

Sexual Dysfunctions and Sexual Disorders Issues and Management

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Abstract

Sexuality in India has evolved over time and has been immensely influenced by various rulers and religions. Human sexuality is inherently related to some of the social and public health problems in India. This paper has been presented to sensitize the intellectual fraternity towards sexual health and sexual dysfunctions. This review highlights the available evidence in the field of Psychosexual health and its management in India.

Keywords: Sexual dysfunction, management etc.

Introduction

India is a vast country depicting wide social, cultural and sexual variations. Sexuality in India has evolved over time and has been immensely influenced by various rulers and religions. Sexuality is manifested in our attire, behavior, recreation, literature, sculptures, scriptures, religion and sports. It has influenced the way we perceive our health, disease and device remedies for the same. In modern era, with rapid globalization the unique Indian sexuality is getting diffused.

Human sexuality is inherently related to some of the social and public health problems in India. These problems may involve contraceptive use, child abuse, sex education, legal issues of homosexuality and AIDS. These health problems have a significant impact on existing health infrastructure and budget. These problems also need to look within the context of poverty, stressful living situations, diverse cultural belief systems, quackery, ignorance and inadequate health services. There is a need to research sexual experiences and dysfunctions, which further influence adult behavior patterns in India. Present paper is highlighting and addressing the sexual dysfunctions in an Indian perspective.

What is sexual health?

A concept defined in 1975 by the WHO as “the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and enhance personality, communication and love.

Sexual dysfunction

Sexual dysfunction refers to a problem occurring during any phase of the sexual response cycle that prevents the individual or couple from experiencing or wanting satisfaction and enjoying the sexual activity. It is a

significant disturbance in the sexual response cycle, which is not due to an underlying organic cause. Sexual response is a psychosomatic process; and both psychological and somatic processes are usually involved in the causation of sexual dysfunction. It can happen anytime, from that first blush of excitement to orgasm. The sexual response cycle traditionally includes five phases:

1. **Appetitive Phase:** The phase before the actual sexual response cycle. This consists of sexual fantasies and a desire to have sexual activity.
2. **Excitement Phase:** The first true phase of the cycle, which starts with the physical stimulation and/or by appetitive phase. Desire and arousal are both part of the excitement phase of the sexual response. The major changes during this phase are:
Males: Penile erection, due to vasocongestion of the corpus cavernosa; elevation of testes with scrotal sac.
Females: Lubrication of vagina by a transudate; erection of nipples (in most women); erection of clitoris; thickening of labia minora. The duration of this phase is highly variable and may last for several minutes (or longer).
3. **Plateau Phase:** The intermediate phase just before actual orgasm, at the height of the excitement. It is often difficult to differentiate the plateau phase from the excitement phase. The following important changes occur during this phase:
Males: Sexual flush (inconsistent); autonomic hyperactivity; erection and engorgement of penis to full size; elevation and enlargement of testes; dew drops on glans penis.
Females: Sexual flush (inconsistent); autonomic hyperactivity; retraction of clitoris behind the

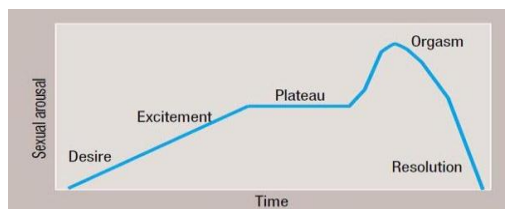
prepuce; development of orgasmic platform in the lower 1/3rd of vagina, with lengthening and ballooning of vagina; enlargement of breasts and labia minora; increased vaginal transudate. The duration of this phase may last from half to several minutes.

4. **Orgasmic Phase:** The phase with peak of sexual excitement followed by release of sexual tension, and rhythmic contractions of pelvic reproductive organs. The important changes are as follows:

Males: 4-10 contractions of penile urethra, prostate, vas, and seminal vesicles; at about 0.8 second intervals; autonomic excitement becomes marked in this phase. Doubling of pulse rate and respiratory rate, and 10-40 mm increase in systolic and diastolic BP occurs; ejaculatory inevitability precedes orgasm; ejaculatory spurt (30-60cm; decreases with age); contractions of external and internal sphincters.

Females: 3-15 contractions of lower 1/3rd of vagina, cervix, and uterus: at about 0.8 seconds intervals. No contractions occur in clitoris; autonomic excitement becomes marked in this phase. Doubling of pulse rate and respiratory rate, and 10-40 mm increase in systolic and diastolic BP occurs; contractions of external and internal sphincters. The duration of this phase may last from 3-15 seconds.

5. **Resolution Phase:** This phase is characterized by the following common features in both sexes: A general sense of relaxation and well being, after the slight clouding of consciousness during the orgasmic phase; disappearance of sexual flush followed by fine perspiration; gradual decrease in vasocongestion from sexual organs and rest of the body; refractory period for further orgasm in males varies from few minutes to many hours; there is usually no refractory period in females.



Sexual disorder

The term refers to any disorder involving sexual functioning or desire or performance more specifically any such disorders that are caused at least in part by psychosocial factors. Those characterized by decrease or other disturbance of sexual desire are called Sexual Dysfunctions and those characterized by unusual or bizarre sexual fantasies or acts are called Paraphilias also called Psycho Sexual Disorder.

Prevalence

Men and women of all ages experience sexual dysfunction, although it is more common in those over 40

because it is often related to a decline in health associated with aging.

In Males

Gupta and his colleagues (2004) investigated clinical profiles of 150 patients attending skin OPD for psychosexual problems. Among them, erectile dysfunction (34%) was the commonest problem, followed by premature ejaculation (16.6%), and nocturnal emission (14%).

In Females

Avasthi and his colleagues (2008) carried out a study on women at Department of Pediatrics and observed that 17% of the subjects encountered one or more difficulties during sexual activities. These difficulties were in the form of headache after sexual activity (10%), difficulty reaching orgasm (9%), painful intercourse (7%), lack of vaginal lubrication (5%), vaginal tightness (5%), bleeding after intercourse (3%) and vaginal infection (2%). 14% subjects attributed these difficulties to their own health problems; further lack of privacy (8%), spouse's health problems (4%) and conflict with spouse (4%) were the other cited reasons for those difficulties. None considered their sexual difficulty significant enough to demand a thorough clinical assessment.

Types of sexual dysfunctions

Sexual dysfunction generally is classified into four categories:

- Desire disorders —lack of sexual desire or interest in sex on an ongoing basis
- Arousal disorders —inability to become physically aroused or excited during sexual activity
- Orgasm disorders —delay or absence of orgasm (climax)
- Pain disorders — pain during intercourse

Symptoms

In men: Diabetes can cause nerve and artery damage in the genital area, disrupting the blood flow necessary for an erection. This is more common in older men who have had diabetes for a long time. High cholesterol, high blood pressure and obesity - all common among men with diabetes - as well as smoking, can contribute to the problem.

Some men with diabetes experience retrograde ejaculation, which means that the ejaculate goes backward into the bladder instead of being discharged during climax. This condition does not affect orgasm, but it can make it difficult to father a child.

- Inability to achieve or maintain an erection suitable for intercourse (erectile dysfunction)

- Absent or delayed ejaculation despite adequate sexual stimulation (retarded ejaculation)
- Inability to control the timing of ejaculation (early or premature ejaculation)

In women: Diabetes-related nerve damage can cause vaginal dryness that makes intercourse uncomfortable. Nerve damage also can lead to loss of sensation in the genital area, making orgasm difficult or impossible to achieve.

- Inability to achieve orgasm
- Inadequate vaginal lubrication before and during intercourse
- Inability to relax the vaginal muscles enough to allow intercourse

In men and women: Urinary infections are more common in people with poorly controlled diabetes and can cause discomfort for women during intercourse and for men during urination and ejaculation. These generally are temporary complications, but they can recur. Sexual activity should be stopped during treatment of urinary tract and yeast infections, which also are relatively common in people with diabetes.

Sexually transmitted diseases (STDs) can be transmitted easily because of the dry, cracked skin found in many people who have diabetes. This makes it important to practice safe sex.

Chronic high blood sugar levels can lead to reduced testosterone and may contribute to decreased sexual interest (libido).

Chronic high blood sugars can lead to abnormal nerve function, leading to pain with only light touch. Heightened sense of pain associated with neuropathy can make sexual relations uncomfortable.

Because intercourse is exercise, people with diabetes should watch for signs of hypoglycemia (low blood sugar) after sex.

- Lack of interest in or desire for sex
- Inability to become aroused
- Pain with intercourse

Sexual dysfunctions according to ICD 10:

F52 Sexual dysfunction, not caused by organic disorder or disease

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. There may be lack of interest, lack of enjoyment, failure of the physiological responses necessary for effective sexual interaction (e.g. erection), or inability to control or experience orgasm.

Some types of dysfunction (e.g. lack of sexual desire) occur in both men and women. Women, however, tend to present more commonly with complaints about the

subjective quality of the sexual experience (e.g. lack of enjoyment or interest) rather than failure of a specific response. The complaint of orgasmic dysfunction is not unusual, but when one aspect of a women's sexual response is affected, others are also likely to be impaired. Men, on the other hand, though complaining of failure of a specific response such as erection or ejaculation, often report a continuing sexual appetite.

F52.0 Lack or loss of sexual desire

Loss of sexual desire is the principal problem and is not secondary to other sexual difficulties, such as erectile failure or dyspareunia. Lack of sexual desire does not preclude sexual enjoyment or arousal, but makes the initiation of sexual activity less likely.

F52.1 Sexual aversion and lack of sexual enjoyment

F52.10 Sexual aversion

The prospect of sexual interaction with a partner is associated with strong negative feelings and produces sufficient fear or anxiety that sexual activity is avoided.

F52.11 Lack of sexual enjoyment

Sexual responses occur normally and orgasm is experienced but there is a lack of appropriate pleasure. This complaint is more common in women than in men.

F52.2 Failure of genital response

In men, the principal problem is erectile dysfunction, i.e. difficulty in developing or maintaining an erection suitable for satisfactory intercourse. If erection occurs normally in certain situations, e.g. during masturbation or sleep or with a different partner, the causation is likely to be psychogenic. Otherwise, the correct diagnosis of nonorganic erectile dysfunction may depend on special investigations (e.g. measurement of nocturnal penile tumescence) or the response to psychological treatment. In women, the principal problem is vaginal dryness or failure of lubrication. The cause can be psychogenic or pathological (e.g. infection) or estrogen deficiency (e.g. postmenopausal). It is unusual for women to complain primarily of vaginal dryness except as a symptom of postmenopausal estrogen deficiency.

F52.3 Orgasmic dysfunction

Orgasm either does not occur or is markedly delayed. This may be situational (i.e. occur only in certain situations), in which case etiology is likely to be psychogenic, or invariable, when physical or constitutional factors cannot be easily excluded except by a positive response to psychological treatment. Orgasmic dysfunction is more common in women than in men.

F52.4 Premature ejaculation

The inability to control ejaculation sufficiently for both partners to enjoy sexual interaction. In severe cases, ejaculation may occur before vaginal entry or in the absence of an erection. Premature ejaculation is unlikely to be of organic origin but can occur as a psychological reaction to organic impairment, e.g. erectile failure or pain. Ejaculation may also appear to be premature if erection requires prolonged stimulation, causing the time interval between satisfactory erection and ejaculation to be shortened; the primary problem in such a case is delayed erection.

F52.5 Nonorganic Vaginismus

Spasm of the muscles that surround the vagina, causing occlusion of the vaginal opening. Penile entry is either impossible or painful. Vaginismus may be a secondary reaction to some local cause of pain, in which case this category should not be used.

F52.6 Nonorganic dyspareunia

Dyspareunia (pain during sexual intercourse) occurs in both women and men. It can often be attributed to a local pathological condition and should then be appropriately categorized. In some cases, however, no obvious cause is apparent and emotional factors may be important. This category is to be used only if there is no other more primary sexual dysfunction (e.g. vaginismus or vaginal dryness).

F52.7 Excessive sexual drive

Both men and women may occasionally complain of excessive sexual drive as a problem in its own right, usually during late teenage or early adulthood. When the excessive sexual drive is secondary to an affective disorder (F30-F39) or when it occurs during the early stages of dementia (F00-F03), the underlying disorder should be coded.

Sexual dysfunctions in men

The types of sexual dysfunction men may experience include:

- **Erectile dysfunction (ED).** Erectile dysfunction is when a man cannot achieve or maintain an erection appropriate for intercourse. This can be due to a problem with blood flow, a nerve disorder, or injury to the penis. It can be caused by medical conditions, such as diabetes or high blood pressure, or by anxiety about having sex. Depression, fatigue, and stress can also contribute to erectile dysfunction.
- **Ejaculation problems.** These include premature ejaculation (ejaculation that occurs too early during intercourse) and the inability to ejaculate at all. When ejaculation happens before or immediately after penetration, it is called premature ejaculation.

This is often a consequence of performance anxiety. Causes include medications, like some antidepressants, anxiety about sex, a history of sexual trauma (such as a partner being unfaithful), and strict religious beliefs.

- It can also be due to other psychological stressors or sexual inhibitions. Nerve or spinal cord damage and certain medications can interfere with normal ejaculation.
- Inhibited ejaculation is when you can't ejaculate at all. Some men, particularly those who have diabetic neuropathy, experience something called retrograde ejaculation. During orgasm, ejaculation enters the bladder instead of exiting out of the penis.
- **Low libido.** Psychological issues like stress and depression, as well as anxiety about having sex also can lead to a decreased or no sexual desire. Decreased hormone levels (particularly if testosterone is low), physical illnesses, and medication side effects may also diminish libido in men.

Sexual dysfunction in women

Sexual dysfunction in women is grouped into different disorders: sexual pain, problems with desire, arousal problems, and orgasm difficulty. Changes in hormone levels, medical conditions, and other factors can contribute to low libido and other forms of sexual dysfunctions in women. For example, if a woman is unable to experience orgasm, she will often find herself unable to enjoy other aspects of lovemaking and will thus lose much of her sexual appetite. Specifically, sexual dysfunction in women may be due to:

- **Vaginal dryness.** This can lead to low libido and problems with arousal and desire, as sex can be painful when the vagina isn't properly lubricated. Vaginal dryness can result from hormonal changes that occur during and after menopause or while breastfeeding, for example. Psychological issues, like anxiety about sex, can also cause vaginal dryness. And anticipation of painful intercourse due to vaginal dryness may, in turn, decrease a woman's desire for sex.
- **Low libido.** Lack of sexual desire can also be caused by lower levels of the hormone estrogen. Hormonal changes following childbirth, breastfeeding, and menopause can interfere with a woman's interest in sex. Fatigue, depression, and anxiety can also lead to low libido, as can certain medications, including some antidepressants.
- **Difficulty achieving orgasm.** Orgasm disorders, such as delayed orgasms or inability to have one at all, can affect both men and women. Again, some antidepressant medications can also cause these problems.
- **Pain during sex.** Pain is sometimes from a known cause, such as vaginal dryness or endometriosis. But sometimes the cause of painful sex is elusive. Known as vulvodynia or vulvar vestibulitis, experts don't

know what's behind this mysterious type of chronic, painful intercourse. A burning sensation may accompany pain during sex.

Management of sexual dysfunctions

Psychological Management

A therapist can teach you how to cope with stress and anxiety. Joint counseling with your partner can help improve communication and increase intimacy. Sometimes, a little support and education about sexual behavior is all that is needed. Body image and other inhibitions can be addressed in counseling. For deeply rooted sexual dysfunction, psychotherapy may be required. When clinicians first turned their attention to sexual dysfunction at the beginning of the 20th century, they believed it was caused by masturbation in childhood or too much sex as an adult. The treatment: Preventing masturbation and reducing sexual activity.

These days, psychologists and other clinicians focus on restoring sexual functioning and pleasure. They have developed effective treatments for many common conditions. Here are some effective coping strategies for sexual problems.

- **Lack of desire.** This increasingly common problem occurs when people lack any interest in sexual fantasies or activity and suffer distress or relationship problems as a result. Treatment is a multi-step process. Therapists begin by helping clients identify negative attitudes about sex, explore the origins of those ideas and find new ways of thinking about sex. The focus then shifts to behavior; therapists may ask clients to keep diaries of their sexual thoughts, watch erotic films or develop fantasies. Therapists also address any relationship problems.
- **Erectile dysfunction.** When the penis fails to become or stay erect, intercourse becomes impossible. The cause is typically a mix of physical and psychological factors. Physical causes include illnesses like diabetes or medication side effects (Psychiatric medicines). One of the main psychological causes is performance anxiety. After the first incident, men sometimes get so nervous the problem occurs again.
 - a. Therapy focuses on reducing anxiety by taking the focus off intercourse.
 - b. **Premature ejaculation.** Ejaculation is premature when it occurs so soon after intercourse begins that it causes emotional distress. While the causes still are not understood, treatment works in almost all cases. Therapy focuses on behavioral training. With his partner's help, the man learns to withstand stimulation for longer and longer periods.

Painful intercourse: Painful intercourse, or dyspareunia, is recurrent or persistent genital pain that causes significant distress or relationship problems. Most cases especially among men involve a physical problem. An

urologist or gynecologist should rule out or address any medical concerns. For women, the typical treatment focuses on relaxation training.

Pharmacological Treatment: If no psychological cause is found, physical treatment may help. Treatment depends on the specific cause. Sometimes, treating an underlying medical condition will resolve the situation. In some cases, switching medications may do the trick.

ED treatment has advanced a lot in recent years. Many men have positive results using prescription medications like Sildenafil citrate (Viagra). Other remedies include mechanical aids, penile implants, or surgery.

Lubricating gels or creams or hormone therapy may solve the problem of vaginal dryness.

Long Term Outlook: Often, the longer a sexual dysfunction goes on, the more your level of stress and anxiety rises. This can perpetuate the problem. Most of the time, the prognosis for sexual dysfunction is quite good. However, some medical conditions make it more difficult to overcome.

When approached openly, sexual dysfunction brought on by stress or temporary circumstances can be reversed in short order. Deep-seated psychological issues may take longer, or may never be fully resolved.

Communication is important. If you have any type of sexual dysfunction, talk to your partner. Don't hesitate to seek medical advice. The National Institutes of Health (NIH) urge victims of sexual assault to seek counseling. You are more likely to experience sexual dysfunction if you abuse alcohol or drugs. Before taking new medication, learn about potential side effects and take only as directed.

Give yourself a break. Sexual dysfunction happens to most people at one time or other. If it becomes an ongoing problem, don't let embarrassment stop you from seeking help.

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