstract**: It is clearly mentioned.
- 15) **Recommendations**: It is not mentioned.
- 16) **Limitations of the study**: are not discussed by the researchers.

- 17) **The general appearance of the paper:** is good, it is formed of only 4 pages.

**16- Subject: Sex hormones serum levels in men with temporal lobe epilepsy (Awny, 1997).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not mentioned.
- 12) **Pilot study:** the study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good, but the thesis is small in size (120 pages) as a thesis of M.D.

**17- Subject: Presentation of female sexual dysfunctions in medical practice (Abed, 1998).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 255 pages.

**18- Subject: Late psychiatric sequelae of childhood sexual abuse (Sayed, 1998).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not mentioned.
- 12) **Pilot study:** The study is preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but the researcher mentions (Chu and Dill, 1990), (Finkelhor and Browne, 1985) and (Briere and Runtz, 1990) in the discussion without refers to them in the reference.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 405 pages.

**19- Subject: Domestic violence and female genital mutilation (Refaat et al., 1999).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not clearly mentioned as it mentioned in subjects and methods.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is not mentioned.
- 7) **Sample design:** It is not mentioned or described sample.
- 8) **Sample size:** It is not mentioned.
- 9) **Tools:** Methods of assessment are not mentioned.
- 10) **Statistical methods:** are described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but there is mistake in table (4) as the title of the table refers to acceptance of husband beating but it is mentioned in the table as never beaten and ever beaten.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is not good. It is formed of 10 pages.

**20- Subject: Descriptive study of some Egyptian females having sexual dysfunction (Owida and Amin, 1999).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly stated giving an explanation for why the study was carried out.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but the researchers mention (Levin, 1992) in the discussion without refers to him in the reference.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned within discussion.
- 16) **Limitations of the study:** It is not mentioned.
- 17) **The general appearance of the paper:** is good, it is formed of 9 pages.



**21- Subject: Childhood sexual abuse in female depressed psychiatric inpatients: Prevalence and relationship to depression (Soliman et al., 1999).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is clearly mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 11 pages.

**22- Subject: Childhood sexual abuse in depressed female inpatients: A 2-year follow-up study and an explanatory cognitive model (Soliman and Effat, 2000).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is not mentioned.
- 3) **Study design:** Prospective follow up cohort study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned with discussion.
- 16) **Limitations of the study:** are discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 9 pages.

**23- Subject: Marital satisfaction in parents living with a schizophrenic offspring: a neglected topic (Sarhan et al., 2000).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but there is mistake in table (3) as the title of the table refers to marital satisfaction inventory (fathers and mothers) but it is mentioned in the table as (patients group and control group).
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 8 pages.

**24- Subject: Some psychosexual aspects of female circumcision: A pilot study in Sharkia (Abdel Azim et al., 2000).**

- 1) **Title**: Clear and to the point.
- 2) **Aim of the study**: It is mentioned.
- 3) **Study design**: It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study**: It is clearly mentioned.
- 5) **Time of the study**: It is mentioned.
- 6) **Study population**: It is clearly mentioned.
- 7) **Sample design**: Random sample, but not described.
- 8) **Sample size**: It is not calculated but the sample size appears to be adequate as a pilot study.
- 9) **Tools**: Methods of assessment are mentioned and referenced.
- 10) **Statistical methods**: are well described.
- 11) **Consent**: The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study**: The study itself is considered as a pilot study.
- 13) **Results and discussion**: The results are mentioned and discussed but (1) in table 1 and 2, the researchers don't mention if the results are significant or not, (2) in table 2, the words and the numbers and percents are not in the same level, (3) in table 3, the results of females are mixed with the results of males and (4) the researcher mentions (Bahaman, 1989) in the introduction without refers to him in the reference.

- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 12 pages.

**25- Subject: The prevailing sexual activities in substance use culture in Egypt using focus group technique (Ismail and Hafez, 2000).**

- 1) **Title:** It is not clear.
- 2) **Aim of the study:** It is not clearly mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated. The sample is small size (14 cases).
- 9) **Tools:** not clearly mentioned.
- 10) **Statistical methods:** It is not mentioned.
- 11) **Consent:** The researchers have obtained oral consent from subjects before doing the study.
- 12) **Pilot study:** It is not present but there is preliminary preparatory phase.

- 13) **Results and discussion:** The results are not clearly mentioned and discussion is mentioned.
- 14) **Abstract:** It is mentioned.
- 15) **Recommendations:** It is mentioned with discussion.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is not good as
  - (1) the titles are incorrect as aim of the work is replaced by purpose of the research and results are replaced by findings.
  - (2) There are no tables in the paper.
  - (3) There are no statistical methods.
  - (4) The Arabic title is not corresponding to the English title.
  - (5) The title of the paper is generalized as the researchers mention “in Egypt” but they study 14 cases only. It is formed of 11 pages.

**26- Subject: Sexual dysfunction and paraphilias of general medical hospital male in-patients (Habeeb, 2000).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated. The sample is small (6 diabetic patients only).

- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but (1) There is no statistical method of table 9 (page 126). (2) In table 7 (page 122), the title is about debilitating diseases but the comment of the table is about non debilitating diseases. (3) Table 8 and table 9 have no titles. (4) The researcher mentions (Hautazt, 1994) and (Mc Elroy, 1999) in the discussion without refers to them in the reference.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 225 pages.

**27- Subject: Gender difference regarding knowledge and attitude towards sexuality among university students in Port Said, Egypt (Nagia et al., 2001).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned with abstract.
- 3) **Study design:** Cross sectional descriptive study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated but the sample size appears to be adequate.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not mentioned.
- 12) **Pilot study:** The study is preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is mentioned.
- 15) **Recommendations:** It is mentioned with discussion.
- 16) **Limitations of the study:** It is mentioned with discussion.
- 17) **The general appearance of the paper:** is good, it is formed of 11 pages.



**28- Subject: Psychiatric aspects of juvenile delinquency (Mohammed, 2001).**

- 1) **Title:** It is generalized, but the researcher studies females only in a specific place.
- 2) **Aim of the study:** It is mentioned but not definite.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** It is not mentioned.
- 8) **Sample size:** It is not calculated and the sample 30 cases only, although the researcher mentions that the study is descriptive.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is not taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data is well presented in clear form. It contains about 230 pages.

**29- Subject: Study of changes of sex hormones and sexual functions in a sample of Egyptian male epileptics (El-Azoony, 2002).**

- 1) **Title**: Clear and to the point.
- 2) **Aim of the study**: It is mentioned.
- 3) **Study design**: Cross-sectional study.
- 4) **Setting of the study**: It is mentioned.
- 5) **Time of the study**: It is not mentioned.
- 6) **Study population**: It is clearly mentioned.
- 7) **Sample design**: It is not described.
- 8) **Sample size**: It is not calculated.
- 9) **Tools**: Methods of assessment are mentioned and referenced.
- 10) **Statistical methods**: are well described.
- 11) **Consent**: It is not taken.
- 12) **Pilot study**: The study is not preceded by a pilot study.
- 13) **Results and discussion**: The results are clearly mentioned and discussed.
- 14) **Summary and conclusion**: They cover all the findings of the study.
- 15) **Recommendations**: It is clearly mentioned.
- 16) **Limitations of the study**: are not discussed by the researcher.
- 17) **The general appearance of the study**: is good and data was well presented in clear form. It contains about 320 pages.

**30- Subject: Sexual dysfunction in female psychiatric patients (El Fangary, 2003).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 260 pages.

**31- Subject: Role of the spouse in addiction: Is there a contribution (Abolmagd et al., 2004).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is clearly stated giving an explanation for why the study was carried out.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is mentioned.
- 7) **Sample design:** It is not mentioned or described.
- 8) **Sample size:** It is not calculated and the sample is small in size (not adequate sample size).
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** It is taken.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed, but the researchers don't mention the number of patients in the results, they mention their percentages only.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is good, it is formed of 8 pages.

**32- Subject: A study of sexual aspects in a sample of male schizophrenic patients (Mohammed, 2005).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional comparative study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** It is not mentioned.
- 17) **The general appearance of the paper:** is good. It contains about 190 pages.

**33- Subject: A comparative study of sexual function in paranoid versus non- paranoid schizophrenic patients and its relation serum prolactin level (Hashem et al., 2006).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** It is not mentioned.
- 17) **The general appearance of the paper:** is good, it is formed of 20 pages.

**34- Subject: Child abuse among preparatory school students in Cairo and its psychiatric sequelae (Hamed, 2006).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 195 pages.

**35- Subject: Sexual dysfunction and relation to used drugs and smoking in a sample of chronic schizophrenic patients (Abdel Azim et al., 2007).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.
- 11) **Consent:** The researchers have obtained informed consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed but (1) the numbers of the cases in the tables are not corresponding to their percents and (2) there is a controversial result as in the conclusion, the researchers mentioned that sexual dysfunction is common in patients taking conventional neuroleptic medication, but in the result, they mention that there are insignificant difference between the type of antipsychotic drugs and overall means of Sexual Functioning Questionnaire (SFQ)..



- 14) **Abstract and conclusion:** are clearly mentioned.
- 15) **Recommendations:** It is mentioned.
- 16) **Limitations of the study:** It is mentioned.
- 17) **The general appearance of the paper:** is good, it is formed of 15 pages.

**36- Subject: The prevalence of child abuse and its effect on the mental health (Riyadh et al., 2007).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** It is not mentioned but we can describe it as a cross-sectional study.
- 4) **Setting of the study:** It is not mentioned.
- 5) **Time of the study:** It is not mentioned.
- 6) **Study population:** It is not mentioned.
- 7) **Sample design:** Stratified random sample.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are not used.
- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** (a) The results and discussion are mentioned together, (b) the researchers refer to figures 1 and 2 in the results and discussion but there are no figures or tables in the paper, (c) the results are mentioned

in percents only without the numbers of the cases, (d) the references of the paper are few in number, (e) there are no statistical methods of the results, (f) there are some results mentioned in method and (g) there is a false result, as child abuse is present among 77.3% of the cases but it is mentioned in the abstract as 77.5%.

- 14) **Abstract:** It is clearly mentioned.
- 15) **Recommendations:** It is not mentioned.
- 16) **Limitations of the study:** are not discussed by the researchers.
- 17) **The general appearance of the paper:** is not good. It is formed of only 5 pages.

### **37- Subject: Sexual dysfunction in epileptic male patients (Mourad, 2009).**

- 1) **Title:** Clear and to the point.
- 2) **Aim of the study:** It is mentioned.
- 3) **Study design:** Cross-sectional, case control study.
- 4) **Setting of the study:** It is mentioned.
- 5) **Time of the study:** It not is mentioned.
- 6) **Study population:** It is clearly mentioned.
- 7) **Sample design:** Random sample, but not described.
- 8) **Sample size:** It is not calculated.
- 9) **Tools:** Methods of assessment are mentioned and referenced.
- 10) **Statistical methods:** are well described.

- 11) **Consent:** The researchers have obtained consent from subjects before doing the study.
- 12) **Pilot study:** The study is not preceded by a pilot study.
- 13) **Results and discussion:** The results are clearly mentioned and discussed.
- 14) **Summary and conclusion:** They cover all the findings of the study.
- 15) **Recommendations:** It is clearly mentioned.
- 16) **Limitations of the study:** are not discussed by the researcher.
- 17) **The general appearance of the study:** is good and data was well presented in clear form. It contains about 280 pages.

We collected 45 Egyptian psychiatric researches done in sexual and gender identity disorders (12 M.D. and M.Sc thesis from El Azhar University, 5 M.D. and M.Sc thesis from Cairo University, 2 M.D thesis from Ain Shams University, 16 studies from the Egyptian Journal of Psychiatry and 10 studies from the Current Psychiatry Journal). Although there are many papers done by staff of faculty of medicine- Suez Canal university, there is no one M.Sc or M.D. thesis done on this topic in Suez Canal university

Regarding the researches done in Egypt we found the following:

## **(A) Epidemiology of sexual and gender identity disorders:**

### **(1) Prevalence:**

#### **(I) Sexual dysfunctions not caused by organic disorders:**

*Owida and Amin (1999)* reported that 3.1%, 1.8% and 1.2% of wives with sexual dysfunctions have lack or loss of sexual desire, sexual aversion disorder and sexual arousal disorder respectively. Whereas, in a German study, *Bancroft (1988)* found that 43% of the female sample reported some problems with sexual enjoyment and arousal, with further 9% expressing actual sexual aversion.

*El Nagdy\* (1984)* reported that 53.2% of sexual disorders male patients have erectile dysfunction. Whereas, *Lewis et al.*

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\* Arabic Reference.

(2004) reported that the prevalence of erectile dysfunction varies from a rate of 1% to 9% in men below 40 years of age to as high as 75% in those older than the age of 70 years. Also, in Iran, *Safarinejad (2003)* found that 18.8% of Iranian men interviewed reported erectile dysfunction. Moreover, *Rosen (2000)* reported that the prevalence of sexual dysfunction in men is 31% after doing a population survey.

*Owida and Amin (1999)* reported that 12.3% of wives with sexual dysfunctions have orgasmic dysfunction. Also, *Spector and Carey (1990)* found similar result in their study and concluded that inhibited female orgasm amounts to 5% to 10%.

*El Nagdy\* (1984)* reported that 4.2% and 42.6% of sexual disorders male patients have delayed ejaculation and premature ejaculation respectively. In other community- or population-based studies, some 20% to 30% of men have been found to endorse the statement that they “ejaculate sooner than desired”. Such endorsements, however, do not necessarily confirm a clinical diagnosis of premature ejaculation; and therefore such techniques (the only ones realistic for surveys of large populations) probably overestimate the actual prevalence (*Patrick et al., 2005*).

Moreover, Nathan’s surveys showed that 15% of men and 35% of women have inhibited sexual desire. 10% - 20% of men have difficulty in erection, 35% of men have premature ejaculation and 5% - 30% or more of the women have inhibited orgasm (*Bartlike et al., 1999*).

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\* Arabic Reference.

*Owida and Amin (1999)* reported that 15.3% and 11.7% of wives with sexual dysfunctions have non organic vaginismus and dyspareunia respectively. Whereas in western study, *Clement and Pfafflin (1980)* found that 20% of their female sample referred for sex therapy received a diagnosis of vaginismus. *Masters and Johnson (1970)* reported that transient dyspareunia is common among women.

## **(II) Sexual dysfunctions in psychiatric patients:**

*Ahmed and Ezz El-Din (1992)* reported that 54% of depressed male patients have sexual dysfunction. Whereas, *Kolodny et al (1979)* reported that sexual dysfunction occurs in fewer than one third of depressed patients.

*Ahmed and Ezz El-Din (1992)* reported that 37.03% of depressed male patients with sexual dysfunction have lack of sexual desire. This is in contrast with *Rosen et al (1997)* who reported that systematic studies suggest that low sexual desire is present in up to 75% of depressed patients. Also, *Kolodny et al. (1979)* noted that 70% of depressed patients have impaired libido.

*Ahmed and Ezz El-Din (1992)* reported that 22.22% of depressed male patients have lack of erection. Also, in a series of forty consecutive male patients with unipolar depression, impotence was reported by 27.5% (*Kolodny et al., 1979*).

So, even the sexual dysfunction as a symptom of depression is not the same in all patients, this may lead us to advice the psychiatrists to bear this in mind, they should ask about the sexual power before starting treatment and during follow up and to reassure the patients if there is any problem.

*Abdel Azim et al. (2007)* reported that 69% of male chronic schizophrenics and 53% of female chronic schizophrenics have sexual dysfunction. This result is nearly similar to the result of *Smith et al. (2002)* who reported that 45% of schizophrenics taking conventional antipsychotic medications have sexual dysfunction.

*Abdel Azim et al. (2007)* reported that 62% of male chronic schizophrenics and 61% of female chronic schizophrenics have reduced libido. *El Fangary (2003)* reported that 63.3% of psychiatric female patients with sexual dysfunction have arousal dysfunction. Also, *Abdel Azim et al. (2007)* reported that 86% of male chronic schizophrenics have ejaculatory dysfunction. This is in agreement with *Van Lankveld and Grotjohann (2000)* who stated that psychiatric patients have significantly more sexual dysfunction than non psychiatric patients and also more than in the general population.

Indeed, sexual dysfunction is very common in patients with schizophrenia. This reflects another aspect of the poor quality of life led by many people with schizophrenia that should be addressed.

### **(III) Substance-induced sexual dysfunctions:**

*Hashem and El-Orabi (1993)* reported that 35.5% and 29.4% male chronic heroin abusers have decrease libido and impotence respectively. Also, *Abolmagd et al. (2004)* reported that 73.3% of the wives of addicts have sexual dissatisfaction. Sexual dissatisfaction can be explained by the addict's loss of sexual interest and the lack of intimacy between the couple.

**(IV) Sexual dysfunctions among medical patients:**

***Zein El Abedeen\**** (1988) reported that 63.33% of impotent diabetic patients have mixed “psychogenic and organic” etiological factors. Previously, psychogenic impotence was believed to be the most common type, with 90% of impotent men thought to suffer from this condition (***Masters and Johnson, 1970***). However, the substantial progress in understanding the peripheral mechanisms involved in erection and erectile dysfunction reveals that most men with erectile dysfunction have mixed “organic and psychogenic” etiological factors (***Lue, 2002***).

***Ibrahim et al. (1995)*** 85% of 1ry ESRD patients have sexual dissatisfaction after regular haemodialysis. Also, ***Sherman, (1975) and Abram et al., (1975)*** concluded that patients with chronic renal failure manifest a multitude of abnormalities in their sexual functions.

***Mourad (2009)*** reported that 75% and 93.3% of epileptic male patients with sexual dysfunction on monotherapy and polytherapy have desire dysfunction respectively. Whereas, ***Herozag et al. (2004), Isojarvi et al. (2004) and Herozag et al. (2005)*** reported that the prevalence of hyposexuality in epileptic patients ranged from 30% to 70%. Also, ***Bahary\**** (1987) reported that 25.2% and 22% of epileptic female

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\* Arabic Reference.



patients with sexual disorders have inhibited sexual excitement and inhibited orgasm respectively.

*El-Azoony (2002)* reported that 30% of epileptic male patients have erection failure. This is in agreement with *Nikoobakht et al. (2007)* who established in a study on epileptic male patients the prevalence of erectile dysfunction to be 42.5%.

**(V) Sexual assault can lead to sexual dysfunctions:**

**a) Childhood sexual abuse (CSA):**

*Hamed (2006)* reported that 5.2% of preparatory school students are subjected to sexual abuse. Also, *Fahmy et al. (1995)* reported that 9% of female psychiatric patients and 7.77% of male psychiatric patients have history of CSA. This is contrary to western culture, where the prevalence of CSA before the age of 16 years was 32% (*Mullen et al., 1994*).

**b) Rape:**

*Abdelmessih et al. (1980)* reported that 52.86% of cases prosecuted to sexual offences are cases of rape. Whereas in western study, *Bancroft (1989)* stated that 44% of women in general population had exposed to rape.

**(VI) Female genital mutilation may lead to sexual dysfunctions:**

**Female circumcision:**

*Lotfy and El-Defrawy (1995)* reported that 80% of wives are circumcised. Also, *El Fangary (2003)* found that 98.3% of psychiatric female patients with sexual dysfunction are

circumcised. According to *World Health Organization (1998)*, the prevalence of female circumcision in Egypt is about 97%. In Egypt, the result of the Demographic Health Survey in 2000 revealed that 97% of married women included in the survey experienced female genital mutilation (FGM). The prevalence of FGM among schoolgirls in Egypt is 50.3% (*Tag-Eldin, 2008*), concluded that the prevalence of FGM in Egypt is lowering.

*Abdel Azim et al. (2000)* reported that 40% of circumcised wives and 12.85% of uncircumcised wives have sexual dysfunctions. *El-Defrawy et al. (1996)* reported that 41.5% of circumcised wives have no sexual desire. *Abdel Azim et al. (2000)* reported that 5.71% and 20% of circumcised wives have sexual arousal disorder and orgasmic dysfunction respectively. *Lotfy and El-Defrawy (1995)* reported that 46% of circumcised wives have pain during intercourse. This is in agreement with *Cutner (1985)* and *Douglas (1984)* who reported that female circumcision appears to be significantly associated with negative psychosexual and gynecological problems like dysmenorrhea, dyspareunia, reduced sexual desire and less occurrence of orgasm. Also, *Dorkenoo (1996)* concluded that female genital mutilation have psychological and sexual complaints.

### **(VII) Homosexuality and lesbianism:**

*Ashour\* (1984)* reported that 50% of male rape offenders have homosexuality. *Lotaief et al. (1994)* reported that 9.67% of males have homosexual experience and 6.95% of females

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\* Arabic Reference.

have lesbian experience, whereas in western study done by **Kinsey (1953)**, the rates for women were nearly half of men. A possible explanation for such discrepancy is that lesbianism between females represents one form of the amenable sexual outlets, due to the strong restrictions on mixing between both sexes in Eastern cultures.

### **(VIII) Paraphilias:**

**Ashour\*** (1984) reported that 22%, 2%, 20%, 44% and 2% of male rape offenders have exhibitionism, masochism, sadism, voyeurism and zoophilia respectively. **Bahary\*** (1987) reported that 11%, 2.4% and 0.8% of female epileptic patients with sexual disorders have exhibitionism, fetishism and transvestitism respectively. **Quinsey et al. (1993)** stated that the prevalence of most paraphilias in the Western world is unknown due to an absence of representative epidemiological studies of paraphilias in the general population. Recently, however, **Langstrom and Seto (2006)** reported the prevalence of exhibitionism, voyeurism, and transvestic fetishism in a representative sample of the Swedish population between 18 and 74 years of age. They found that 4.1% of men and 2.1% of women had at least one episode of exhibitionistic behavior. The lifetime prevalence for voyeuristic behavior was 11.5% for men and 3.9% for women. At least one episode of transvestic fetishism was experienced by 2.8% of men and by 0.4% of women.

### **(IX) Gender identity disorder:**

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\* Arabic Reference.

**Transsexualism:**

**Bahary\*** (1987) reported that 1.6% of female epileptic patients with sexual disorders have transsexualism. Whereas, in a recent study of population-based data in Belgium, **De Cuypere et al.** (2007) revealed the prevalence of transsexualism is about 1:12,900.

**(B) Age distribution:**

**Owida and Amin** (1999) reported that 53.4% of wives with sexual dysfunction are in the age group 20 - less than 30 years old. **Fahmy et al.** (1995) reported that 75% of male and 55.3% of female psychiatric patients had < 10 years old at the time of CSA.

**Abdelmessih et al.** (1980) reported that 41.4% of rape victims are raped in the age group from 13 to 17 years old. In a study of 646 cases of rape in Philadelphia, **Amir** (1967) found that 24.9% were in the age group 15 to 19 years constituting the maximum incidence.

**Lotaief et al.** (1994) reported that the age of starting homosexuality and lesbianism of 53.3% of homosexual males and 62.5% of lesbian females is 10 - 15 years old and the age of starting homosexual practice is younger in males than females. Early exposure and more permissiveness in males could be a factor behind such a difference.

**(C) Religion distribution:**

*Lotaief et al. (1994)* reported that religiosity scores are significantly higher in lesbian females than in homosexual males. This may be explained by the fact that there is not much mentioning of lesbianism in religious books, thus, it has a less negative religious attitude than male homosexuality.

#### **(D) Marital status distribution:**

*Sayed (1998)* reported that 81.6% of history of CSA psychiatric patients are singles. *Lotaief et al. (1994)* reported that 86.7% of homosexual males are singles while 62.5% of lesbian females are married. Several aspects could be considered in interpreting this results; the 1<sup>st</sup> is a biological one reflecting the difference in sexual activity between men and women, in the sense that a female can have successful sexual intercourse without a desire, unlike males, where desire is an important prerequisite for development of erection which is a necessary step in successful intercourse. The 2<sup>nd</sup> factor is related to social expectance and gender role behaviour, where a female is expected to be dependent and non-assertive, hence, not accepted as being unmarried. The 3<sup>rd</sup> factor is of economic origin, where female may accept to be married against their will, just for financial support, without interfering with her true sexual orientation.

#### **(E) Residence distribution:**

*El Fangary (2003)* reported that 70% of psychiatric female patients with sexual dysfunction are from urban areas. Also, *Sayed (1998)* reported that 86.7% of history of CSA psychiatric patients are from urban areas. This is probably due

to the catchment area which Kasr El Aini hospitals (from which the sample is taken) serve.

*Abdel Azim et al. (2000)* reported that 62.86% of circumcised wives are coming from rural areas. This is in agreement with *Cutner (1985) and Douglas (1984)* who reported that female circumcision appears to be significantly more prevalent in rural than urban communities whether a general sequential sampling or randomly selected samples were studied.

### **(F) Educational level distribution:**

*Owida and Amin (1999)* reported that 33.1% of wives with sexual dysfunction are illiterates. *El Fangary (2003)* reported that 50% of psychiatric female patients with sexual dysfunction are illiterates. It is worth noting that, *Bernard (2001)* stated that the low level of education could be a risk factor in female sexual dysfunction.

*Refaat et al. (1999)* reported that 45.3% of circumcised women are illiterates. This is in agreement with *Cutner (1985) and Douglas (1984)* who reported that female circumcision appears to be significantly associated with illiteracy and low level of education.

*Lotaief et al. (1994)* reported that 33.3% of homosexual males are preparatory school education and 37.5% of lesbian females are just read and write. It seems that uneducated women have less chance for mixing with the other sex, and thus, homosexual activity may be an overreaction to this.

### **(G) Occupation distribution:**

*Owida and Amin (1999)* reported that 37.4% of wives with sexual dysfunction are housewives. *El Fangary (2003)* reported that 88.3% of psychiatric female patients with sexual dysfunction are housewives. *Refaat et al. (1999)* reported that 84.5% of circumcised women are not working.

### **(H) Social class distribution:**

*Abed (1998)* reported that 60.6% of women presented with a sexual complaint are belonging to class V. *Abdel Rahman and Nashed (1994)* reported that 3.42% of primary school children of low class school are sexually abused. This is consistent with *Straus et al. (1986)* who reflected a higher occurrence of childhood sexual abuse in low class families.

*Abdel Azim et al. (2000)* reported that 60% of circumcised wives are of low social class. Because of the poor schooling for girls, particularly in rural areas and some persisting cultural values that do not permit them to attend mixed co-educational or schools outside their communities, all are factors leading to negative impact on the status of women and their socialization process (*Farrag, 1995*).

### **I) Order of birth distribution:**

*Bahary\* (1983) and Demerdash et al. (1986)* reported that 59% of epileptic male patients with sexual disorders belong to the middle ranks of their sibship. It seems therefore

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\* Arabic Reference.

that no particular rank is more susceptible to develop epilepsy and sexual disorder in combination. *Hamed (2006)* reported that 7.94% of preparatory school students of eldest position in their families are subjected to sexual abuse, while no one of students of only child in their families are subjected to sexual abuse.

### **(J) Family size distribution:**

*Demerdash et al. (1986)* reported that 65% of epileptic male patients with sexual disorders came from large family size (mean = 6 or more). This may be attributed to lack of privacy and overcrowding. *Hamed (2006)* reported that 26.67% of preparatory school students of large size family (more than 6 persons) are subjected to sexual abuse, while no one of students of small size family (less than 4 persons) are subjected to sexual abuse. So, large size family is an important risk factor for childhood sexual abuse.

## **(B) Etiology of sexual and gender identity disorders:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

There are several etiological factors that cause female sexual dysfunctions as family history of sexual dysfunction (*Owida and Amin, 1999*), parental emotional detachment in the families, paternal psychopathology, gynecological problems, female genital mutilation (circumcision), history of sexual



abuse and sexual trauma in the wedding night and sexual problems among the partner (*Abed, 1998*).

Family history, negative feelings towards parents, psychogenic precipitating factors, pre-pubertal sexuality and pre-marital coitus may lead to male erectile disorder (impotence) (*Demerdash, 1970*).

## **(II) Cause of sexual dysfunctions in psychiatric patients:**

### **(A) Causes of female sexual dysfunctions among psychiatric patients:**

*El Fangary (2003)* reported that manual defloration may cause sexual dysfunctions among female psychiatric patients. This is in accordance with the study done by *Abed (1998)* who reported up to 30% of female with sexual dysfunctions were subjected to sex trauma at wedding night. Sex trauma was referred as ignorance of both partners and prolonged or harsh maneuvers for hymenal perforation that magnify anxiety tension and then pain in an already frightened bride.

*El Fangary (2003)* reported that changes in sex hormones may cause sexual dysfunctions among female psychiatric patients. This is in agreement with the study done by *Riley and Riley (2000)* who concluded that positive correlation between testosterone level and sexual drive.

*El Fangary (2003)* reported that 43.3% of psychiatric female patients with sexual dysfunction have discriminative family influence in favor of males. This attitude may lead to a negative impact on female development and function including

sexual function (*Mc Neil and Rubin, 1977*). Also, *Kinzel et al. (1995)* reported that women with any kind of sexual disorder reported more frequently familial isolation, and lack of parental stimulation in childhood, as well as a more negatively experienced parental educational behaviour and a lack of parent-child relationship than did women without any kind of sexual disorder.

5% of female psychiatric patients have history of masturbation (*El Fangary, 2003*). This finding is contrary to the study of *Abed (1998)* who found that 21.1% to 33.3% of females with sexual dysfunction have history of masturbation. Although this study shows higher incidence, however still less than western cultures, as *Kinsey et al. (1953)* stated in his survey that up to 40% of women have masturbated to orgasm at any time of their lives. Also, *Arafat and Cotton (1974)* showed in their study that 60.98% of females had history of masturbation.

It is worth noting that, *Bobes et al (2000)* reported that the prevalence of sexual dysfunction among psychiatric patients is higher in comparison to non psychiatric patients and the general population. In addition, *Khalil (2003)* reported that a wealth of clinical literature suggests that a currently prevailing depression, or anxiety disorders, alcohol and substance abuse, psychoses, or medication used in psychiatric treatment may be psychiatric causes of sexual dysfunction.

**(B) Causes of male sexual dysfunctions among depressed patients:**

**Ahmed and Ezz El-Din (1992)** reported that past history of drug abuse, recurrent attack of illness, marital conflict, increased level of prolactin and decreased level of testosterone may be the causative factors of sexual dysfunctions among male depressed patients.

**Khalil (2003)** noted that sexual dysfunction may be a symptom of depression itself, a cause of depression or due to a side effect of antidepressants. Neurotransmitters, hormones and peptides play an important role in sexual functioning; levels of these substances may be altered by depression or psychiatric medication. Whereas, **Yang (2004)** reported that sexual dysfunction may have an important role in the neurobiology of major depressive disorder. However, **Morrell and Guldner (1996)** didn't find any correlation between sexual disorder and depression.

### **(C) Causes of sexual dysfunctions among schizophrenic patients:**

**Mohammed (2005) and Hashem et al. (2006)** reported that secondary depression among schizophrenics, early age of onset of schizophrenia, long duration of schizophrenia and changes in sex hormones may lead to sexual dysfunctions among schizophrenics.

**Abdel Azim et al. (2007)** reported that anti-cholinergic side effects of antipsychotics may lead to sexual dysfunctions among schizophrenics. In this respect, **Diederik et al. (2006)** found that depot antipsychotic treatment resulted in sexual dysfunction. Also, **Atmaca et al. (2004)** concluded that sexual dysfunction is an important problem in schizophrenics even

with novel antipsychotics. In a study done by **Kockott and Pfeiffer (1996)** to study sexual disorder in non acute psychiatric patients, he found that schizophrenic patients on neuroleptic medications are most frequently affected, whereas schizophrenic patients not in medications have fewer dysfunctions. Moreover, **Smith et al. (2002)** found that 45% of schizophrenics taking conventional antipsychotic medications have sexual dysfunction.

**Abdel Azim et al. (2007)** reported that hyperprolactinaemia may lead to sexual dysfunctions among schizophrenics. This is consistent with the study done by **Bruno (2006)** who reported that hyperprolactinaemic patients reported significant degree of sexual enjoyment dysfunction; which is a neurochemical mediator of "life's pleasures" (**Wise, 1982**).

Long duration of hospitalization of schizophrenics may lead to sexual dysfunctions among schizophrenics (**Mohammed, 2005 and Hashem et al., 2006**). Both sexual performance and frequency of sexual activity were affected by the duration of schizophrenia; the sexual desire, sexual excitement, erectile function (in the form of achievement of erection) and orgasm impaired as the duration of schizophrenia increased. Moreover, frequency of sexual intercourses significantly decreased as the duration of the illness increased, which might be explained by tendency of patients with schizophrenia to be more isolated and withdrawn from social and emotional activities, during the deterioration course of the illness (**Slater and Roth, 2001**), and was supported by the correlation between longer duration of illness and negative symptoms (conceptual disorganization, blunted affect, poor

rapport, lack of spontaneity of speech and stereotyped thinking). The effect of an increase in the length of stay in hospital, we found a parallel impairment in the sexual excitement as well as increase incidence of delayed ejaculation, which could be due to understimulatory social environments in hospitals and the significant correlation between hospitalization and negative symptoms (*Oshima et al., 2003*).

### **(III) Causes of sexual dysfunctions among male heroin abusers:**

*Hashem and El-Orabi (1993)* reported that decreased level of serum testosterone, decreased level of serum FSH and increased level of serum prolactin cause sexual dysfunctions in male heroin abusers. This should speculate that opiates exert an inhibitory effect on secretion of testosterone by the testis.

### **(IV) Causes of sexual dysfunctions among medical patients:**

#### **(A) Causes of sexual dysfunction in epileptic patients:**

*Bahary\* (1983) and Demerdash et al. (1986)* reported that the long duration of epilepsy could favour the development of sexual dysfunction in epileptic patients. This could be accounted for by secondary personality changes, social factors and effects of anticonvulsants as reported by *Taylor (1972)*.

*Bahary\* (1983) and Demerdash et al. (1986)* reported that fits at night or in the evening could favour the development of sexual dysfunction in epileptic patients. This

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\* Arabic Reference.

help to explain the occurrence of sexual inadequacy in view of the fact that sexual activity usually takes place at the end of the working day. The occurrence of seizures in this particular period would certainly interfere with normal sexual activity.

**Awny (1997)** reported that temporal lobe epilepsy may cause sexual dysfunction in epileptic patients. This is in agreement with **Hellmis (2008)** who reported that temporal lobe epilepsy results in hypogonadism, hyperprolactinaemia that leads to hyposexuality, lack of libido, erectile dysfunction and reduced sperm quality. Also, **Bean and Fedia (1977) and Herzog et al. (1990)** found that reproductive and sexual dysfunctions among men with epilepsy are related to both diminished free testosterone level and temporal lobe seizures. Hyposexuality is more common in patients with focal seizures especially those originating from the temporal lobe (**Saunders and Rawson, 1970 ; Shukla et al., 1979 ; Fenwick et al., 1986 ; Toone et al., 1989 and Silveira et al., 2001**). On the other hand, **Jensen et al. (1990)** reported that there is debate as to the extent to which epilepsy increase the risk of sexual disorder.

**Bahary\* (1983) and Demerdash et al. (1986)** reported that high frequency of fits may cause sexual dysfunction in epileptic patients. This is in contrast with the study done by (**Silveira et al., 2001**) who didn't find any significant difference between hyposexual and non hyposexual epileptic patients as regards seizure frequency. Recently, **Nikoobakht et al. (2007)** revealed a correlation between frequency of epileptic seizures and dysfunctions in different sexual function parameters, erection and sexual desire.

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\* Arabic Reference.

*Mourad (2009)* reported that polypharmacy of antiepileptic drugs may be responsible for sexual dysfunction in epileptic patients. In temporal lobe epilepsy, antiepileptic drugs especially carbamazepine worsen the negative effects of epilepsy on serum levels of reproductive hormones (*Bauer et al., 2004*).

**(B) Causes of sexual dysfunction in 1ry ESRD patients under regular haemodialysis:**

*Ibrahim et al. (1995)* found that sexual dysfunction is common in haemodialysis patients. This finding comes in accordance with that reported by *Lawrence et al. (1998)* who reported that sexual dysfunction remains a common distressing problem in the male dialysis population.

**(C) Causes of male sexual dysfunction in various medical diseases patients:**

*Habeeb (2000)* reported that old age, deep venous thrombosis (D.V.T.), psychiatric disorders, manual work and low social support are important precipitating factors of erectile dysfunction among various medical patients.

*Habeeb (2000)* reported that diabetes mellitus (D.M.) is an important precipitating factor of erectile dysfunction among various medical patients. Impotence has been reported in over 50% of male diabetes in some surveys (*Schiavi and Hogan, 1979*). In addition, erectile dysfunction occurs in 32% of Type 1 and 46% of Type 2 diabetic men (*Vickers and Wright, 2004*). Moreover, diabetes mellitus, although the most common endocrinologic disorder, causes erectile dysfunction through

vascular, neurologic, endothelial, and psychogenic complications rather than through a hormone deficiency per se (*Moore and Wang, 2006*).

*Habeeb (2000)* found that the sexual function is negatively correlated with age. This is consistent with the study done by *Zaki et al. (1999)* on men at different age groups, who found that the prevalence of erectile dysfunction increases with advancing age; which is the same result of *Lewis et al. (2004)* who reported that of the prevalence of erectile dysfunction as well as other sexual dysfunctions in both women and men increases with aging.

*Habeeb (2000)* found that the patients who used to pray and fast all the time had worse sexual function than those who pray and fast sometimes and those who never pray and fast, had the best sexual function. This is consistent with the study done by *Spector and Fremeth (1996)* who concluded that religiosity was negatively correlated with sexual attitudes. The hypothesis explaining these results is that religiosity is frequently associated with sexual inhibition.

#### **(V) Causes of homosexuality and lesbianism:**

The causes of the first homosexual experience are seduction, imitation, opposite sex unavailable or inaccessible and spontaneous desire (*Demerdash, 1970*).

#### **(C) Clinical description of sexual and gender identity disorders:**



**(I) Sexual dysfunctions not caused by organic disorders:**

Some females come to the clinic complaining indirectly of sexual dysfunction as inaccessible intercourse, pelvic heaviness, low back pain and vague sexual complaint (*Owida and Amin, 1999*).

**(II) Sexual dysfunctions in psychiatric patients:**

*El Fangary (2003)* reported that 75% of psychiatric female patients with sexual dysfunction are afraid at the onset of menstruation (menarche) and they have lower scores of sexual functioning questionnaire and marital satisfaction than non psychiatric female patients with sexual dysfunction. In addition, *Bhui et al. (1995)* concluded that there is higher rate of marital conflict and divorce rates in psychiatric patients.

Severity of depression is significantly more in depressed male patients with sexual dysfunction than depressed male patients without sexual dysfunction (*Ahmed and Ezz El-Din, 1995*).

Epileptic male patients with sexual disorders have low scores on the pornography; this reflects reluctance to practice an activity, they are shy and inhibited as regards sex, they have high scores on prudishness that reflect avoidance of any expression of spontaneous sexual feelings, they have high scores on sexual disgust which may be considered as an expression of frustration with sex and they have low scores on

sexual excitement that reflect impaired libido (*Bahary\* , 1983 and Demerdash et al., 1986*).

The duration of sexual dysfunction among the polytherapy epileptic patients is significantly longer than among the monotherapy epileptic patients (*Mourad, 2009*).

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **(A) Childhood sexual abuse (CSA):**

*Sayed (1998)* reported that the mean age at time of CSA among 60 psychiatric patients is 8.6 years. 85% of the perpetrators of history of CSA among 60 psychiatric patients are males. *Soliman et al. (1999)* reported that 42.9% of CSA depressed women have history of sexual abuse with penetration of genitalia, and 71.4% of them have threatened violence to be abused. 82.91% of depressed women with history of CSA could not disclose the abuse for years after the abuse had stopped. *Fahmy et al. (1995)* reported that 62.5% of male psychiatric patients with history of CSA and 86.9% of female psychiatric patients with history of CSA have frequent abuse. The family reaction of 75% of male psychiatric patients with history of CSA and 71.05% of history of CSA female psychiatric patients is passive.

#### **(B) Rape:**

*Abdelmessih et al. (1980)* reported that the assailant of 61.2% of rape victims is a stranger, 89.8% of rape victims are raped by a single assailant, 69.4% of rape victims are raped in a participant's place, 25.5% of rape victims have ruptured hymen

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\* Arabic Reference.

and the incidence of rape is high in spring and autumn, and lower in summer and winter. This seasonal variation might be explained by the fact that the fair weather in spring and autumn encourages outdoor activity thus leading to increased liability to sexual assault.

#### **(IV) Female genital mutilation may lead to sexual dysfunctions:**

*Lotfy and El-Defrawy (1995)* reported that 76% of circumcised wives have undergone circumcision between ages 8 and 12 years. Moreover, the age at which FGM is performed varies according to country, tribe and circumstances, including infants, children and adolescents (*The Royal Women's Hospital, 2009*).

57.5% of circumcised wives are circumcised at home, 48.5% of circumcised wives are circumcised by dayas and 54.5% of circumcised wives are circumcised with excision of the clitoris (*El-Defrawy et al., 1996*). Traditionally, the procedure is carried out by women with no medical training. Anesthetics and antiseptic treatment are not often used and the practice may be carried out using basic tools such as scissors, knives, scalpels, pieces of glass and razor blades. Iodine or a mixture of herbs is often placed on the wound to tighten the skin in and around the vagina and stop the bleeding. In recent years, the procedure has been medicalized in some regions and it is carried out in health care facilities by trained health care personnel (*World Health Organization, 2008*).

53.5% of circumcised wives have recalled complications following the procedures (*Lotfy and El-Defrawy, 1995*) as

excessive bleeding, infection, urinary retention, vaginal infections, infertility, dysmenorrhoea, pelvic pain and vulval abscess. These complications depend on the type, practitioner, where it's performed, and method used (*The Royal Women's Hospital, 2009*).

#### **(V) Homosexuality and lesbianism:**

*Demerdash (1970)* reported that the duration of homosexual experience is less than one year in 50% of impotent Egyptian patients with past history of homosexuality. *Lotaief et al. (1994)* reported that the age of the other partner at first experience is from 16 to 30 years among 40% of homosexual males and from 31 to 50 years among 50% of lesbian females.

#### **(D) Management of sexual and gender identity disorders:**

*Ahmed and Ezz El-Din (1992)* reported that most of depressed patients with sexual dysfunction show sexual improvement after treatment with tricyclic antidepressant (75 mg to 100 mg/day for six months). *El Akabawi and Idarous (1982)* reported that 92.9% of impotent patients improved with talk therapy (without drug therapy) and 68.8% of impotent patients improved with drug therapy. In this respect, *Frank (1982)* reported that placebo effect account for improvement in impotent patients given drug therapy inspite of the fact that there are usually no definite indications for their use.

## **(E) Outcome of sexual and gender identity disorders:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

*Owida and Amin (1999)* reported that 28.8% of wives with sexual dysfunction have no children. Also, *Abed (1998)* reported that 27.3% of women presented with a sexual complaint have marital dissatisfaction. Moreover, *El Fangary (2003)* reported that 38.3% of psychiatric female patients with sexual dysfunction become worse in sexual functioning after onset of psychiatric illness.

### **(II) Sexual dysfunctions among medical patients:**

*Bahary\* (1983) and Demerdash et al. (1986)* reported that 65% of male epileptic patients with sexual disorders have psychiatric disorders in the form of neurotic depression and anxiety neurosis. These psychiatric disorders may be attributed to the impact of epilepsy itself and the disordered sexuality.

### **(III) Sexual assault can lead to sexual dysfunctions:**

#### **Childhood sexual abuse (CSA):**

*Hamed (2006)* reported that most of sexually abused preparatory school students have low self esteem and major depressive episode. This is consistent with *Stein et al. (2001)* who reported that CSA leads to low self esteem. In addition, *Bifulco et al. (1991)* found that 58.3% of depressive cases had

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\* Arabic Reference.

early sexual abuse. Moreover, Childhood sexual abuse is associated with low self esteem (*Dent and Teasdale, 1988 and Brown et al., 1990*) and poor quality of marital relationship (*Hooly et al., 1986*).

*Sayed (1998)* reported that 71.6% of psychiatric patients with history of CSA have unsatisfactory sexual functioning. This finding comes in accordance with that reported in most literature (*Finkelhor and Baron, 1986 ; Briere and Runtz, 1990 ; Hilton and Mezey, 1996 ; Johnson and Harlow, 1996 and McCauley et al., 1997*). This higher prevalence of unsatisfactory sexual functioning among survivors of CSA could be mediated through the traumagenic dynamic described by *Finkelhor and Baron (1986)*; traumatic sexualisation. These authors hypothesize that the child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. Traumatic sexualisation leads to confusion about sexual norms and standards and may result in associating sex with negative connotations.

*Soliman and Effat (2000)* reported that depressed women with history of CSA are less socially adjusted than depressed women without history of CSA. In addition, *Soliman et al. (1999)* reported that the age of onset of depression is significantly lower among the depressed women with history of CSA than among the depressed women without history of CSA. Depressed women with history of CSA had poor prognostic factors as early onset of depression (*Eccleston and Scott, 1991*), more frequent episodes (*Keller et al., 1983*) and

substance abuse (*McLeod et al., 1992*). Moreover, victims of child sexual abuse have higher levels of depression, attempting suicide or making a plan about how would attempt suicide (*Chen et al., 2004*).

Depression is more severe among the depressed women with history of intra-familial CSA than among depressed women with history of extra-familial CSA. Also, it is more severe among the depressed women with history of CSA with genital penetration (*Soliman et al., 1999*). This comes in accordance with *Sedney and Brooks (1984)* who found that, being sexually abused by a family member has been associated with worse psychological symptoms.

*Fahmy et al. (1995)* reported that 25% of sexually abused psychiatric patients with adult personality and behavioral disorders have psychological and behavioral disorders associated with sexual development and orientation. Also, there is significant association between sexual abuse and anxiety withdrawal, attention problems, socialized aggression and motor excess (*Hamed 2006*).

It is worth noting that childhood sexual experiences with adults may increase the risk of mental illness (*Freud, 1896*). Moreover, Childhood sexual abuse has a role in of the development of self injurious behaviour (*Klonsky and Moyer, 2008*).

#### **(IV) Female genital mutilation may lead to sexual dysfunctions:**

##### **Female circumcision:**

*Lotfy and El-Defrawy (1995)* reported that the circumcised wives have significantly less initiation of sexual relationship with husband, less enjoyment of sexual life, less achieving the orgasm, difficulty to time orgasm with husband, dryness during intercourse and dysmenorrhea than the uncircumcised wives. Also, 51.5% of circumcised wives do not foreplay before sex. This is in agreement with *Dorkenoo (1996)* who concluded that female genital mutilation has psychological and sexual complaints. In addition, female genital mutilation (circumcision) violates a serious of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to bodily integrity, the right to life (in cases where the procedure results in death), and the right to the highest attainable standard of physical and mental health (*World Health Organization, 2008*).

*Refaat et al. (1999)* found that 87.5% of circumcised women accept husband beating whatever their future educational level, working status, economic level or residence. This reflects that female circumcision shapes the attitude of women to accept abuse and beating and the practice of FGM on young girls leads to their future acceptance of violence from husbands.

## **(F) Knowledge and opinion about human sexuality:**

### **(I) The difference between males and females as regards the sexual knowledge:**



*Nagia et al. (2001)* reported that the mean scores of knowledge about sexuality and about STDs including AIDs of male university students are significantly higher than female university students. This result is supported by many other western researches where this difference is significant in all of them (*Sorenson, 1973 ; Hass, 1979 ; Persson and Jarlbro, 1992 ; Kiragu and Zabin, 1993 ; Evans et al., 1993 and Graham et al., 1996*).

*Nagia et al. (2001)* reported that sports and fasting are the mainly methods of coping with sexual needs among both male and female university students. This may reflect the influence of social desirability which might mean what students perceive “best accepted answer”.

## **(II) Sexual knowledge of the wives:**

*El Fangary (2003)* reported that 81.7% of psychiatric female patients with sexual dysfunction had their main source of sex information from their family. Unlike the study on educated employed wives by *Loutfi et al. (1984)* where source of sexual information mainly was from friends (29.2%) and books (21.2%). However the difference could have been due to the selection of the sample. Whereas in western societies, *Schofield (1967)* reported that, although parents are the proper people to instruct children about sex, yet most of his studied sample obtained their sex information from their friends.

*Loutfi et al. (1984)* reported that 48.2% of educated employed wives defined marital relation as family relation only. This is a reflection of the cultural view that females are

married only to form a family and that sex is a taboo. Also, sexual needs of females are usually ignored.

*El Fangary (2003)* showed that first information about sex was at age of 14.9 years and was more delayed in psychiatric patients at age of 15.37 years, and it is more delayed in the study of *Loutfi et al. (1984)* who found that 79.5% of educated employed wives acquired their sexual knowledge immediately before or after their marriage. This finding reflects the cultural tendencies that females need not be informed about sex matter except when necessary. Thus formal sex education is denied for females unless they are to be married. This is contrary to western culture, where there is an earlier age of first information about sex which is usually before the onset of puberty (*Farley et al., 2002*), as well as premarital practices which are usually accepted in western societies.

### **(III) Sexual rights of the wives:**

*Loutfi et al. (1984)* reported that the majority of educated employed wives stated that sexual relations should always be initiated by the man and that the female shouldn't refuse it. This reflects the general view that females should be passive in sex and merely to tolerate it and that males are the ones to be aggressive and perform all the "work". In this respect, *Davenport (1977) and Woods (1979)* stated that culture dictates whether the woman plays an active or passive role in sexual activity.

*Loutfi et al. (1984)* reported that the majority of educated employed wives stated that women do not have the right to seek advice in case of sexual problems. This finding reflects

the inhibitory roles of females. Sex is a taboo and thus should never be discussed by a decent female. Also it is a very personal and confidential matter and should not be talked about except with very close relatives. This may be due to the fact that the wives believed that the health professionals have neither the skill, the time nor the inclination to deal with sexual problems. In addition, they may not think that sexual problem is a matter of medical concern. In this respect, *Nelson (1977)* reported a crisis of confidence between public and health professionals in sexual problems.

*Loutfi et al. (1984)* reported that 43.8% of educated employed wives stated that sexual orgasm and enjoyment of sexual intercourse is not essential for females. This shows that females are impelled to participate in sexual relation because of moral and cultural obligations rather than satisfaction of their own needs.

#### **(IV) Knowledge about impotence among the males:**

*Demerdash (1970)* reported that 36.4% of Egyptian impotent patients explain the cause of impotence as disease of genitalia and 89.5% of them have willing towards consulting a psychiatrist. This reflects the importance of erectile function for the impotent patients for doing good sex.

#### **(V) Knowledge and attitude about sexuality among male substance users:**

*Ismail and Hafez (2000)* reported that male substance users comment on “most people use drugs in order to do good sex” as this is true, they don’t raise the issue of importance of

wearing the condom on practicing sex and they don't care about regular screen for the possible infection of one of sexually transmitted diseases. This reflects the life style of these individuals is far below the health standards because of the substance use. All their daytime is consumed by looking for the substance, administering it, going through its effects or suffering from its withdrawal.

**(VI) Knowledge about childhood sexual abuse (CSA) among the child care providers:**

*El-Defrawi et al. (1993)* reported that 77% of child care providers report child sexual abuse is an important risk factor for psychiatric problems and further child abuse. So, recognition and identification of risk factors, developmental, behavioural, psychological and emotional problems in community children has important implications for the children themselves and the community in terms of both current disability and further disorders.

**(VII) Knowledge about circumcision among the females:**

*El Fangary (2003)* reported that 78.3% of psychiatric female patients with sexual dysfunction agree on circumcision and indicated that it is necessary to circumcise their daughters. *El-Defrawy et al. (1996)* found that 41% of circumcised wives intend to circumcise their daughters. Also, *Lotfy and El-Defrawy (1995)* reported that 61.5% of circumcised wives intend to circumcise their daughters (for religious tradition, family tradition or hygienic tradition). Moreover the reasons

for female circumcision remain a very controversial issue; it is probably a trial to protect female virtue by decreasing sexual drive. Also regarding circumcised females by their husbands as more appealing, indirectly affects female's opinion about the importance of circumcision. The reasons given for the practice are multiple and complex, thus it is critical to engage communities and work with them to eliminate the practice. The reasons include: preservation of traditional practice/cultural identity and conformity to the values of the group; hygiene; protection of virginity; family honour; to promote marriageability and social and economic status; to enhance the husband's sexual pleasure; aesthetics; purity and religious observation. FGM is not prescribed by any religion, despite it is being practiced by Muslims and Christians. Religious leaders from Islamic and Christian communities have made statements condemning the practice of FGM (*The Royal Women's Hospital, 2009*).

Female circumcision has proven to be a harmful procedure in females, as 69% of circumcised women perceive circumcision as painful operation (*Lotfy and El-Defrawy, 1995*). So, education towards ameliorating such practice is recommended. Such education should not just address females only but also males, as they are usually the decision-makers in their families.

## **Conclusion:**

Forty five Egyptian studies discussed the topic of sexual and gender identity disorders, these studies are still defective and deficient.

We can conclude that most of the Egyptian studies done on sexual and gender identity disorders are on the epidemiology (34 studies) followed by the etiological studies (15 studies) and the clinical description (15 studies) then the outcome (12 studies) and knowledge and opinion about human sexuality (9 studies) and lastly management (3 studies).

There were 5 Egyptian studies done on sexual dysfunctions not caused by organic disorders which cover the period from 1970-2003 (33 years), 6 Egyptian studies done on sexual dysfunctions in psychiatric patients which cover the period from 1992-2007 (15 years), 2 Egyptian studies done on substance-induced sexual dysfunctions which were in 1993 and in 2004, 10 Egyptian studies done on sexual dysfunctions among medical patients which cover the period from 1983-2009 (26 years), 9 Egyptian studies done on sexual assault can lead to sexual dysfunctions (7 studies done on childhood sexual abuse and 2 studies done on rape) which cover the period from 1980-2007 (27 years), 5 Egyptian studies done on female genital mutilation (female circumcision) which cover the period from 1995-2003 (8 years), 5 Egyptian studies done on homosexuality and lesbianism which cover the period from 1970-2001 (31 years), 5 Egyptian studies done on paraphilias which cover the period from 1983-2000 (17 years), only one Egyptian studies done on gender identity disorder which were

in 1987 and 9 Egyptian studies done on knowledge and opinion about human sexuality which cover the period from 1970-2003 (33 years).

Common missed points were found in these studies such as good description of the study design and justification of the sample size to meet their aims. Describing the statistical methods used, discussing the unwanted events occurred during the study and how they were dealt with, sources of bias and how they were eliminated were also common missed points in many Egyptian researches. There is a need for further studies discussing this important topic.

We are in need to review our Egyptian studies done on sexual and gender identity disorders in a systematic way, to appraise its results across the time and place, in order to illustrate points of power and weakness, to generate recommendations which may help us in constructing guidelines in our next researches on this important topic.

In order to achieve this goal the following databases were explored; 1- Library of faculty of medicine- Ain Shams University. 2- Library of faculty of medicine- Cairo University. 3- Library of faculty of medicine- El Azhar University. 4- Library of faculty of medicine- Suez Canal University. 5- Databases of Egyptian Journal of Psychiatry and Current Psychiatry Journal.

After exploring these databases, a list of 45 Egyptian psychiatric researches on sexual and gender identity disorders is generated (12 M.D. and M.Sc thesis from El Azhar University, 5 M.D. and M.Sc thesis from Cairo University, 2 M.D thesis from Ain Shams University, 16 studies from the Egyptian Journal of Psychiatry and 10 studies from the Current Psychiatry Journal).

After reviewing these studies, they are categorized in the following: 1-Epidemiology, 2-Etiology, 3-Clinical description, 4- Management, 5- Outcome and 6- Knowledge and opinion about human sexuality. All researches which were used in the review were critically appraised.

Regarding researches done, it was found that:



## **A- Epidemiology:**

### **(I) Sexual dysfunctions not caused by organic disorders:**

*Owida and Amin (1999)* found that 3.1%, 1.8%, 1.2% and 12.3% of wives with sexual dysfunctions have lack or loss of sexual desire, sexual aversion disorder, sexual arousal disorder and orgasmic dysfunction respectively. *El Nagdy\** (1984) reported that 53.2%, 4.2% and 42.6% of sexual disorders male patients have erectile dysfunction, delayed ejaculation and premature ejaculation respectively.

### **(II) Sexual dysfunctions in psychiatric patients:**

*Abdel Azim et al. (2007)* found that 69% of male chronic schizophrenics and 53% of female chronic schizophrenics have sexual dysfunction. *Ahmed and Ezz El-Din (1992)* reported that 54% of depressed male patients have sexual dysfunction.

### **(III) Substance-induced sexual dysfunctions:**

*Hashem and El-Orabi (1993)* reported that 35.5% and 29.4% of male chronic heroin abusers have decrease libido and impotence respectively. *Abolmagd et al. (2004)* found that 73.3% of the wives of addicts have sexual dissatisfaction.

### **(IV) Sexual dysfunctions among medical patients:**

*Ibrahim et al. (1995)* reported that 85% and 45.8% of 1ry ESRD patients have sexual dissatisfaction and impaired erection respectively after regular haemodialysis. *El-Azoony (2002)* reported that 18%, 20%, 30% and 27% of epileptic male

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\* Arabic Reference.

patients have global sexual dysfunction, desire dysfunction, erection failure and ejaculatory dysfunction respectively.

**(V) Sexual assault can lead to sexual dysfunctions:**

*Hamed (2006)* reported that 5.2% of preparatory school students are subjected to sexual abuse. *Abdelmessih et al. (1980)* found that 52.86% of cases prosecuted to sexual offences are cases of rape.

**(VI) Female genital mutilation may lead to sexual dysfunctions:**

*Refaat et al. (1999)* reported that 97.1% of women are circumcised. *Abdel Azim et al. (2000)* reported that 40% of circumcised wives and 12.85% of uncircumcised wives have sexual dysfunctions.

**(VII) Homosexuality and lesbianism:**

*Lotaief et al. (1994)* reported that 9.67% of males have homosexual experience and 6.95% of females have lesbian experience.

**(VIII) Paraphilias:**

*Bahary\** (1987) reported that 11%, 2.4% and 0.8% of female epileptic patients with sexual disorders have exhibitionism, fetishism and transvestitism respectively. *Ashour\** (1984) reported that 22%, 2%, 20%, 44% and 2% of

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\* Arabic Reference.

male rape offenders have exhibitionism, masochism, sadism, voyeurism and zoophilia respectively.

**(IX) Gender identity disorder:**

***Bahary*<sup>\*</sup> (1987)** reported that 1.6% of female epileptic patients with sexual disorders have transsexualism.

Regarding the age distribution in sexual and gender identity disorders; ***Fahmy et al. (1995)*** reported that 75% of male and 55.3% of female psychiatric patients had < 10 years old at the time of CSA.

Regarding the religion distribution; ***Lotaief et al. (1994)*** reported that 60% of homosexual males and 62.5% of lesbian females are religious but no practice.

Regarding the marital status distribution; ***Lotaief et al. (1994)*** reported that 86.7% of homosexual males are singles while 62.5% of lesbian females are married.

Regarding the residence distribution; ***Abdel Azim et al. (2000)*** reported that 62.86% of circumcised wives are coming from rural areas.

Regarding the educational level distribution; ***Refaat et al. (1999)*** reported that 45.3% of circumcised women are illiterates.

Regarding the occupation distribution; ***Refaat et al. (1999)*** reported that 84.5% of circumcised women are not working.

Regarding the social class distribution; ***Abdel Azim et al. (2000)*** reported that 60% of circumcised wives are of low social class.

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<sup>\*</sup> Arabic Reference.

Regarding the order of birth distribution; *Bahary*\* (1983) and *Demerdash et al.* (1986) reported that 59% of epileptic male patients with sexual disorders belong to the middle ranks of their sibship.

Regarding the family size distribution; *Hamed* (2006) reported that 26.67% of preparatory school students of large size family (more than 6 persons) are subjected to sexual abuse.

### **(B) Etiology of sexual and gender identity disorders:**

Several etiological factors may lead to female sexual dysfunctions as family history of sexual dysfunction (*Owida and Amin, 1999*), parental emotional detachment, paternal psychopathology, gynecological problems, female genital mutilation (circumcision), history of sexual abuse, sexual trauma in the wedding night and sexual problems among the partner (*Abed, 1998*).

Family history, negative feelings towards parents, psychogenic precipitating factors, pre-pubertal sexuality and pre-marital coitus may lead to male erectile disorder (impotence) (*Demerdash, 1970*).

Fits at night, long duration of epilepsy, high frequency of fits, (*Bahary*\* , 1983 and *Demerdash et al., 1986*), temporal lobe epilepsy (*Awny, 1997*) and polypharmacy of antiepileptic drugs (*Mourad, 2009*) may be responsible for sexual dysfunction in epileptic patients.

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\* Arabic Reference.

Old age, deep venous thrombosis (D.V.T.), diabetes mellitus (D.M.) and psychiatric disorders are important precipitating factors of erectile dysfunction among various medical patients (*Habeeb, 2000*).

### **(C) Clinical description of sexual assault and of sexual and gender identity disorders:**

Some females come to the clinic complaining indirectly of sexual dysfunction as inaccessible intercourse, pelvic heaviness, low back pain and vague sexual complaint (*Owida and Amin, 1999*).

Severity of depression is significantly more in depressed male patients with sexual dysfunction than depressed male patients without sexual dysfunction (*Ahmed and Ezz El-Din, 1992*).

*Mourad (2009)* reported that the duration of sexual dysfunction among the polytherapy epileptic patients is significantly longer than among the monotherapy epileptic patients.

*Sayed (1998)* reported that the mean age at time of CSA among 60 psychiatric patients is 8.6 years. *Soliman et al. (1999)* reported that 42.9% of CSA depressed women have history of sexual abuse with penetration of genitalia, and 71.4% of them have threatened violence to be abused.

The incidence of rape is high in spring and autumn, and lower in summer and winter. This seasonal variation might be

explained by the fact that the fair weather in spring and autumn encourages outdoor activity thus leading to increased liability to sexual assault (*Abdelmessih et al., 1980*).

*Lotfy and El-Defrawy (1995)* reported that 76% of circumcised wives have undergone circumcision between ages 8 and 12 years. *El-Defrawy et al. (1996)* reported that 57.5% of circumcised wives are circumcised at home, 48.5% of circumcised wives are circumcised by dayas and 54.5% of circumcised wives are circumcised with excision of the clitoris. 53.5% of circumcised wives have recalled complications following the procedures (*Lotfy and El-Defrawy, 1995*) as excessive bleeding, infection, urinary retention, vaginal infections, infertility, dysmenorrhoea, pelvic pain and vulval abscess. These complications depend on the type, practitioner, where it's performed, and method used (*The Royal Women's Hospital, 2009*).

#### **(D) Management of sexual and gender identity disorders:**

*El Akabawi and Idarous (1982)* reported that 92.9% of impotent patients improved with talk therapy (without drug therapy) and 68.8% of impotent patients improved with drug therapy. *Ahmed and Ezz El-Din (1992)* reported that most of depressed patients with sexual dysfunction show sexual improvement after treatment with tricyclic antidepressant (75 mg to 100 mg/day for six months).

## **(E) Outcome of sexual and gender identity disorders:**

*Abed (1998)* reported that 27.3% of women presented with a sexual complaint have marital dissatisfaction.

*Bahary\* (1983) and Demerdash et al. (1986)* reported that 65% of male epileptic patients with sexual disorders have psychiatric disorders in the form of neurotic depression and anxiety neurosis. These psychiatric disorders may be due to the sexual disorders.

*Hamed (2006)* reported that most of sexually abused preparatory school students have low self esteem and major depressive episode. *Sayed (1998)* reported that 71.6% of psychiatric patients with history of CSA have unsatisfactory sexual functioning.

*Lotfy and El-Defrawy (1995)* reported that circumcised wives have significantly less initiation of sexual relationship with husband, less enjoyment of sexual life, less achieving the orgasm, difficulty to time orgasm with husband, dryness during intercourse and dysmenorrhea than the uncircumcised wives. *Refaat et al. (1999)* reported that circumcised women are significantly ever beating and accepting husband beating more than the uncircumcised women.

## **(F) Knowledge and opinion about human sexuality:**

*Nagia et al. (2001)* reported that the mean scores of knowledge about sexuality and about STDs including AIDs of

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\* Arabic Reference.

male university students are significantly higher than female university students. Also, they reported that sports and fasting are the mainly methods of coping with sexual needs among both male and female university students.

*Loutfi et al. (1984)* reported that 48.2% of educated employed wives defined marital relation as family relation only. This is a reflection of the cultural view that females are married only to form a family and that sex is a taboo. Also, sexual needs of females are usually ignored.

*El Fangary (2003)* reported that 81.7% of psychiatric female patients with sexual dysfunction had their main source of sex information from their family. Unlike the study on educated employed wives by *Loutfi et al. (1984)* where source of sexual information mainly was from friends (29.2%) and books (21.2%).

*Loutfi et al. (1984)* reported that 43.8% of educated employed wives stated that sexual orgasm and enjoyment of sexual intercourse is not essential for females. This shows that females are impelled to participate in sexual relation because of moral and cultural obligations rather than satisfaction of their own needs.

*Lotfy and El-Defrawy (1995)* reported that 61.5% of circumcised wives intend to circumcise their daughters (for religious tradition, family tradition or hygienic tradition). FGM is not prescribed by any religion, despite it is being practiced by Muslims and Christians. Religious leaders from Islamic and Christian communities have made statements condemning the practice of FGM (*The Royal Women's Hospital, 2009*).



Critical appraisal of the Egyptian studies on sexual and gender identity disorders was done intending to shed light on the missed points in these studies to overcome them in the future.

We report two limitations among most of the studies; first, the study design is not mentioned clearly, second, the size of the sample (power of the study) is not statistically calculated.

Finally, summary of all the studies which were used in our study are generated in order to evaluate our present state to aid the next researcher to identify new targets in their researches, (see appendix).

## **Recommendations:**

1. Establishing a national register system for all Egyptian researches and studies is an essential need. Presence of such system will allow recording of all Egyptian studies and so obtaining of these studies will be easier.
2. A more comprehensive national Egyptian survey involving all Egyptian governorates is needed to assess the prevalence of sexual and gender identity disorders.
3. It is important to have a research strategy aiming from time to time to revise the researches done, looking at the end for a complimentary work system.
4. Establishing strategic psychiatric research plan covering different aspects of each subject, as we found that some aspects of sexual and gender identity disorders were missed or neglected and it is observed that most of the studies have raised question for further research work and recommended many items to complete these researches, so, there is still a need for a well planned system of designing the research work.
5. Regarding thesis; study design and sample size calculation are crucial to be mentioned as study design is important in assessment of how much it is appropriate to the aim, while sample size calculation is important for the reliability of the study results.

6. We need more studies about gender identity disorders and management of sexual disorders. Also, further studies are needed to explore the genetic considerations implicated in the etiology of sexual and gender identity disorders.
7. We recommend that Library of Faculty of Medicine, Al-Azhar University would allow researchers to borrow or photocopy their available studies.

## **Limitations of the study:**

Some studies are not listed, as all Cairo University M.D. and M.Sc theses before 1990 are not presented in this study because they are neither available nor indexed in the library of faculty of medicine - Cairo University.

## **Appendix (1)**

- **Subject:** A psycho-social study of cases of psychogenic impotence (1970).

1. **Author:** Demerdash A.M.

**Supervisors:** Prof. Abbas Hassan, Prof. Moustafa Soueif, Prof. Paul Ghaliounghi and Dr. Ahmed Okasha.

2. **Document:** M.D. Thesis, Faculty of medicine, Ain Shams University, 1970.

3. **Site:** The department of Psychiatry, Ain Shams Faculty of medicine, The department of Psychiatry, Cairo Faculty of medicine and The Kuwait Psychiatric Hospital.

4. **Time:** Between June 1968 and October 1969.

5. **Aim of the work:** To study the psychogenic impotence and its etiological factors which are prominent in a given culture and less in another.

6. **Design of the study:** Cross sectional study.

7. **Method:** The sample is composed of 68 impotent patients (32 Kuwaitis, 17 Palestinians and 19 Egyptians). No case has organic or structural abnormalities, affective disorder, schizophrenia, drug or narcotic addiction. All patients are subjected to semi-structured psychiatric interview based on Maudsley psychiatric sheet, physical examination and EEG.

8. **Results:** (1) 75% of the Kuwaiti impotent patients, 70% of the Palestinian impotent patients and 73% Egyptian impotent patients are suffering from sexual inadequacy for more than 2 years. (2) A positive family history of mental illness is higher and statistically significant among Egyptian impotent patients as compared to

Kuwaiti and Palestinian impotent patients. (3) The incidence of pre-marital petting is significantly lower among Kuwaiti impotent patients as compared to Egyptian and Palestinian impotent patients. (4) The duration of the past history of homosexuality do not correlate significantly with the severity of sexual inadequacy.

- 9. Conclusion:** Impotent patients are religiously inactive, they smoke less, their scores are higher on neuroticism, they show a greater linearity of physique and they have a higher alpha index in the EEG.

## **Appendix (2)**

- **Subject:** A psychological and forensic study of rape in Cairo (1980).
  - 1. Author:** Abdelmessih M.S., Wagih. I.M. and Assaad F.
  - 2. Document:** Egyptian Journal of Psychiatry (1980).
  - 3. Site:** It is not mentioned.
  - 4. Time:** During 1978 and 1979.
  - 5. Aim of the work:** To study psycho-medicolegal aspects of rape.
  - 6. Design of the study:** Cross sectional study.
  - 7. Method:** 157 cases of rape are studied from various psycho-medicolegal aspects.
  - 8. Results:** The age of maximum incidence in rape victims is below 17 years, constituting 71.4% of cases. Interpersonal association shows that in 61.2% of the cases they are strangers. The most common place for committing rape is in close places. 89.8% of cases of rape are committed by a single assailant. The maximum

incidence is in spring and the minimum incidence was in winter.

- 9. Conclusion:** The results of sexual violence arising from crimes of rape are modified by a variety of factors. These include the circumstances of the encounter, the age of the victim. In addition to physical trauma, psychological concomitants are possible consequences of rape.

### **Appendix (3)**

- **Subject:** Sex therapy compared with placebo in the treatment of impotence (1982).
  1. **Author:** El Akabawi A.S. and Idarous A.
  2. **Document:** Egyptian Journal of Psychiatry (1982) 5: 271-281.
  3. **Site:** The outpatient department of the Venereal and Skin Diseases, Al Hussein University Hospital in Cairo.
  4. **Time:** During April and May 1981.
  5. **Aim of the work:** To observe treatment outcome using two models of therapy for impotent patients in Egypt, one is the often used drug therapy, the other is a combination of modified Masters and Johnson's instructions together with behavioural non directive interventions expressive psychotherapeutic sessions.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** The sample composed of 30 patients presenting with a complaint of impotence. In all patients, no organic cause was detected and the thirty patients satisfying the diagnostic criteria of secondary functional impotence used by Masters and Johnson (1970). Both

workers together met with each patient in an interview where patient were offered the choice between two types of treatment; a drug therapy or a talk therapy, without giving details of either. According to self selection, patient were divided into two groups; (1) non drug therapy group, consisted of 14 patients, all were seen by both therapists together, without their wives for 15 therapy sessions, sessions were 20 minutes each , held twice daily, (2) drug therapy group, consisted of 16 patients. All completed 15 prostatic massage sessions allowing for follow up notes to be recorded weekly, till the end of the study period (8 weeks). All patients in the two groups did not have previous treatment for impotence by a physician or a traditional healer.

- 8. Results:** (1) In non drug therapy group, 13 of the 14 patients improved, recording successful intercourse at and after the time of specified session. Timing of improvement varied, with the majority (10) taking place by 13<sup>th</sup> session. Only one patient did not improve, he showed a clinical syndrome of depression. Causative factors in all problems were related to interpersonal behavioral aspects of sexual activities except in 3 cases where intrapsychic aspects were more prominent. (2) In drug therapy group, 11 of 16 patients improved. Cases which did not improve were not suffering from an associated psychiatric disorder to warrant a psychiatric diagnosis other than impotence. Search for causative factors was not feasible as the explorative interview might have become in itself a therapeutic factor.
- 9. Conclusion:** Behavioral instructions are important in treating impotence. Involvement of the female partner does not seem essential in sex therapy. Brief



psychotherapy sessions seem to be as good as drug therapy.

## **Appendix (4)**

- **Subject: Knowledge and opinion of educated females about human sexuality (1984).**

1. **Author:** Loutfi I., El Geneidy M.M., El Geneidy M.M. and Ali F.A.
2. **Document:** Egyptian Journal of Psychiatry (1984) 7: 107-120.
3. **Site:** The Alexandria University Administration and the Egyptian copper factory in Alexandria.
4. **Time:** not mentioned.
5. **Aim of the work:** To obtain facts about the sexual knowledge, opinions and behaviour of educated Egyptian females and to identify the psycho-social factors associated with sexual experience.
6. **Design of the study:** Cross sectional study.
7. **Method:** The sample composed of 137 married, educated and employed females. The interviews were conducted by a highly qualified, well trained interviewer. Women were interviewed privately in their working places. The questionnaire sheet includes data about the characteristics of the ladies, their knowledge about human sexuality, their source of knowledge, time of acquiring this knowledge, problems related to human sexuality and their management.
8. **Results:** Sex is a subject avoided by Egyptian females and that females are inhibited in their sex practice. The main source of sex knowledge is outside the family.

Males are considered more knowledgeable and can discuss their problems more openly. The role of health professionals in sex counseling is denied by respondents.

- 9. Conclusion:** Human sexuality is a delicate subject avoided by most parents. Egyptian females play a passive role and are satisfied with their state of knowledge in relation to sexual matters. Health professionals are not seen as resource persons in sex counseling and thus sex problems would be discussed with close relatives and friends.

## **Appendix (5)**

- **Subject:** The sexual behaviour of a sample of male Egyptian epileptics (1986).
  1. **Author:** Demerdash A.M., Shaalan M.M., Osman A.M. and Kamal M.H.
  2. **Document:** Egyptian Journal of Psychiatry (1986) 9: 83-105.
  3. **Site:** The epileptic and dental outpatient clinics of El Hussein University Hospital in Cairo.
  4. **Time:** during 1983.
  5. **Aim of the work:** To study the sexual disorders among the male Egyptian epileptics.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** Seventeen male epileptic patients with sexual disorders selected from the epileptic outpatient clinic of El Hussein University Hospital and twenty randomly selected, closely matched healthy controls selected from the dental outpatient clinic of the same hospital. Each patient was subjected to the following: (1) A complete

psychiatric interview and neurological examination. (2) Sexual history according to the questionnaire devised by *Kinsey et al. (1948)*. (3) The patient's wife was interviewed when feasible in order to verify the former's statements regarding his sexual life. (4) *Eysenck and Wilson* questionnaire of sexual behaviour and attitudes (1976). (5) Wechsler Adult Intelligence Scale. (6) An EEG was done and detailed history of epilepsy was taken. The controls are subjected to *Eysenck and Wilson* questionnaire of sexual behaviour and attitudes (1976).

8. **Results:** A positive relation was found between family size, duration of illness, time and frequency of fits, type of epilepsy and the development of sexual disorders.
9. **Conclusion:** (1) Several forms of sexual disturbances are associated with epilepsy. (2) The causes of the occurrence of sexual disorders in epilepsy may be grouped under three main headings: (a) Psycho-social causes. (b) Biological causes. (c) Iatrogenic causes.

## **Appendix (6)**

- **Subject:** Sexual dysfunction in patients with major depression (1992).
  1. **Author:** Ahmed M.M. and Ezz El-Din S.
  2. **Document:** Egyptian Journal of Psychiatry (1992) 15: 2 July.
  3. **Site:** The outpatient psychiatric clinic of a private hospital in Saudi Arabia.
  4. **Time:** It not mentioned.
  5. **Aim of the work:** To study sexual dysfunction in depressed patients and its relation to hormonal

disturbance (testosterone and prolactine). Also to study the effect of treatment with tricyclic antidepressant on both the sexual dysfunction and the prolactin and testosterone levels.

- 6. Design of the study:** Cross sectional, case control longitudinal study.
- 7. Method:** Fifty male patients diagnosed as major depression according to DSM-III-R were selected randomly from outpatient psychiatric clinic of a private hospital in Saudi Arabia. They were initially assessed by psychometric tools as regards personality, anxiety and depression. Also their psychosexual functioning was asked about. Serum level of testosterone and prolactine were measured. Patients received tricyclic antidepressant in the doses of 75 mg to 100 mg/day for six months after which they were reassessed. Patients were divided into two groups according to their sexual functioning (27 patients suffered sexual dysfunction from the start and 19 patients admitted satisfied sexual performance in spite of their illness). Four patients were excluded because the possibility of organicity i.e. prostatic.
- 8. Results:** The depressed patients with sexual dysfunction have high significant level of anxiety, criminality and neuroticism and they are more significantly introvert. After treatment most of patients show sexual improvement but some patients do not improve sexually. Even some developed decrease in their sexual performance. There is significant increase in the level of prolactin and significant decrease in the level of testosterone in whole depressed patients, and there is no significant difference between those who improved sexually and those who do not improve sexually.

- 9. Conclusion:** 27/50 depressed patients complained of sexual dysfunction, 4/50 complained of organic sexual dysfunction and 15/27 depressed patients improved sexually although there is increase in the prolactin level and decrease in the testosterone level.

## **Appendix (7)**

- **Subject: Assessment of knowledge of child abuse in Suez Canal Area (1993).**

- 1. Author:** El-Defrawi M.H., Atef A., Ragab L. and Sobhy S.A.
- 2. Document:** Egyptian Journal of Psychiatry (1993) 16: 57-67.
- 3. Site:** Primary health care centers, maternal and child care centers, nurseries, kindergartens and day care centers.
- 4. Time:** It is not mentioned.
- 5. Aim of the work:** To assess the knowledge of nurses in primary health care units and nursery supervisors about the risk, developmental factors and behavioral problems that predispose preschool children to psychiatric disorders and child abuse in Ismailia, Suez and Port-Said governorates.
- 6. Design of the study:** Cross sectional descriptive study.
- 7. Method:** A sample of 453 child care providers (21 nurses from 21 primary health care centers in Ismailia rural areas, 120 nursery supervisors from all the 43 nurseries in urban Ismailia city, 23 nurses from all rural Suez villages, 63 nursery supervisors from nurseries in urban Suez city, 34 nurses working in maternal and child

care centers in Port Said governorate and 192 nursery supervisors in Port Said city) were interviewed to assess their knowledge and awareness about the risk, developmental factors and behavioral problems that predispose preschool children to psychiatric disorders and child abuse in Suez Canal Area. The Arabic form of the Child Behavioral Checklist originally designed to obtain standardized reports on children's problems (from parents and teachers) was used (*El-Defrawi, 1992*).

- 8. Results:** Results show a satisfactory level of knowledge about the risk factors. Nurses with longer duration of work experience are significantly more accurate to identify risk and developmental factors of child abuse.
- 9. Conclusion:** Child care providers should receive systematic training to identify potential cases for child abuse.

## **Appendix (8)**

- **Subject:** Effect of heroin abuse on pituitary-gonadal axis in male subjects (1993).
  - 1. Author:** Hashem A. and El-Orabi H.
  - 2. Document:** Egyptian Journal of Psychiatry (1993) 16: 91-97.
  - 3. Site:** Inpatients of Al-Salama Hospital in Jeddah, Kingdom of Saudi Arabia.
  - 4. Time:** It not mentioned.
  - 5. Aim of the work:** To investigate the effect of chronic opiate abuse on the pituitary gonadal axis.
  - 6. Design of the study:** Cross sectional, case control study.

- 7. Method:** The sample composed of 17 male chronic heroin abusers (7 with cannabinoid abuse and 10 without cannabinoid abuse) (more than six months duration) in the age range of 20 – 50 years and the controls are 13 apparently healthy male individuals with no previous drug taking for at least six months. Abusers and controls are subjected to the following: (1) Full psychiatric history concentrating on heroin abuse. (2) Sexual history concentrating on decrease libido and decrease erection. (3) Medical history and examination. (4) ECG, liver function tests, serum BUN and serum creatinine to exclude any medical disease. (5) Urine opiates and urine tetrahydrocannabinol, serum benzodiazepine, serum cocaine and serum amphetamine to exclude any other substance abuse except the cannabinoids. (6) Serum prolactin, serum FSH, serum LH and serum testosterone.
- 8. Results:** 47% of the patients reported symptoms of sexual dysfunctions. Hormonal assays demonstrated a significant reduction in serum testosterone and serum FSH in the patient group. A direct inhibitory effect of opiates on the secretory function of the testes and an indirect inhibitory effect on spermatogenesis were speculated.
- 9. Conclusion:** Chronic opiate abuse has an effect on the pituitary-gonadal axis in human male subjects mainly through reduction of testosterone and FSH secretion.

## **Appendix (9)**

- **Subject:** Psychiatric aspects of child abuse in Egypt (1994).
  1. **Author:** Abdel Rahman S. and Nashed E.R.
  2. **Document:** Egyptian Journal of Psychiatry (1994) 17: 137-145.
  3. **Site:** Two Egyptian primary schools.
  4. **Time:** not mentioned.
  5. **Aim of the work:** To explore child abuse with its subsequent hazards and psychiatric aspects from culture to culture.
  6. **Design of the study:** Cross sectional study.
  7. **Method:** The study was done on 1203 non-clinical primary school children (718 from low class schools and 485 from high class school). The age ranged from 6y to 12y and both sexes are included. A self-reported questionnaire (41 items) was constructed, the essential topics studied are: parental respect of child's needs, degree of parental care or negligence, parental attitude towards child's behaviour, firm aggressive rules in the family, magnitude of family aggression, parental psychological disturbance and addiction, abusing behavior (physical, sexual and psychological) and the possibility of the child to be a future abuser.
  8. **Results:** For sexual abuse; the rate of occurrence in both classes was 3.48% and 0.62% for low and high classes respectively.
  9. **Conclusion:** Sexual abuse appeared to be underestimated and accurate figures are difficult to obtain practically, the inquiry about sexual items was very difficult even in self-reported area.



## **Appendix (10)**

- **Subject:** A socio-demographic study of homosexuality in an Egyptian sample (1994).
  1. **Author:** Lotaief F., Asaad T., El-Mahalawy N., Shawky I., Ghanem M. and Refaat M.R.
  2. **Document:** Current Psychiatry Vol. 1 No. 2 December 1994.
  3. **Site:** It is not mentioned.
  4. **Time:** It is not mentioned.
  5. **Aim of the work:** To study the problem of homosexuality in an Egyptian sample.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** A sample of 270 individuals of different ages, sexes and educational level selected randomly. Each individual was given a structured questionnaire covering different items about the sexual orientation and behavior, in addition to socio-demographic data and a scale for religiosity.
  8. **Results:** A difference has been found in the socio-demographic profile between male homosexuals and female lesbians. The age of starting homosexuality tended to be younger in males, with lower marriage rate and less religiosity than females.
  9. **Conclusion:** There is no significant difference between homosexual men and lesbian women as regards the parental attitude, socialization and housing conditions (crowding).

## **Appendix (11)**

- **Subject:** Psychosexual impact of female circumcision (1995).
  1. **Author:** Lotfy G. and El-Defrawi M.H.
  2. **Document:** Egyptian Journal of Psychiatry (1995) 18: 123-131.
  3. **Site:** Family planning centers located in Maternal and Childhood Centers in Ismailia.
  4. **Time:** It not mentioned.
  5. **Aim of the work:** To assess the circumcision status and investigate the psychosexual activity of randomly selected wives.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** Two hundred and fifty women, who were attending the family planning centers located in Maternal and Childhood Center in Ismailia were gynecologically examined to assess their circumcision status, and if they were circumcised, the history concerning their circumcision was obtained including age and place at circumcision, the person who performed the circumcision and any associated complications. All recruited females were interviewed by a psychiatrist and a trained female nurse to obtain information about the psychosexual life and problems of those females by the use of the Arabic Version of the Sexual Behaviour Assessment Schedule - Adult (SEBA.A) (*Myer-Bahlburg and Erhardt, 1983*) which was translated into colloquial Arabic language, with accepted reliability and validity (*El – Defrawi, 1992*).

8. **Results:** Circumcision has a negative impact on the women psychosexual life and is still practiced on a large scale in Egypt.
9. **Conclusion:** (1) The assault on the female sex organs by circumcision, excision or infibulation has a profound effect on sex behaviour. (2) Female circumcision by excision with complete or partial removal of the clitoris gives psychological disturbance and less sex performance.

## **Appendix (12)**

- **Subject: Sexual dysfunction in relation to dialysis adequacy in haemodialysis patients (1995).**
  1. **Author:** Ibrahim M.A., Ghanem M., Barakat S., Abdel Ghani M. and El Said W.
  2. **Document:** Egyptian Journal of Psychiatry (1995) 18: 231-239.
  3. **Site:** The dialysis Units of Ain Shams University Hospitals and El-Bakry General Hospital.
  4. **Time:** not mentioned.
  5. **Aim of the work:** To investigate the possible value of KT/V and PCR in the prediction of sexual dysfunction in both male and female haemodialysis patients.
  6. **Design of the study:** Cross sectional study.
  7. **Method:** Sixty patients (48 male and 12 female) with primary end stage renal failure under regular haemodialysis treatment (30 under twice 6 hourly / week and 30 under thrice 4 hourly / week) with age range 22-67 years and duration of dialysis range 6-132 months were randomly selected from the dialysis Units of Ain

Shams University Hospitals and El-Bakry General Hospital. All Patients were subjected to the following steps: (1) Full history and routine clinical examination. (2) Sexual function questionnaire applied before and after the start of dialysis. (3) Zung's scale for depression and Taylor's test for anxiety. (4) Predialysis blood urea, serum creatinine, haemtocrite value. (5) Calculation of KT/V. (6) Calculation of protein catabolic rate (PCR). The statistical analysis of this work was done using personal computer with t-student test and r-test for correlations.

- 8. Results:** The only significant correlation detected was as positive one between age of the patient and disturbance in each of sexual petting, orgasm in female or ejaculation and erection in male.
- 9. Conclusion:** The parameters recently used to assess dialysis adequacy as KT/V and PCR are not sufficient to judge the sexual life of haemodialysis patients and that should be separately assessed and investigated to ensure general well being of these patients.

## **Appendix (13)**

- **Subject:** Remote psychiatric sequelae of sexual abuse in childhood (1995).
  - 1. Author:** Fahmy E.M., Michael V.S., Abdo A.S. and Al-Sheikh H.A.
  - 2. Document:** Current Psychiatry Vol. 2 No. 2 December 1995.
  - 3. Site:** Outpatient psychiatric clinics.
  - 4. Time:** It is not mentioned.

- 5. Aim of the work:** To findout demographic description of sexual abuse during childhood and study its relations to the different psychiatric disorders that might develop after.
- 6. Design of the study:** Cross sectional longitudinal study.
- 7. Method:** 627 patients (421 females and 206 males) attending outpatient psychiatric clinics, all above the age of 18 years. All cases were subjected to the following procedures: (1) Semi-structured psychiatric sheet and history of child sexual abuse. (2) Full psychiatric examination and diagnosis according to “International Classification of Diseases” ICD-10. (3) All cases with child sexual abuse are followed up in a psycho-analytically oriented psychotherapy weekly for two months, to find up any interrelation between sexual assault and psychiatric disorders.
- 8. Results:** There is a significant correlation between sexual abuse during childhood and disorders of adult personality and behavior especially disorders associated with sexual development and orientation, borderline personality disorder, substance abuse and behavioral syndromes associated with psychological disturbance.
- 9. Conclusion:** Sexual abuse in childhood has a constant and persistent destructive effect that reflects on the long term developmental process of the personality and remote impact on the psychological functions especially the behavior of human being and although its immediate effect may be cooled down, yet its deep, continuous pathological effect is continuously playing a destructive role.

## **Appendix (14)**

- **Subject: Female circumcision in Ismailia. A descriptive study (1996).**
  1. **Author:** El-Defrawi M.H., Lotfy G., Megahed H.E. and Sakr A.A.
  2. **Document:** Egyptian Journal of Psychiatry (1996) 19: 137-145.
  3. **Site:** Family planning centers of the ministry of health in Ismailia.
  4. **Time:** In the first six months of the year 1995.
  5. **Aim of the work:** To study the circumcised wives and the effects of circumcision on their psychosexual life.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** Two hundred circumcised wives and a control group of one hundred uncircumcised wives are randomly selected at the family planning centers in Ismailia. All women of both groups are gynecologically examined for the presence of any gynecological problems in the form of scar, infection and to exclude any gross pelvic pathology. Both groups (circumcised and uncircumcised wives) are interviewed by a psychiatrist and a trained female nurse by using the Arabic Version of the Sexual Behaviour Assessment Schedule- Adult (SEBA.A) (*Myer- Bahlburg and Erhardt, 1983*) to obtain information about the psychosexual life.
  8. **Results:** (1) While female circumcision was homogenously distributed in rural (27.5% and 41%) vs urban (31.5%), the highest percentages of uncircumcised women were from Ismailia city. (2) Female circumcision has a negative impact on the women psychosexual life.

- 9. Conclusion:** Female circumcision appears to be significantly associated with illiteracy and low level of education, more prevalent in rural than urban communities, and also, associated with negative psychosexual life and gynecological problems.

## **Appendix (15)**

- **Subject:** ECT and sexual activity in males with major depressive illness (1997).

1. **Author:** El Sheikh H.E. and El Fouly M.
2. **Document:** Current Psychiatry Vol. 4 No. 1 July 1997.
3. **Site:** Benha University Hospital.
4. **Time:** It is not mentioned.
5. **Aim of the work:** To study the acute effects of a clinical course of ECT on pituitary sex hormones (PRL, LH and FSH) among a group of males having major depressive disorder.
6. **Design of the study:** Cross sectional study.
7. **Method:** ECT was done to 15 major depressive male patients (DSM-IV), their age ranged between 34 and 65 years old. Blood sample were taken before the anaesthetic was administered and 15 minutes after convulsions (the last one). All hormones were measured in the same laboratory with radio immune assay prolactin. LH and FSH were measured using commercially available kits.
8. **Results:** ECT levels of prolactin and LH were significantly higher than pre-ECT levels. Changes of FSH were not significant.

**9. Conclusion:** ECT resulted in an elevation of basal prolactin and LH and this may prove the antidopaminergic effect of ECT. Post ECT improvement of sexual activity in depressed patients may be related to elevated levels of LH and subsequent elevation of testosterone.

## **Appendix (16)**

- **Subject:** Sex hormones serum levels in men with temporal lobe epilepsy (1997).

**1. Author:** Awny T.M.M.

**Supervisors:** Prof. Abdel Latif Moussa Osman and Prof. Fathi Mohammed Afifi.

**2. Document:** M.D. Thesis, Faculty of medicine, Al-Azhar University, 1997.

**3. Site:** The epilepsy clinic at Al-Hussein University Hospital.

**4. Time:** During the period between December 1, 1995 and August 30, 1996.

**5. Aim of the work:** It is mentioned.

**6. Design of the study:** Cross sectional, case control study.

**7. Method:** 20 male patients with complex partial seizures of temporal lobe origin, 20 male patients with epilepsies other than temporal lobe origin and 20 apparently healthy males, have normal EEGs. Sexual dysfunctions are diagnosed according the criteria of *American Psychiatric Association (1994)*. EEG and the serum levels of F.S.H., L.H., prolactin, testosterone, free testosterone and sex hormone binding globulin are assayed for each subject.



8. **Results:** Sexual dysfunctions are common among men with temporal lobe epilepsy. Moreover, decreased free testosterone levels or hyperprolactinemia are commonly associated with these sexual dysfunctions. Hyperprolactinemia which is found in men with temporal lobe epilepsy is mostly caused by the epilepsy itself.
9. **Conclusion:** Sexual dysfunctions and changes in the sex hormones serum levels are reported.

## **Appendix (17)**

- **Subject:** Presentation of female sexual dysfunctions in medical practice (1998).

1. **Author:** Abed M.G.  
**Supervisors:** Prof. Mostafa Kamel Ismail, Prof. Salah El-din Kamel and Prof. Khadiga Ragheb.
2. **Document:** M.D. Thesis, Faculty of medicine, Al-Azhar University for Girls, 1998.
3. **Site:** Gynecological outpatient clinic of Al-Zahraa University hospital.
4. **Time:** It is not mentioned.
5. **Aim of the work:** (1) To detect the relative frequency of common sexual problems presenting to outpatient clinic of Al-Zahraa University hospital. (2) To throw lights on the characteristics of the disguised forms of sexual dysfunctions. (3) To find out the possible psychological factors underlying sexual dysfunctions.
6. **Design of the study:** Cross sectional, case control study.
7. **Method:** 33 women with sexual complaint (sexual group SI). 33 women with gynecological complaint while they

reveal their sexual problem after screening (disguised group DII). 33 women declare the presence of some sexual difficulties that they do not consider problematic (comparative group CIII). The following tools are used: (1) A general sexual screen proposed by *Sheahan (1989)*. (2) A semi-structured interview tailored to fit the aim of the work. (3) The multi axial problem oriented questionnaire for sexual dysfunction proposed by *Schover et al (1982)*. (4) A marital satisfaction inventory (global version) designed by *El Biblawy\* (1987)*. (5) The DSFI (Derogatis sexual functioning inventory) designed by Derogatis, translated into arabic version and tested for validity and reliability by *Mohammed\* (1989)*.

- 8. Results:** (1) Sexual group tend to significantly present their arousal problems by dyspareunia (83.3% of cases). They significantly present the chronic problems associated with general unresponsiveness and anorgasmia by somatic presentation in 66.7% of cases. Vaginal redundant presentation, while is gynecologically free is a typical disguised presentation of chronic desire problems with general unresponsiveness. (2) Vaginismus and vaginal redundancy are typical presentation of sexual group. (3) Sexually presented women tend relatively to accept sexuality as integral part of their identity.
- 9. Conclusion:** (1) Isolation of sexual problems from the marital relation is a tendency furtherly proved among the studied sample, as it was detected a lack of association between somatic presentation and marital satisfaction. (2) No association was proved between a definite

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\* Arabic Reference.

gynecological presentation and any of the disguised presentation i.e. the disguised problems couldn't be practiced from their gynecological presentation.

## **Appendix (18)**

- **Subject: Late psychiatric sequelae of childhood sexual abuse (1998).**

**1. Author:** Sayed H.Y.

**Supervisors:** Prof. Sanaa Ahmed Ali, Assist. Prof. Lamis El-Raey and Assist. Prof. Azza El-Bakrey.

**2. Document:** M.Sc Thesis, Faculty of medicine, Cairo University, 1998.

**3. Site:** Psychiatric outpatient clinic in Kasr el Aini hospital.

**4. Time:** From 1<sup>st</sup> of June to the end of August 1997.

**5. Aim of the work:** To determine the prevalence of childhood sexual abuse among a sample of psychiatric patients and to study the impact of childhood sexual abuse on adult psychological functioning.

**6. Design of the study:** Cross sectional, case control study.

**7. Method:** 60 patients with history of childhood sexual abuse are selected and are compared with 60 patients without a history of sexual abuse. All are subjected to the following measures; full psychiatric sheet, Symptoms Check List-90, Ego Strength Scale, Defense Style Questionnaire and a structured adult sexual functioning. Also, abused patients are subjected to Negative Appraisals of Sexual Abuse Questionnaire.

**8. Results:** (1) A significant proportion of psychiatric patients are survivors of childhood sexual abuse. (2)

Many survivors of childhood sexual abuse do not seek treatment for the abuse itself, but for other symptoms such as depression, somatisation, sexual dysfunction, or substance abuse. Some of these patients may not be identified as sexual abuse victims throughout the entire course of their treatment.

- 9. Conclusion:** Certain psychiatric disorders are prevailing more in patients with history of childhood sexual abuse.

## **Appendix (19)**

- **Subject: Domestic violence and female genital mutilation (1999).**

- 1. Author:** Refaat A., Dandash K. and El-Defrawi M.H.
- 2. Document:** Egyptian Journal of Psychiatry (1999) 22: 209-218.
- 3. Site:** not mentioned.
- 4. Time:** not mentioned.
- 5. Aim of the work:** To determine the association between female circumcision and attitude of Egyptian women towards wife beating by husbands.
- 6. Design of the study:** Cross sectional, case control study.
- 7. Method:** Secondary analysis of women status questionnaire of EDHS-95 was conducted. The characteristics of wife beaten including their circumcision status were investigated. Acceptance that husbands are justified to beat wife was examined.
- 8. Results:** Ever beaten women were universally circumcised (99%), mostly from rural areas, living in lower economic levels, not educated or had primary education, married to uneducated husband or who had

primary education, and not working in their majority. Acceptance of husbands are justified to beat wife was more likely to be 7.5 times among circumcised women than not circumcised ones. Results of multivariate analysis showed that this influence is still the strongest determinant even after introduction of education, working, economic level and residence variables.

- 9. Conclusion:** Female circumcision shapes the attitude of women to accept abuse and beating. The practice of female genital mutilation on young girls leads to their future acceptance of violence from husbands mainly for refusing sex with them.

## **Appendix (20)**

- **Subject:** Descriptive study of some Egyptian females having sexual dysfunction (1999).
  - 1. Author:** Owida M.A. and Amin A.E.
  - 2. Document:** Egyptian Journal of Psychiatry (1999) 22: 257-265.
  - 3. Site:** Gynecological outpatient clinics of Al-Azhar University Hospitals in Cairo.
  - 4. Time:** From 15 March – 14 August 1998.
  - 5. Aim of the work:** To illustrate the socio-demographic and clinical profile of some Egyptian females patients having sexual dysfunction and attending Al-Azhar University Hospitals irrespective of having direct complaints of sexual dysfunction or not.
  - 6. Design of the study:** Cross sectional study.
  - 7. Method:** a sample of 163 wives having sexual dysfunction was selected randomly from gynecological

outpatient clinics of Al-Azhar University Hospitals in Cairo. They are subjected to semi-structured psychiatric interview, semi-structured sexual dysfunction questionnaire and gynecological examination to exclude organic causes.

8. **Results:** Most of the sample are working and educated. Only 30.1% of the sample complains directly from manifestations of sexual dysfunction. The majority of the sample complains from pelvic heaviness (38.7%) and low back pain (28.8%). The most common diagnoses are: nonorganic dyspareunia (15.3%), nonorganic vaginismus (14.7%) and lack or loss of sexual desire (13.5). The least frequent are: marked feeling of inadequacy of body and sex organs (1.8%), failure of genital response (2.5%) and excessive masturbation (3.1%).
9. **Conclusion:** Career and educated women constituted the majority of the sample, as seeking problems of sexual dysfunction are oftenly distressing to patients and their partners.

## **Appendix (21)**

- **Subject:** Childhood sexual abuse in female depressed psychiatric inpatients: Prevalence and relationship to depression (1999).
1. **Author:** Soliman A., Okasha T. and El Rasheed A.H.
  2. **Document:** Current Psychiatry Vol. 6 No. 3 July 1999.
  3. **Site:** Acute adult psychiatric unit at Thameslink NHS Trust, Kent, England.
  4. **Time:** During 1999.

- 5. Aim of the work:** To increase awareness of childhood sexual abuse (CSA) and its consequences in adult life.
- 6. Design of the study:** Cross sectional study.
- 7. Method:** 78 depressed inpatient women between the age of 18-49, admitted to acute adult psychiatric unit at Thameslink NHS Trust, Kent, England. Diagnoses ranged from moderate to severe depressive episodes with or without psychotic symptoms according to ICD-10 criteria (*World Health Organization, 1992*). Patients are interviewed, as a part of a semi-structured psychiatric interview, regarding occurrence of sexual abuse during childhood. Subjects who reported CSA are compared with those who did not report these experiences.
- 8. Results:** 35 (44.9%) depressed women reported CSA with 19.2% having genital penetration. Intrafamilial abuse, threatened or used violence and inability to disclose the abuse occurred in the majority. CSA is associated with higher indices of psychopathology.
- 9. Conclusion:** The study showed that approximately 4 to 5 every 10 depressed inpatient women suffered CSA and at least 2 every 5 of abused women had genital penetration and that more than 50% of abuse was inside the family. The presence of CSA is a poor prognostic factor as depressed women with history of sexual abuse were more likely to have longer periods of hospitalization, more frequent episodes and unsatisfactory response to medication.

## **Appendix (22)**

- **Subject:** Childhood sexual abuse in depressed female inpatients: A 2-year follow-up study and an explanatory cognitive model (2000).
  1. **Author:** Soliman A.E. and Effat S.M.
  2. **Document:** Egyptian Journal of Psychiatry (2000) 23: 1 January.
  3. **Site:** It is not mentioned.
  4. **Time:** During 1997, with follow up for 24 months.
  5. **Aim of the work:** To study the impact of childhood sexual abuse (CSA) on the severity and long-term outcome of depression.
  6. **Design of the study:** Cross sectional study.
  7. **Method:** 75 depressed female inpatients, who were admitted for moderate and severe depression during 1997, were prospectively followed up for 24 months. Age ranged from 18 to 49 years. All patients completed Beck Depression Inventory (BDI) (*Beck et al, 1961*) after one and two years from admission and were clinically assessed by a semi-structured interview on both occasion for DSM-IV (*American Psychiatric Association, 1994*) axis-I diagnoses. Patients also completed The Social Adjustment Scale, self-reported version (SAS-SR) (*Weissman and Bothwell, 1976*) on both occasions.
  8. **Results:** (1) Sexually abused patients have higher rates of suicidal attempts and service utilization, and are more socially maladjusted than non-abused patients. (2) Analysis of depressive symptoms revealed a



characteristic negative cognitive set linking child sexual abuse (CSA) to depression in these patients.

- 9. Conclusion:** Depression is one of the most common sequelae of CSA. CSA is associated with poor outcome in depressed women and highlights the importance of preventive and early interventive measures of CSA.

## **Appendix (23)**

- **Subject:** Marital satisfaction in parents living with a schizophrenic offspring: a neglected topic (2000).
  1. **Author:** Sarhan Z., El-Gindy T., Abdel Latif A.M., El Batrawi M. and Ezat M.
  2. **Document:** Egyptian Journal of Psychiatry (2000) 23: July.
  3. **Site:** Private mental hospital in Cairo.
  4. **Time:** In the period from 1/10 /1997 to 1/5/1998.
  5. **Aim of the work:** To study nature of marital stresses in parents living with a schizophrenic offspring and compare them with a control group of normal parents.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** Parents of 30 single schizophrenic patients, compared with a control group of 20 parents of normal offspring. Full psychiatric sheet applied to patients and the arabic version of marital satisfaction inventory (*El Biblawy*\*, 1987) applied to the parents of the patients and control group.
  8. **Results:** (1) Fathers of schizophrenics have significantly higher score of sexual dissatisfaction subscale of marital

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\* Arabic Reference.

satisfaction inventory than fathers of normal offspring.  
(2) Mothers of schizophrenics have higher score of sexual dissatisfaction subscale of marital satisfaction inventory than mothers of normal offspring, but without significant difference.

- 9. Conclusion:** Fathers of schizophrenics express significantly higher marital distress and sexual dissatisfaction.

## **Appendix (24)**

- **Subject:** Some psychosexual aspects of female circumcision: A pilot study in Sharkia (2000).
  1. **Author:** Abdel Azim E., Shalanda A.A., Abdellatef R.R., Basiouny M., Khashaba A.M., Sweelem Sh. and Askar A.
  2. **Document:** Current Psychiatry Vol. 7 No. 2 July 2000.
  3. **Site:** Gynecological outpatient clinic for family planning at Zagazig University Hospitals.
  4. **Time:** In the period from September 1999 to March 2000.
  5. **Aim of the work:** To study the sexual satisfaction and dysfunction in married females and their couples correlated to female circumcision.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** 70 circumcised wives and 70 uncircumcised wives with age range from 18 to 45 years old are subjected to questionnaire for circumcision for the circumcised wives, gynecological and pelvic examination and semi-structured psychiatric interview. The wives diagnosed as having sexual dysfunction by

psychiatric interview are submitted to the sexual dysfunction questionnaire based on the questionnaires of *Clayton et al. (1997) and Corty et al. (1998)* to confirm the diagnosis. The husbands must be healthy without general medical illness and psychiatric disorder or taking medications. The sexual satisfaction is further investigated by the Golombok Rust Inventory of Sexual Satisfaction (GRISS) (*Rust and Golombok, 1985*) for both circumcised and uncircumcised wives and their husbands.

- 8. Results:** (1) The circumcised wives have more sexual dysfunction than the uncircumcised wives especially in the following types: orgasmic dysfunction, disturbed resolution phase with pelvic heaviness and low backache and non organic vaginismus and dyspareunia. (2) The circumcised wives and their husbands are significantly less sexually satisfied than the uncircumcised wives and their husbands.
- 9. Conclusion:** Female circumcision affects some of the psychosexual aspects (sexual satisfaction and dysfunction) either to the wives or indirectly to their husbands.

## **Appendix (25)**

- **Subject:** The prevailing sexual activities in substance use culture in Egypt using focus group technique (2000).
  - 1. Author:** Ismail I.A. and Hafez A.S.
  - 2. Document:** Current Psychiatry Vol. 7 No. 2 July 2000.
  - 3. Site:** Substance Use Treatment Center in Abbasia Mental Hospital.

4. **Time:** It is not mentioned.
5. **Aim of the work:** To discover opinions, beliefs and attitudes about sexual practices prevailing among substance users in Egypt.
6. **Design of the study:** Cross sectional study.
7. **Method:** A volunteer sample of 14 male substance users inpatients, aged from 21 to 45 years, all are unemployed for at least one year; at the time of the study. Five of them are married, two are divorced and seven are singles. The researchers use a qualitative design, namely “focus group technique” to understand attitudes and beliefs that are developed within a social context (*Ramirez and Shepperd, 1988*). After a preparatory phase, they sit with the patients 3 times for preparation over a period of 2 weeks length before conducting the group. They hold two sessions on 2 successive days for 90 minutes each and detailed notes are taken by two trained note takers.
8. **Results:** Substance users mention that drugs are use in order to do good sex. Also, they used that no one of substance users wears the condom on practicing sex and no one of substance users cares about regular screen for the possible infection of one of sexually transmitted diseases.
9. **Conclusion:** The findings highlight the urgent need for health education for the substance users as well as their need to be enrolled in a health surveillance system for early detection and proper management of any emerged infection among these patients and/or their relatives.

## **Appendix (26)**

- **Subject: Sexual dysfunction and paraphilias of general medical hospital male in-patients (2000).**

**1. Author:** Habeeb B.F.

**Supervisors:** Prof. Said Abdel Azim, Prof. Kamal Zaki and Prof. Ahmed Abdel Latif.

**2. Document:** M.Sc Thesis, Faculty of medicine, Cairo University, 2000.

**3. Site:** Medical and surgical departments in Cairo University Hospitals.

**4. Time:** It is not mentioned.

**5. Aim of the work:** To study the sexual dysfunction and paraphilias in general medical hospital male in-patients, to study the effect of different demographic variables on sexual function, to study the effect of psychiatric comorbidity - if present - on sexual function.

**6. Design of the study:** Cross sectional study.

**7. Method:** 80 male patients, age ranged from 20 to 60 years, collected from medical and surgical departments, not having terminally ill and can read and write are subjected to: (a) Detailed psychiatric sheet. (b) General Health Questionnaire (GHQ). (c) International Index of Erectile Function (IIEF). (d) A questionnaire derived from the DSM IV asking for sexual deviations in addition to homosexuality. (e) Norbeck Social Support Questionnaire (NSSQ). (f) Two hours post prandial blood sugar.

**8. Results:** (1) There is a highly negative correlation between age and sexual function. (2) Patients diagnosed as having D.V.T. have significantly the worst sexual

function and patients diagnosed as having minor anal surgical problem have significantly the best sexual function among the patients of different diseases. (3) There is a significant difference in the sexual function respecting the religious history. (4) There is a significant negative correlation between erectile function and somatization, anxiety and interpersonal sensitivity, while there is a significant negative correlation between erectile function and O.C.D.

- 9. Conclusion:** Type of education, type of work and the amount of social support do not have significant effect on sexual function. Religiosity has significant negative effect on the sexual function.

## **Appendix (27)**

- **Subject:** Gender difference regarding knowledge and attitude towards sexuality among university students in Port Said, Egypt (2001).
  - 1. Author:** Nagia I., Akram K.W., Mervat M.G. and Abdulmajeed A.
  - 2. Document:** Current Psychiatry Vol. 8 No. 1 March 2001.
  - 3. Site:** Faculties and institutions of Suez Canal University in Port Said governorate.
  - 4. Time:** It is not mentioned.
  - 5. Aim of the work:** To assess knowledge and attitude of university students about sexuality to identify factors affecting them and to know their education need.
  - 6. Design of the study:** Cross sectional descriptive study.

- 7. Method:** A sample of 170 males and 286 females of first year university students. A written structured questionnaire is designed and used to assess the knowledge and attitudes about sexuality and sex education.
- 8. Results:** (1) The total mean of knowledge of different areas is higher among males ( $38.7 \pm 20.8$ ) than females ( $21.4 \pm 17.7$ ). (2) The total score of males ( $25.3 \pm 15.5$ ) are more than females ( $17.9 \pm 11.7$ ) regarding their knowledge about STDs and AIDs. (3) Most of the sample population believes that they can cope with their sexual needs by sporting (80% of males and 46.2% of females).
- 9. Conclusion:** (1) Males have more knowledge about the anatomy of the female reproductive system than females themselves. (2) Male students have more knowledge about masturbation than females. (3) The sample knowledge about sexually transmitted diseases shows that both sexes have knowledge about AIDs more than other diseases (gonorrhea, syphilis and viral hepatitis). (4) As regards methods of coping with sexual needs, the majority choose sports and fasting.

## **Appendix (28)**

- **Subject:** Psychiatric aspects of juvenile delinquency (2001).

**1. Author:** Mohammed H.T.

**Supervisors:** Prof. Khadiga Ragheb and Prof. Adel Demerdash.

2. **Document:** M.Sc Thesis, Faculty of medicine, Al-Azhar University for Girls, 2001.
3. **Site:** The Ain Shams Institute for female juvenile.
4. **Time:** It is not mentioned.
5. **Aim of the work:** To study the psychological characteristics of a sample of young delinquent females.
6. **Design of the study:** Cross sectional study.
7. **Method:** 30 delinquent females aged from 12-20 years, referred from juvenile courts committing one or more sexual crime. Physical, neurological and psychiatric examination were done, also psychological tests (Beck depression Inventory, Hamilton Anxiety Scale, Hand Projection Scale and personality disorder according to DSM-III-R) are done to assess the personality and any psychiatric disorder.
8. **Results:** As regards the sexual experience: (1) about one fifth of the sample 6/30 (20%) report prepubertal sexual experience, in the form of rape. (2) The incidence of a positive history of postpubertal sexual experience (petting – rape – sexual intercourse) reaches a value of 28/30 (93%) of the sample. (3) 10/30 (33.3%) of the subjects report sexual relations with the same sex (lesbianism).
9. **Conclusion:** (1) Sexual activity among delinquent adolescents is greater than that the general adolescent population. (2) Female adolescent antisocial behaviour is primarily sexual in nature and takes predominant form of delinquent behaviour.



## **Appendix (29)**

- **Subject:** Study of changes of sex hormones and sexual functions in a sample of Egyptian male epileptics (2002).

**1. Author:** El-Azoony A.A.M.

**Supervisors:** Prof. Mohamed El-Etribi, Prof. Samia Ashour, Prof. Nevin El Nahas and Dr. Azza Abd El-Nasser.

**2. Document:** M.D. Thesis, Faculty of medicine, Ain Shams University, 2002.

**3. Site:** Outpatient clinics of Neurology department, Ain Shams University hospital and Ain Shams University specialized hospital.

**4. Time:** it is not mentioned.

**5. Aim of the work:** (1) To detect the possible changes in sex hormones in male epileptic patients and to assess their sexual functions. (2) To study the role of anti-epileptic medication on those hormonal changes.

**6. Design of the study:** Cross sectional study.

**7. Method:** One hundred male epileptic patients, aged from 18-50 years are subjected to epilepsy sheet, psychosexual questionnaire, CT scan brain, MRI, EEG, hormonal assay (FSH, LH, prolactin, total testosterone, free testosterone and estradiol), serum level of anti-epileptic drugs and liver function tests.

**8. Results:** Global hyposexuality is presented in 18% of the male epileptics which involve the three spheres of sexual functions: (libido, potency and ejaculation). In those patients with global hyposexuality we found significantly low level of free testosterone, higher level

of estradiol and significant hyperprolactinaemia. This global hyposexuality is commoner among patients with partial epilepsy than patients with generalized epilepsy.

- 9. Conclusion:** (1) Hormonal disturbances and hyposexuality met with in epileptic men are more prevalent among partial epileptics than generalized epileptic men. (2) Drug related hormonal changes met with in our study could be a major contributing factor of hyposexuality and impotence among epileptic men.

## **Appendix (30)**

- **Subject: Sexual dysfunction in female psychiatric patients (2003).**

**1. Author:** El Fangary N.M.

**Supervisors:** Prof. Said Abd-El Azim Mohammed, Prof. Mohsen Abd El Aziz Askar and Prof. Maher Mohamed Ahmed.

**2. Document:** M.D. Thesis, Faculty of medicine, Cairo University, 2003.

**3. Site:** Psychiatric and gynecological outpatient clinics in Kasr el Aini hospital.

**4. Time:** It is not mentioned.

**5. Aim of the work:** To explore the frequency and the characteristics of sexual dysfunction in female psychiatric patients, to explore the relationship between hormone levels and sexual dysfunction and to identify the extent of marital adjustment.

**6. Design of the study:** Cross sectional, case control study.

**7. Method:** 150 new female cases sexually active presenting to the psychiatric or gynecological outpatient

clinics haven't organic cause for sexual dysfunction and not menopause. At first screening is done for sexual dysfunction. Patients are divided into three groups; group (A): 60 psychiatric patients without sexual dysfunction, group (B): 60 psychiatric patients with sexual dysfunction and group (C): 30 non psychiatric patients with sexual dysfunction. Then assessment for personality, marital adjustment, sexual functioning, general information, sexual drive, sexual attitude, body image and sexual satisfaction, screening for the level of testosterone, prolactine, F.S.H. and L.H. hormones was performed to the patients with sexual dysfunction (group B and C).

- 8. Results:** (1) Psychiatric patients show more sexual dysfunction, personality pathology and marital dissatisfaction than non psychiatric patients. (2) Psychiatric patients show less general information, less sexual drive and a worse sexual attitude than non psychiatric patients.
- 9. Conclusion:** (1) Sexual dysfunction is a common problem in psychiatric patients. (2) Personality plays an important role in sexuality as it affects attitude towards sex and sexual behavior. (3) Culture plays an important role in the presentation of sexual dysfunction in females.

## **Appendix (31)**

- **Subject: Role of the spouse in addiction: Is there a contribution (2004).**
  - 1. Author:** Abolmagd S., Erfan S.M.F., Abdel Wahab M. and Abdel Gawad T.M.S.

2. **Document:** Egyptian Journal of Psychiatry Vol. 23 No. 1 January 2004.
3. **Site:** It is not mentioned.
4. **Time:** It is not mentioned.
5. **Aim of the work:** To assess the psychological profile of spouses of addicts and to identify patterns of marital dysfunction among heroin addicts.
6. **Design of the study:** Cross sectional, case control study.
7. **Method:** 30 heroin addicts for at least two years, married for at least two years also. The age range between 24-45 years. Evidence for organic, psychotic or substance use disorder is excluded in the spouses of the 30 heroin addicts. The control group composed of 30 male adults and their spouses matched for age, social background and duration of marriage. Heroin addicts were subjected to Guilford aggression scale and marital satisfaction inventory. Spouses were subjected to the same scales in addition to Hamilton depression and Hamilton anxiety scales.
8. **Results:** Spouses of addicts show significant dissatisfaction on all parameters of marital satisfaction inventory (includes sexual satisfaction) as compared to controls.
9. **Conclusion:** Spouses of addicts show significantly high levels of dissatisfaction in all domains of marital relations (include sexual satisfaction).

## **Appendix (32)**

- **Subject:** A study of sexual aspects in a sample of male schizophrenic patients (2005).

1. **Author:** Mohammed H.Y.  
**Supervisors:** Prof. Abdel Hamid Hashem, Prof. Tarek Mohammed Samy Abd El-Gawad and Prof. Mohammed Ezzat Amin Khalil Arafa.
2. **Document:** M.Sc Thesis, Faculty of medicine, Cairo University, 2005.
3. **Site:** In-patient department of private psychiatric hospital in Cairo (Dar El Mokattam for mental health).
4. **Time:** From April 2003 to December 2003.
5. **Aim of the work:** To study the sexual dysfunction in a sample of male paranoid schizophrenics and non-paranoid schizophrenics and to determine the underlying factors that control sexual dysfunction.
6. **Design of the study:** Cross sectional comparative study.
7. **Method:** 60 male schizophrenics (DSM-IV) (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia), the age range from 18-60 years old. Every patient is subjected to a semi-structured psychiatric interview, Positive and Negative Symptom Scale (PANSS) (*Kay et al., 1987*), Sexual Behavioural Questionnaire (SBQ) by *MacDonald et al. (2003)* and serum prolactin level.
8. **Results:** 80% of paranoid schizophrenics and 86.7% of non-paranoid schizophrenics have at least one sexual dysfunction. Sexual function of paranoid schizophrenics is affected by socio-demographic factor (aging) and clinical factors (age of onset, duration of illness and duration of hospitalization) and hyperprolactinaemia. Sexual function of non-paranoid schizophrenics is affected by onset of illness and hyperprolactinaemia. Paranoid schizophrenics report more satisfaction with

their intensity of orgasm than non-paranoid schizophrenics.

- 9. Conclusion:** Patients with schizophrenia report higher rates of sexual dysfunction. This sexual dysfunction is due to multiple factors; subtype of schizophrenia, age, age at onset, duration of the illness, duration of hospitalization, hyperprolactinaemia and mental state.

## **Appendix (33)**

- **Subject:** A comparative study of sexual function in paranoid versus non- paranoid schizophrenic patients and its relation serum prolactin level (2006).
  1. **Author:** Hashem A.H., Abd El-Gawad T., Ezzat M., Assal A., Goueily T. and El Rakhawy M.
  2. **Document:** Current Psychiatry Vol. 13 No. 2 July 2006.
  3. **Site:** In-patient department of private psychiatric hospital in Cairo (Dar El Mokattam for mental health).
  4. **Time:** From April 2003 to December 2003.
  5. **Aim of the work:** To study the sexual dysfunction in a sample of male paranoid schizophrenics and non-paranoid schizophrenics and to determine the underlying factors that control sexual dysfunction.
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** 60 male schizophrenics (DSM-IV) (30 with paranoid schizophrenia and 30 with non-paranoid schizophrenia), the age range from 18-60 years old. They can read and write. No history of physical disorder that may share in sexual dysfunction and no recent history of substance abuse. Every patient is subjected to a semi-structured psychiatric interview, Positive and Negative

Symptom Scale (PANSS) (*Kay et al., 1987*), Sexual Behavioural Questionnaire (SBQ) by *MacDonald et al. (2003)* and serum prolactin level.

- 8. Results:** 80% of paranoid schizophrenics and 86.7% of non-paranoid schizophrenics have at least one sexual dysfunction. Sexual function of paranoid schizophrenic patients is affected by socio-demographic factor (aging) and clinical factors (age of onset, duration of illness and duration of hospitalization) and hyperprolactinaemia. Sexual function of non-paranoid schizophrenic patients is affected by onset of illness and hyperprolactinaemia. Paranoid schizophrenics report more satisfaction with their intensity of orgasm than non-paranoid schizophrenics.
- 9. Conclusion:** Sexual dysfunction is common in male schizophrenics. Paranoid schizophrenics and non-paranoid schizophrenics have a different pattern of sexual dysfunction and are affected differently with different factors.

## **Appendix (34)**

- **Subject:** Child abuse among preparatory school students in Cairo and its psychiatric sequelae (2006).
  - 1. Author:** Hamed R.A.  
**Supervisors:** Prof. Khadiga Ragheb, Prof. Said Abdel Azim, Prof. Amira Seif El-din, Assist. Prof. Hussein Attia and Dr. Reda Ismail.
  - 2. Document:** M.D. Thesis, Faculty of medicine, Al-Azhar University for Girls, 2006.

3. **Site:** 6 preparatory schools present in Nasr city, El Zeitoun and El Waily; in Cairo.
4. **Time:** The academic years 2003-2004 and 2004-2005.
5. **Aim of the work:** To study child abuse among a sample of preparatory school students in Cairo.
6. **Design of the study:** Cross sectional, case control study.
7. **Method:** 1500 preparatory school students, age ranged between 12-16 years, 900 from governmental schools (60%) and 600 from language schools (40%), 801 males (53.4%) and 699 females (46.6%). The following tools are used: (1) The arabic version of Child Maltreatment Questionnaire (*Straus, 1990*) translated by Hassan et al, (1999). (2) The arabic version of Mini International Neuropsychiatric Interview for children and adolescents (*Sheehan et al*). (3) Revised Behaviour Problem Checklist (RBPC) (*Achenbach, 1991*). (4) The arabic version of Copper smith Self-Esteem Inventory (*Mussa and Dusuki, 1991*). In most cases, the headmaster referred the researcher to the school sociologist to facilitate the research conduction.
8. **Results:** (1) Adolescents living in large families, illiterate mother, lower level of father education, unemployment of mother and father are in the higher risk for being exposed to all types of abuse and neglect. (2) Adolescents from governmental schools, eldest or middle in position, with chronic health status problems are of great risk to abuse and neglect. (3) Sexual abuse is more common in males. (4) Low self esteem is related to exposure to all types of abuse and neglect. (5) About half the children who exposed to sexual abuse suffer from major depressive episode; also anxiety is related to sexual abuse.



- 9. Conclusion:** (1) A significant proportion of Adolescents living in large families, illiterate mother, lower level of father education, unemployment of mother and father suffer from all types of abuse and neglect. (2) Low self esteem, a major depressive episode and anxiety withdrawal are related mostly to sexual abuse.

## **Appendix (35)**

- **Subject:** Sexual dysfunction and relation to used drugs and smoking in a sample of chronic schizophrenic patients (2007).
  1. **Author:** Abdel Azim E., Khashaba A., Sherra Kh. and Shalendah A.
  2. **Document:** Current Psychiatry Vol. 14 No. 2 July 2007.
  3. **Site:** Multi-center study at Riyadh, K.S.A.
  4. **Time:** From July 2006 till April 2007.
  5. **Aim of the work:** To ascertain the frequency of sexual dysfunctional problems in a sample of schizophrenic patients receiving anti-psychotics compared with non-schizophrenic control group and to determine the possible underlying mechanisms
  6. **Design of the study:** Cross sectional, case control study.
  7. **Method:** 120 schizophrenic or schizoaffective married patients (DSM-IV TR), aged 25-45 years, on anti-psychotics medications for at least one year, free from any medical diseases that may affect sexual activity. 120 healthy controls matched with the cases. All patients and controls are subjected to: (1) Sexual Functioning Questionnaire (SFQ) after *Smith et al. (2002)* by using Arabic translation. (2) Sexual Behavioural Questionnaire

(SBQ) after *MacDonald et al. (2003)* by using Arabic translation. The schizophrenics group is also subjected to: (a) Semi-structured psychiatric interview. (b) Positive and Negative Symptom Scale (PANSS). (c) prolactin levels.

8. **Results:** Sexual dysfunction occurs in 45% of patients taking antipsychotic medication compared with 17% of normal controls. At least one sexual dysfunction is reported in 82% of men and 76% of women with schizophrenia. Sexual dysfunctions in female patients are associated with negative schizophrenic symptoms. There is no association between sexual dysfunction and type of antipsychotic medication; also patient's smoking has no significance relation with any type of sexual dysfunctions except non smokers have less sexual desire. The presence of hyper-prolactinaemia overrode other causes of sexual dysfunction. For women, hyper-prolactinaemia is the main cause of sexual dysfunction.
9. **Conclusion:** Sexual dysfunction is very common among schizophrenics. Erectile dysfunction is present among the majority of male patients.

## **Appendix (36)**

- **Subject:** The prevalence of child abuse and its effect on the mental health (2007).
  1. **Author:** Riyadh M., Hassan A., Algammal M. and Abdelrahman A.
  2. **Document:** Current Psychiatry Vol. 14 No. 3 November 2007.
  3. **Site:** It is not mentioned.

4. **Time:** It is not mentioned.
5. **Aim of the work:** To study and identify the prevalence and forms of child abuse among children and its effect on mental health.
6. **Design of the study:** Cross sectional study.
7. **Method:** a sample of 304 children had been chosen randomly from children who are living in the suburban area in the south of Cairo; their age range is between 13 to 16. Assessment measures of abuse and neglect was administrated by using Childhood Traumatic Questionnaire (CTQ) (*Bernestein and Fink, 1997*). Base line axis I was obtained by trained psychiatrists conducting semi-structured clinical interview (ICD10 check list) for all subjects.
8. **Results:** Child abuse is present among 235/304 (77.3%) of the cases and 1.7% of the males and 15.7% of the females suffer from sexual abuse.
9. **Conclusion:** Abuse is one of the most disturbing experiences in child psychiatry. Children who have been physically or sexually abused exhibit many psychiatric disturbances.

## **Appendix (37)**

- **Subject: Sexual dysfunction in epileptic male patients (2009).**

1. **Author:** Mourad H.S.A.

**Supervisors:** Prof. Ahmed Talaat El Ghoneimy, Prof. Mohammed Mohammed Farid, Prof. Maged Abd El Naseer and Prof. Hatem Samir Mohammed.

2. **Document:** M.D. Thesis, Faculty of medicine, Cairo University, 2009.
3. **Site:** Kasr El-Aini Epilepsy Outpatient Clinic.
4. **Time:** It is not mentioned.
5. **Aim of the work:** To study the impact of epilepsy management (monotherapy and polytherapy ), duration, frequency and types on male sexual function.
6. **Design of the study:** Cross sectional, case control study.
7. **Method:** 50 epileptic male patients having sexual dysfunction (20 patients on monotherapy and 30 patients on polytherapy) and 20 epileptic male patients without sexual dysfunction (10 patients on monotherapy and 10 patients on polytherapy). 20 healthy subjects with no history of sexual dysfunction. The age ranged from 20 to 40 years old. All subjects are subjected to the following: (1) Bedside tests for autonomic function. (2) Questionnaire for sexual dysfunction; International Index of Erectile Function (IIEF). (3) Andrological examination. (4) Routine laboratory investigation. (5) Hormonal serum analysis. (6) EEG. (7) Brain MRI. (8) Nocturnal Penile Tumescence and rigidity (NPT). (9) Penile Doppler.
8. **Results:** (1) The mean ranks of orgasmic function are highly significant lower in frontal lobe epilepsy (FLE) than in both temporal lobe epilepsy (TLE) and generalized epilepsy. (2) Epileptic patients with the lowest seizure frequency have lower mean rank of orgasmic function than those with higher frequencies. (3) There is insignificant difference between monotherapy and polytherapy patients' sexual functions in patients with sexual dysfunction.

**9. Conclusion:** (1) Sexual dysfunctions is more in TLE patients than both generalized epilepsy and FLE. (2) There is no major difference between monotherapy and polytherapy on sexual dysfunction according to sex hormones and IIEF. (3) Frequency of seizures have no effect on either sexual functions or hormones.

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## المقدمة

الجنس ليس مجرد غريزة، فالإرتباط مع الشريك الجنسي هو أمر ذا أهمية كبرى أكثر من كونه إشباع للشهوة الجنسية (Stevens and Price, 2000).

العلاقة الجنسية هي علاقة معقدة، والعوامل التي تؤدي إلى حدوث مشاكل بها كثيرة ومتعددة ويمكن تقسيم هذه العوامل إلى:

- (1) عوامل جسدية.
  - (2) عوامل نفسية فردية.
  - (3) عوامل إرتباطية (ترتبط بالعلاقة) (Bancroft, 1989).
- الكثير من المشاكل الجنسية التي تنتج عن مشاكل نفسية تنتج من طبيعة النفس والمكونات الأخرى للإستجابة الجنسية (Rowland and Incrocci, 2008).

وعلى خلاف أغلب المشاكل الجسدية والكثير من المشاكل النفسية، فإنه يصعب الإقرار بسهولة لأي نقص يتعلق بالأداء الجنسي، وذلك لأن قيم الثقافات المحلية تؤثر على التعرف على المشاكل الجنسية و الإقرار بها (Swan and Wilson, 1979).

ويتم تقسيم الاضطرابات الجنسية وإضطرابات هوية النوع طبقاً للمعايير المحددة في دليل التشخيص الرابع (النسخة المراجعة) للرابطة الأمريكية للطب النفسي

(DSM-IV-TR) إلى: إضطرابات الوظائف الجنسية، الانحرافات الجنسية واضطرابات هوية النوع (Sadock and Sadock, 2005).

ولقد أشار كثير من المعلقين الحاجة إلى التفرقة بين الجنس والنوع، حيث يشير الجنس إلى الطبيعة الحيوية (ذكر أو أنثى)، بينما يشير النوع إلى

السمات النفسية والسلوكية المرتبطة بالطبيعة الحيوية للذكر أو الأنثى، أما هوية النوع فإنها تشير إلى التمييز الأساسي للذكر عن الأنثى والإحساس بالانتماء لجنس معين (Zucker, 2006).

نظراً لإنخفاض معدل إنتشار اضطرابات هوية النوع في الأطفال والمراهقين، فإن عدد قليل فقط من الأطباء والباحثين المهتمين بهذه الفئة، ولكن مع بداية منتصف الستينات من القرن العشرين تم تأسيس الكثير من العيادات المتخصصة والبرامج التي تهتم بهذه الاضطرابات وأدى ذلك وبشكل تدريجي إلى تراكم قدر من المعرفة عن اضطرابات هوية النوع في الأطفال والمراهقين. وفي السنوات القليلة الماضية أصبحت اضطرابات هوية النوع موضوع باعث للإبهار في وسائل الإعلام سواء المرئية أو المطبوعة التي أبدت اهتمام كبير لتغطية هذا الموضوع (Rosenberg, 2007).

ويعرّف اضطراب هوية النوع على أنه عدم توافق بين النمط الجسدي الظاهري وهوية النوع (التعرف على النفس كذكر أو أنثى) (Allen and Gorski, 1990).

في عام 1830، فريدريخ كان أول من كتب بمنظور طبي عن اضطراب هوية النوع، لكن هذا الموضوع لم يستحق المزيد من الدراسة وقتها إلا بعد مرور عدة سنوات (Roberto, 1983).

ولقد أدى وجود اعتقاد كبير بأن وجود الخصية هو المحدد الأساسي للجنس (حيث أن وجود الخصيتين يدل على الذكورة وعدم وجودهما يدل على الأنوثة) إلى بروز الحاجة لإكتشاف جين محدد للجنس (Jost, 1947). وأما مريض اضطراب هوية النوع فإن لديه قناعة بأن سيكولوجية نوعه هي عكس التركيب التشريحي لجنسه (Roberto, 1983).

في الولايات المتحدة خلال الخمسينات والستينات من القرن العشرين كان يُنظر للمتحولون للجنس المقابل على أنهم مختلون عقلياً أو لا أخلاقيين، حيث

أن المجتمع بشكل عام لم يكن يتفهم فكرة التحول للجنس المقابل. وعبر تاريخ طويل تغيرت فكرة الوصمة التي وُصم بها المتحولون في الماضي حيث اكتسب التحول للجنس المقابل فكرة الحرية في اتخاذ القرار، وأن الشخص المتحول لديه إحساس بأنه من جنس مختلف عن الذي وُلد به (Stein, 1999).

وطبقاً لدراسة صدرت في هولندا فإن الأشخاص المصابون باضطراب شديد في هوية النوع وبخاصة المتحولون للجنس المقابل وُجد أنهم يشكلون نسبة واحد لكل 11000 رجل و واحدة لكل 30000 امرأة (Green, 2005).

وبشكل مثالي فإن تقييم أي مشكلة جنسية يتضمن تحليل عميق لخاصية المشكلة وشدتها وأسبابها والعوامل المشاركة. أما بشكل عملي فإن عملية التقييم تختلف كثيراً على حسب الكيفية التي وصلت بها المشكلة الجنسية إلى المعالج. (Rowland and Incrocci, 2008).

وبالتعليم وحدة يمكن الوقاية من ظهور حالات كثيرة من الاضطرابات الجنسية، ولكن لأن مجتمعنا يشعر بالخلل من تقديم التعليم اللازم، ولذلك ينتهي بعدد من الناس بالإصابة بالعديد من المشاكل في أداء الوظائف الجنسية (Barlow, 2005).

أما الصورة الحالية في مصر فتتميز بتحول لم يحدث من قبل تجاه تقليل خدمات الرعاية الصحية الأولية مع زيادة الخدمات على كلا مستويي الرعاية الصحية الثانوية والرعاية الصحية الثالثة (Al-Akabawi, 2001).

### أسباب ودواعي البحث:

قامت بعض الدراسات المصرية بالبحث في موضوع "الاضطرابات الجنسية واضطرابات هوية النوع" لذا يجب علينا دراسة هذه الأبحاث في هذا المجال، لذا نأمل أن تكون هذه الدراسة خطوة لمعرفة وضع الأبحاث المصرية

التي تم عملها فى مجال الاضطرابات الجنسية واضطرابات هوية النوع ومعرفة ما يمكن عمله فى المستقبل.

## **الهدف من العمل:**

1. المراجعة النظامية والتقييم للدراسات المصرية التى تم عملها عن الاضطرابات الجنسية واضطرابات هوية النوع.
2. تقديم التوصيات المطلوبة من أجل دراسات إضافية.
3. تقديم ملحق يحوى ملخصات لرسائل الماجستير والدكتوراه التى تم عملها عن الاضطرابات الجنسية واضطرابات هوية النوع.

## **الطريقة (الإجراءات):**

من أجل إنجاز الأهداف سيتم عمل مراجعة نظامية للأبحاث المصرية المتوفرة عن الاضطرابات الجنسية واضطرابات هوية النوع.

سيتم الاستعانة بأنظمة المعلومات الآتية:

1. مكتبة كلية الطب بجامعة عين شمس.
2. مكتبة كلية الطب بجامعة الأزهر.
3. مكتبة كلية الطب بجامعة القاهرة.
4. مكتبة كلية الطب بجامعة قناة السويس.
5. قواعد معلومات كلا من جريدة (Egyptian Journal of Psychiatry) وجريدة (Current Psychiatry).

سوف يتم تصنيف الدراسات التي تم الحصول عليها كالاتى:

1. الدراسات التى تتناول وبائيات الاضطرابات الجنسية واضطرابات هوية النوع.
2. الدراسات التى تتناول أسباب الاضطرابات الجنسية واضطرابات هوية النوع.
3. الدراسات التى تتناول الوصف الأكلينيكي للاضطرابات الجنسية واضطرابات هوية النوع.
4. الدراسات التى تتناول كيفية التعامل مع الاضطرابات الجنسية واضطرابات هوية النوع.
5. الدراسات التى تتناول مصير الاضطرابات الجنسية واضطرابات هوية النوع.
6. الدراسات التى تتناول المعرفة والأراء عن الجنس البشرى.

### المراجعة النظامية الوصفية:

بعد الإطلاع على قواعد المعلومات تم عمل قائمة من (45) بحث مصرى فى الاضطرابات الجنسية واضطرابات هوية النوع.

### (1) بالنسبة لدراسة وبائيات الاضطرابات الجنسية واضطرابات هوية النوع:

أ) الاضطرابات الجنسية نتيجة لأسباب غير عضوية:

وُجد أن 3.1%، 1.8%، 1.2% و 12.3% من الزوجات المصابات باضطرابات جنسية يعانون من نقص أو إنعدام الرغبة الجنسية، اضطرابات

النفور الجنسي، اضطرابات الإثارة الجنسية وإضطرابات النشوة الجنسية على التوالي (Owida and Amin, 1999).

كما وُجد أن 53.2%، 4.2% و 42.6% من الذكور المصابين باضطرابات جنسية يعانون من اضطراب الانتصاب، القذف المتأخر والقذف المبكر على التوالي (El Nagdy\*, 1984).

#### ب) الإضطرابات الجنسية فى المرضى النفسيين:

وُجد أن 69% من مرضى الرجال المصابين بالفصام المزمن وكذلك 53% من مرضى الإناث المصابات بالفصام المزمن يعانون من اضطرابات جنسية (Abdel Azim et al., 2007). وفى دراسات أخرى وُجد أن 54% من مرضى الذكور المصابين بالاكنتاب يعانون أيضا من إضطرابات جنسية (Ahmed and Ezz El-Din, 1992).

#### ج) الإضطرابات الجنسية الناتجة عن سوء استخدام العقاقير:

وُجد أن 35.5% و 29.4% من مدمنى الهيروين الذكور يعانون من نقص الرغبة الجنسية وضعف الانتصاب على التوالي (Hashem and El-Orabi, 1993)، كما أسفرت دراسات أخرى عن أن 73.3% من زوجات المدمنين تعانين من عدم الرضا الجنسي (Abolmagd et al., 2004).

#### د) الإضطرابات الجنسية فى المرضى المصابين بأمراض عضوية:

وُجد أن 85% و 45.8% من مرضى الفشل الكلوى المزمن تحت علاج الغسيل الدموى المتكرر يعانون من عدم الرضا الجنسي وضعف الانتصاب على التوالي (Ibrahim et al., 1995)، وفى دراسات أخرى تبين أن 18%، 20%، 30% و 27% من مرضى الصرع الذكور يعانون من

\* Arabic Reference.



اضطرابات جنسية كلية، اضطراب الرغبة الجنسية، صعوبة الانتصاب واضطراب القذف على التوالي (El-Azoon, 2002).

#### هـ) الاضطرابات الجنسية الناتجة عن الإيذاء الجنسي:

كشفت دراسات أن 5.2% من طلاب مدراس الإعدادية قد تعرضوا للإساءة الجنسية (Hamed, 2006)، وسجلت دراسات أخرى أن 52.86% من حالات الجرائم الجنسية هي حالات اغتصاب (Abdelmessih et al., 1980).

#### و) الاضطرابات الجنسية المحتمل حدوثها نتيجة التشويه الجنسي للإناث (ختان الإناث):

تبين أن 97.1% من السيدات مختننات (Refaat et al., 1999)، كما لوحظ أن 40% من الزوجات المختننات و 12.85% من الزوجات الغير مختننات يعانون من اضطرابات جنسية (Abdel Azim et al., 2000).

#### ز) الجنسية المثلية في الذكور والإناث:

كشفت دراسات عن أن 9.67% من الذكور وكذلك 6.95% من الإناث لديهم تجارب جنسية مثلية سابقة (Lotaief et al., 1994).

#### ح) الإنحرافات الجنسية:

وُجد أن 11% ، 2.4% و 8% من مرضى الإناث المصابات بالصرع مع اضطرابات جنسية يعانون من الاستعراء، الفيتيشية وتحول الزى على التوالي (Bahary\*, 1987)، كما وُجد أن 22%، 2% ، 44% و 2% من مرتكبي الإغتصاب الذكور يعانون من الاستعراء، الماسوشية، السادية والتفرج الجنسي (انحراف التلصص) (Ashour\*, 1984).

\* Arabic Reference.

ي) اضطراب هوية النوع:

تبين أن 1.6% من مرضى الإناث المصابات بالصرع مع اضطرابات جنسية يعانون من عدم قبول الجنس (الجنس البديل) (Bahary\*, 1987).

بالنسبة لتوزيع الاضطرابات الجنسية واضطرابات هوية النوع حسب العمر، فقد وُجد أن 75% من مرضى الذكور النفسيين و 55.3% من مرضى الإناث النفسيين قد تعرضوا للإساءة الجنسية قبل بلوغهم سن العاشرة (Fahmy et al., 1995).

بالنسبة للتوزيع حسب الديانة، تبين أن 60% من ذكور الجنسية المثلية، 62.5% من إناث الجنسية المثلية هم على قدر من الدين ولكن بدرجة غير كافية (Lotaief et al., 1994).

بالنسبة للتوزيع حسب الحالة الزوجية، أسفرت دراسات أن 86.7% من ذكور الجنسية المثلية هم من غير المتزوجين و أن 62.5% من إناث الجنسية المثلية هن من المتزوجات (Lotaief et al., 1994).

بالنسبة للتوزيع حسب المسكن، وُجد أن 62.86% من الزوجات المختتات هن من المناطق الريفية (Abdel Azim et al., 2000).

بالنسبة للتوزيع حسب مستوى التعليم، وُجد أن 45.3% من السيدات المختتات هن من غير المتعلّقات (Refaat et al., 1999).

بالنسبة للتوزيع حسب المهنة، بينت دراسات أن 84.5% من السيدات المختتات لسن من العاملات (Refaat et al., 1999).

بالنسبة للتوزيع حسب المستوى الاجتماعي، وُجد أن 60% من الزوجات المختتات ينتمون إلى الوسط الاجتماعي المنخفض (Abdel Azim et al., 2000).

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\* Arabic Reference.

بالنسبة للتوزيع حسب ترتيب الميلاد، تبين أن 59% من مرضى الذكور المصابون بالصرع مع اضطرابات جنسية ينتمون إلى الترتيب الأوسط بالنسبة لأخوتهم (Bahary\*, 1983 and Demerdash et al., 1986). بالنسبة للتوزيع حسب ترتيب الميلاد، وُجد أن 26.67% من تلاميذ المرحلة الإعدادية الذين تعرضوا للإساءة الجنسية هم من عائلات ذات أعداد كبيرة (أكثر من 6 أفراد) (Hamed, 2006).

## (2) بالنسبة لدراسة أسباب الاضطرابات الجنسية واضطرابات هوية النوع:

هناك العديد من العوامل المسببة للاضطرابات الجنسية في الإناث منها التاريخ العائلي للاضطرابات الجنسية (Owida and Amin, 1999) ، الانفصال العاطفي في العائلة، أمراض النساء، ختان الإناث، التعرض للإساءة الجنسية أثناء الطفولة، الصدمة الجنسية في ليلة الزفاف وكذلك الأمراض الجنسية في الزوج (Abed, 1998). يعتبر التاريخ العائلي، المشاعر السلبية تجاه الابوين، المشاكل النفسية، ممارسة الجنس قبل سن البلوغ وكذلك ممارسة النكاح قبل الزواج من الأسباب المحتملة لحدوث الضعف الجنسي في الذكور (Demerdash, 1970). وتعتبر نوبات الصرع الليلية، طول المدة الزمنية لمرضى الصرع، تكرار نوبات الصرع (Bahary\*, 1983 and Demerdash et al., 1986)، صرع الفص الصدغي (Awny, 1997)، وتعدد أدوية علاج الصرع (Mourad, 2009)، من الأسباب المسؤولة عن الاضطرابات الجنسية في مرضى الصرع.

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\* Arabic Reference.

وقد أثبتت الدراسات أن كبار السن، جلطات الأوردة العميقة، مرض السكر والأمراض النفسية من العوامل التي تساعد على حدوث الضعف الجنسي بين كثير من المرضى (Habeeb, 2000).

### **(3) بالنسبة لدراسة الوصف الإكلينيكي للاعتداء الجنسي وللإضطرابات الجنسية واضطرابات هوية النوع:**

وُجد أن بعض الإناث يعانون بشكل غير مباشر من الإضطرابات الجنسية على أنها آلام بالحوض وآلام أسفل الظهر وكذلك شكاوى جنسية غير واضحة المعالم (Owida and Amin, 1999).

وقد أسفرت الدراسات عن أن خطورة مرض الاكتئاب فى مرضى الذكور المصابين بالإكتئاب مع إضطرابات جنسية هى أكبر بشكل ملحوظ عنه فى مرضى الذكور المصابين بالاكتئاب بدون إضطرابات جنسية (Ahmed and Ezz El-Din, 1992).

وقد أثبتت الدراسات أن المدة الزمنية للإضطرابات الجنسية بين مرضى الصرع الذين يعالجون بأدوية متعددة هى أطول بشكل ملحوظ من هؤلاء الذين يعالجون بدواء واحد فقط (Mourad, 2009).

ولقد لوحظ أن المرضى النفسيين الذين قد تعرضوا للإساءة الجنسية أثناء الطفولة كان متوسط عمرهم 8.6 سنة حينذاك (Sayed, 1998).

ولقد وُجد أن 42.9% من السيدات المصابات بالإكتئاب ولديهن تاريخ سابق بالإساءة الجنسية أثناء الطفولة كن قد تعرضن لذلك مع تهتك أعضائهن التناسلية، وأن 71.4% منهن قد تعرضن للتهديد بالضرب حتى يخضعن للإساءة الجنسية فى طفولتهن (Soliman et al., 1999).

ومن ناحية أخرى تبين أن معدل حدوث الإغتصاب يكون أكثر فى فصلى الربيع والخريف عنه فى فصلى الصيف والشتاء، وذلك يشير إلى أن

الطقس المعتدل كما في فصلي الربيع والخريف يشجع علي النشاط خارج البيوت مما يزيد التعرض للاعتداء الجنسي (Abdelmessih et al., 1980).  
وقد أسفرت الدراسات عن أن 76% من الزوجات المختننات كن قد أجرى لهن الختان فى سن يتراوح بين الثامنة والأثنى عشر (Lotfy and El-Defrawy, 1995) ، كما وُجد أن 57.5% من الزوجات المختننات قد أجرى لهن الختان بالمنزل، وأن 48.5% منهن قد أُختننوا بواسطة الدايات، 54.5% منهن قد أُختننوا مع استئصال البظر (El-Defrawy et al., 1996) ، 53.5% منهن قد ذكروا حدوث مضاعفات بعد إجراء الختان (Lotfy and El-Defrawy, 1995)، ومن هذه المضاعفات النزف الغزير، احتباس البول، عدوى المهبل، العقم، عسر الطمث وآلام بالحوض، مع ملاحظة أن هذه المضاعفات تعتمد على الطريقة المستخدمة فى عملية الختان، المكان الذى أُجريت فيه والشخص الذى أجراها (The Royal Women's Hospital, 2009).

#### **(4) بالنسبة لدراسة كيفية التعامل مع الإضطرابات الجنسية واضطرابات هوية**

##### **النوع:**

لقد سجلت الدراسات أن 92.9% من مرضى الضعف الجنسى قد تحسنوا على العلاج بالتحدث (بدون علاج دوائى) وأن 68.8% منهم قد تحسنوا على العلاج الدوائى (El Akabawi and Idarous, 1982) ، وفى دراسات اخرى وُجد أن معظم المرضى الذين يعانون من الاكتئاب مع اضطرابات جنسية قد تحسنوا جنسيا مع العلاج بأدوية مضادات الاكتئاب الثلاثية (75مجم — 100مجم / يوميا لمدة ستة أشهر) (Ahmed and Ezz El-Din, 1992).

### **(5) بالنسبة لدراسة مصير الاضطرابات الجنسية واضطرابات هوية النوع:**

أثبتت الدراسات أن 27.3% من السيدات ذوات الشكاوى الجنسية لديهن عدم رضا زواجي (Abed, 1998)، وفي دراسات أخرى وُجد أن 65% من مرضى الذكور المصابين بالصرع مع اضطرابات جنسية لديهم أمراض نفسية في صورة، مثل الاكتئاب العصابي والقلق العصابي، وهذه الأمراض النفسية من المحتمل أن تكون نتيجة للاضطرابات الجنسية (Bahary\*, 1983 and Demerdash et al., 1986).

وقد لوحظ أن معظم تلاميذ المدارس الإعدادية الذين تعرضوا للإساءة الجنسية لديهم نوبات إكتئاب عظمى وعدم ثقة بالذات (Hamed, 2006)، وكذلك وُجد أن 71.6% من المرضى النفسيين الذين لديهم تاريخ سابق بالإساءة الجنسية أثناء الطفولة ليس لديهم وظيفة جنسية مرضية (Sayed, 1998). لخصت الدراسات أن الزوجات المختننات لديهن تأخر في تكوين العلاقة الجنسية مع الزوج وكذلك أقل استمتاعاً بالجنس وأقل تحقيقاً للنشوة الجنسية ولديهن جفاف أثناء الممارسة الجنسية وعسر الطمث عن الزوجات الغير مختننات (Lotfy and El-Defrawy, 1995)، وفي دراسات أخرى تبين أن الزوجات المختننات أكثر تقبلاً للضرب والإهانة من قبل أزواجهن عن الزوجات غير المختننات (Refaat et al., 1999).

### **(6) بالنسبة لدراسة المعرفة والآراء عن الجنس البشري:**

سجلت الدراسات أن طلبة الجامعة الذكور لديهم متوسط درجات معرفة عن الجنس والأمراض المنقولة عن طريق الجنس خاصة الإيدز أكثر بدرجة ملحوظة عن طالبات الجامعة الإناث، وأن ممارسة الرياضة والصوم

\* Arabic Reference.

من الطرق الأساسية للتكيف مع الاحتياجات الجنسية بين الذكور والإناث  
(Nagia et al., 2001).

ولقد وُجد أن 48.2% من الزوجات المتعلّقات الموظفات قد عرّفوا  
العلاقة الزوجية على أنها علاقة عائلية فقط، وهذا يعكس نظرة المجتمع أن  
الإناث يتزوجن فقط لتكوين الأسرة وأن الجنس من الأمور المحرمة، وأيضاً  
الإحتياجات الجنسية لدى الإناث يعد أمراً متجاهلاً (Loutfi et al., 1984).

تعتبر الأسرة هي المصدر الأساسي للمعرفة الجنسية لدى  
81.7% من مرضى الإناث المصابات بأمراض نفسية مع اضطرابات  
جنسية (El Fangary, 2003)، وهذا على خلاف في الدراسات التي أثبتت أن  
المصدر الأساسي للمعرفة الجنسية لدى الزوجات المتعلّقات الموظفات هو  
الأصدقاء (29.2%) والكتب (21.2%) (Loutfi et al., 1984).

سجلت دراسات أن 43.8% من الزوجات المتعلّقات الموظفات أكدن أن  
النشوة الجنسية والاستمتاع بالنكاح ليس أساسياً للإناث، وهذا يبين أن الإناث  
يشاركون في العلاقات الجنسية للالتزامات الأخلاقية والمجتمعية فضلاً عن إشباع  
رغباتهن الجنسية (Loutfi et al., 1984).

ولقد وُجد أن 61.5% من الزوجات المختنّات لديهن النية لعمل  
الختان لبناتهن (لمعتقدات دينية وتقالييد أسرية وعادات صحية)  
(Lofty and El-Defrawy, 1995)، ومع ذلك فإن التشويه الجنسي للإناث  
(ختان الإناث) لم يوصى بها في أي ديانة وبالرغم من ذلك فهي تُمارس بين  
المسلمين والمسيحيين، وقد أكد رجال الدين من كلى المجتمعين المسلم والمسيحي  
على إدانة عملية ختان الإناث (The Royal Women's Hospital, 2009).

## **التقييم النقدي:**

لقد استهدف التقييم النقدي للدراسات المصرية عن الاضطرابات الجنسية وإضطرابات هوية النوع، إلقاء الضوء على النقاط المجهولة لهذه الدراسات للقضاء عليها فى المستقبل.

ونحن نقر ملحوظتان نقديتان فى أغلب الدراسات المتاحة، أولهما عدم ذكر نوع تصميم الدراسة أما ثانيهما عدم ذكر الحساب الإحصائى لحجم العينة المستخدمة فى الدراسة.

وقد تم تقديم التوصيات المطلوبة لعمل أبحاث إضافية فى هذا المجال. وفى النهاية تم عمل ملحق إضافى يحتوى على ملخص لأهم النقاط التى اشتملت عليها البحوث الإكلينيكية التى تناولت موضوع الإضطرابات الجنسية وإضطرابات هوية النوع.



# **مراجعة نظامية للدراسات المصرية عن الاضطرابات الجنسية واضطرابات هوية النوع**

**رسالة**

**نوطنة للحصول على درجة الماجستير في الأمراض العصبية والنفسية**

**مقدمة من**

**الطبيب / سامح إبراهيم عبدالعاطي**

**بكالوريوس الطب والجراحة**

**تحت إشراف**

**الأستاذة الدكتورة/ نجلاء المحلاوي**

**أستاذ الأمراض النفسية والعصبية**

**كلية الطب - جامعة عين شمس**

**الدكتورة/ نيفرت زكى محمود**

**أستاذ مساعد الأمراض النفسية والعصبية**

**كلية الطب - جامعة عين شمس**

**الدكتورة/ دعاء نادر رضوان**

**مدرس بقسم الأمراض النفسية والعصبية**

**كلية الطب - جامعة عين شمس**

**كلية الطب**

**جامعة عين شمس**

**2009**