UNIT 3 PROBLEMS RELATED TO SEX

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3.0 INTRODUCTION

Love and intimacy form the foundation of any relationship. The characteristics of an intimate relationship include an enduring behavioural interdependence, attachment and need fulfillment. Intimate relationships include friendships, dating and marital relationships and spiritual relationships. Intimacy does not necessarily mean sex. Every human interaction offers the possibility of love, “a strong feeling of deep affection”. Love is a total submission of will, the absolute dedication of the entire being to the beloved. Sternberg has described three components of love: intimacy, commitment and passion. Passionate love is marked by a strong sexual longing.

‘Sex’ (as commonly used in English language) refers to male or female based on biological characteristics. However ‘gender’ refers to public lived role as male or female; gender identity refers to the social identity of the individual. Gender identity (usually set before 18 months of age) in a child is irreversibly established before 3 years of age. Psychosexual disorders can be broadly grouped under 3 categories: sexual dysfunctions, gender identity disorders and paraphilias. In this unit, we will be discussing about common problems related to sex and psychosexual disorders.

3.1 OBJECTIVES

After studying this Unit, you will be able to:

- explain the basic concepts of human sexuality;
- describe the problems related to sex and sexual dysfunction;
discuss the etiology and epidemiology of sexual dysfunction; and
• know the common psychosexual disorders and their management.

3.2 SEXUALITY

Sexuality is a multi-dimensional concept which includes the desire for sex, the sexual act and values, and beliefs about sex. (Kaiser, 1996). It is an important aspect of the personality of an individual and has physical, intellectual, psychological and social dimensions. Sexuality involves the whole experience of a person's sense of self, ability to form relationships, and feelings about themselves. Sexual desire is an innate urge of animals and humans alike. The pleasures associated can be some of the most delightful joys experienced by the human being. It should not be ignored or become a boring act, just for the purpose of progeny.

Sexual identity is the pattern of a person's biological sexual characteristics. Gender identity is a person's sense of maleness or femaleness. It is firmly established by the age of 2 or 3 years. Sexual orientation describes the object of a person's sexual impulses: heterosexual, homosexual, or bisexual. Sexual behaviour includes desires, fantasies, pursuit of partners, autoeroticism, and all the activities engaged to express and gratify sexual needs. Normal sexual behaviour brings pleasure to both partners, involves foreplay and stimulation of the primary sex organs including coitus; it is devoid of inappropriate feelings of guilt or anxiety and is not compulsive. In accordance with a patient centered approach, a sexual problem exists when an individual comes with difficulty in sexual functioning which may be associated with behavioural, affective or cognitive symptoms.

Sexual functioning and its disorders have been described in significant detail in ancient writings of India like Vatsayana's 'Kamasutra'. There have been significant contributions from others like Masters and Johnson. The main theme in Kamasutra appears to be the expression of Indian attitude toward sex as a central and natural component of Indian psyche and life.

Sexuality of an individual is an interplay of varied factors; hence an interdisciplinary approach is required (see Fig 1).
3.3 PROBLEMS RELATED TO SEX AND SEXUAL DYSFUNCTION

Sex is an integral part of human life. Though the Indian society is going through changes in attitude towards sex, sexuality and sexual behaviour, open discussion and communication regarding these in the family is still a taboo. There are many myths and misconceptions related to sex and sexual behaviour that creates problems in sexual relationship. Patriarchal attitude, gender and cultural norms of the traditional Indian society concerning expression and conduct related to sex and sexuality may lead to problems of sexual abuse, incest, sexual harassment and rape. Though the scenario is changing, there are also issues about sexual orientation. There are various disorders also related to sex described as Sexual Dysfunctions in DSM V (2013).

DSM V (Diagnostic and Statistical Manual of Mental Disorders 5th Edition) defines Sexual Dysfunctions as “a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person’s ability to respond sexually or to sexual pleasure.” Sexual dysfunctions have been further subdivided into subtypes depending on the duration and other criteria: subtypes include: Lifelong vs acquired and Generalized vs situational. Further i) partner’s and individual vulnerability factors, ii) relationship factors, iii) psychiatric comorbidity, iv) cultural, and v) general medical factors need also to be considered.

Classically, sexual inadequacy refers to some specific disruption of the ‘sexual response cycle’, as described by Masters and Johnson in 1970. Sexual response cycle encompasses phases of desire / appetite, excitement or arousal – plateau, orgasm and resolution, both in men as well as women.

3.3.1 Classification of Sexual Dysfunction

WHO’s International Classification of Diseases, 10th edition (ICD-10) classifies the sexual dysfunctions as below:

- Lack or loss of sexual drive. (includes frigidity)
- Sexual aversion and lack of sexual enjoyment (sexual anhedonia)
- Failure of genital response (erectile dysfunction or impotence)
- Orgasmic dysfunction (inhibited orgasm, anorgasmia)
- Premature ejaculation
- Non-organic vaginismus
- Non-organic dyspareunia.
- Excessive sexual drive (nymphomania)

The detail classification as mentioned in ICD 10 is given in the box below.

**ICD – 10 - W.H.O.(World Health Organization) Classification**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F52</td>
<td>Sexual Dysfunctions, not caused by organic disorder or disease</td>
</tr>
<tr>
<td>F52.0</td>
<td>Lack or loss of sexual drive</td>
</tr>
<tr>
<td>F52.1</td>
<td>Sexual aversion and lack of sexual enjoyment</td>
</tr>
</tbody>
</table>
3.3.2 **Epidemiology of Sexual Dysfunction**

Sexual dysfunctions are quite common but they remain under reported due to various reasons like cultural factors, personal nature of the problem, etc. Further, frequency of reporting and seeking help for sexual problems varies due to i) availability of medical facility ii) inadequate knowledge of individuals, and iii) cultural constraints.

According to the famous sex therapist couple Masters and Johnson, around 50% of all Americans have been reported to have sexual problems sometime during their life. Prevalence increases with age in both sexes; about 40-45% of adult women and 20-30% of adult men have at least one sexual dysfunction. The Committee on Epidemiology/ Risk Factors of Sexual Dysfunction in 2004 reported incidence for erectile dysfunction as 25-30/ 1000 person in a year. Prevalence of erectile dysfunction increases with age going up to 20-40% in 60+ population.

Prevalence rates for ejaculatory dysfunction range from 9% to 31%. Prevalence of low sexual desire in women varies from 17 -55%, disorders of arousal and lubrication from 8 to 15% and orgasmic dysfunction is seen in 25% of 18 to 74 year old women.

The prevalence of ED varies with age as mentioned below:

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Erectile Dysfunction (ED) : Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>1-9%</td>
</tr>
<tr>
<td>40-59</td>
<td>2-9%</td>
</tr>
<tr>
<td>60-69</td>
<td>20-40%</td>
</tr>
<tr>
<td>70+</td>
<td>50-75%</td>
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</table>
In an Indian clinic based study from Mysore (Rao, 2003), 6% of the males had sought psychiatric help primarily for sexual problems in a tertiary care teaching hospital. Sexual misconceptions constitute a large number of cases presenting with sex related problems in the Indian studies.

**Self Assessment Questions 1**

1) **Explain the terms “Love”, “Intimacy” and “Sex”**.

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2) **What do you understand by “Human Sexuality”?**

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3) **Discuss epidemiology of erectile disorders.**

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**3.3.3 Etiology of Sexual Dysfunction**

Human sexual response involves biological, interpersonal social and cultural factors. For the successful completion of the sexual act, the important components include presence of sexual drive (libido), an attractive partner, and an environment free from distraction and anxiety, allowing in turn erection, penile insertion into vagina and coital movements leading to orgasm. Impotence may result if any of these factors is unavailable, e.g., poor libido, unattractive partner or threatening environment. Anxiety, worry, shame, guilt or fear may cause impotence. Ignorance, and a feeling that acts like masturbation and nocturnal emissions make one ‘weak’, also contribute towards impotence. The wife’s unfavourable comments or concern regarding her husband’s virility aggravate the situation.

Diagnosis of sexual dysfunction is not made if the problem is better explained by mental disorder like depression, a psychosocial stressor, substance use or a general medical condition.

**Psychological Causes**

**Socio-cultural factors:** Culture and religious values significantly influence sexual attitude of individuals. Sexual abuse, hasty sexual encounters, emotional trauma in childhood or adolescence can have a predominant negative impact on the sexuality of an individual.
**Individual factors:** Performance anxiety may develop due to self-imposed high standards, which is based on a ‘fantasy model’ of what is seen, heard or read in popular fiction, movies, etc. and may be detrimental. Monitoring one’s own sexual expertise, pleasure (spectatoring); myths, particularly concerning semen, masturbation and menstruation have a negative impact.

**Relationship and partner factors:** Anger, being passive or aggressive, choosing inappropriate time for sex, making oneself physically and psychologically repulsive to partner, finding excuses like claiming exhaustion, feigning illnesses, lack of trust and poor communication skills can make a healthy relationship strained.

Common causes of sexual dysfunction are listed as below:
- Relationship and partner factors (poor communication, partner’s sexual problems, marital discord)
- Psychiatric comorbidity and individual factors (anxiety/depression, other psychiatric disorders)
- Poor body image, performance anxiety
- History of sexual or emotional abuse
- Cultural factors (attitude towards sexual activity)
- General medical disorders
- Drugs (antihypertensives, antidepressants, sedatives, antipsychotics etc.)
- Alcohol and psychoactive substance use

Some of the characteristic psychological factors that act as predisposing, precipitating, perpetuating factors in males and females are detailed below in Table 1.

<table>
<thead>
<tr>
<th>Predisposing factors</th>
<th>Precipitating Factors</th>
<th>Maintaining Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Upbringing in a hostile environment</td>
<td>- Unreasonable expectations</td>
<td>- Performance anxiety( males)</td>
</tr>
<tr>
<td>- History of traumatic sexual experience</td>
<td>- Relationship problems/ Infidelity</td>
<td>- Lack of Intimacy</td>
</tr>
<tr>
<td>- Poor knowledge (Sexual function)</td>
<td>- Partner’s sexual dysfunction</td>
<td>- Impaired self-image</td>
</tr>
<tr>
<td>- Traumatic emotional experiences in early age</td>
<td>- Stress, psychiatric disorders(Anxiety/ Depression)</td>
<td>- Sexual myths</td>
</tr>
</tbody>
</table>

**Note:** Some of precipitating factors may later act as maintaining factors.

**Biological Causes**

**General medical disorders:** This includes a broad range of disorders like: Diabetes, hypertension, neurological disorders (spinal cord lesions), malignancies, traumatic cause, endocrine disorders.

**Drugs:** Sexual dysfunction may be caused by drugs used for treatment of other disorders; commonly implicated among these are: antihypertensives, antidepressants, antipsychotics, antiandrogenic drugs (digoxin), benzodiazepines.
3.3.4 Common Sexual Problems and Dysfunctions: Clinical Picture

We will be discussing common psychosexual dysfunctions here including psychogenic impotence, premature ejaculation, vaginismus, inhibited orgasm and dyspareunia. We will also touch upon masturbation and Dhat syndrome (a culture bound syndrome seen commonly in the Indian sub continent)

**Psychogenic impotence or erectile dysfunction**: Impotence refers to persistent or recurrent and partial or complete failure in a male to attain or maintain erection of penis sufficient for vaginal penetration and completion of sexual activity. It can be primary or secondary. In primary impotence, the man has never been able to achieve and maintain penile erection sufficient to perform coitus. In secondary impotence, a man, who was once able to perform coitus, developed impotence later. In selective impotence, the man is able to have coitus with certain women but not with others. For example, a person may be impotent with his wife but not with a prostitute.

**Premature ejaculation**: Premature ejaculation (PME) is characterized by ejaculation occurring with minimal sexual stimulation, or before or shortly after penetration. To make a diagnosis of PME, the complaint should be recurrent and persistent. A man can be termed as having PME, if he cannot control ejaculation for a sufficient length of time during intravaginal containment to satisfy the partner on at least half of the occasions.

PME is almost always functional in origin. It is very common in young men but most acquire control as they gain experience, and may form 35-40% of the patients presenting to psychosexual clinics in India.

Previous contact with prostitutes or premarital sex in situations where discovery would be embarrassing is responsible for the genesis of dysfunction, since in such places sex act has to be done quickly and the patient becomes conditioned to achieve orgasm rapidly. In an ongoing relationship, an adverse comment or a taunting response by the partner is often responsible for maintaining the problem.

**Inhibited Female Orgasm or Anorgasmia**: Inhibited female orgasm is characterized by recurrent and persistent inhibition of the female orgasm, as manifested by the absence of orgasm after a normal sexual excitement phase. This also includes consistent non-orgasmic response to all forms of physical stimulation, such as manual clitoral stimulation by the partner, masturbation and oral genital contact. If a woman is orgasmic in dreams or fantasies alone, she would also be considered primary non-orgasmic.

Non-orgasmic women may be otherwise symptom-free or experience frustration in a variety of ways including pelvic complaints such as lower abdominal pain, itching and vaginal discharge as well as increased tension, irritability and fatigue. Religious orthodoxy, negative psychosocial influence and male impotence are often the causes. Anorgasmia can also be drug induced. Psychotropic drugs are known to cause anorgasmia.

In situational orgasmic dysfunction, a woman has experienced at least one instance of orgasmic expression, regardless of whether it was induced by self or partner manipulation.

In management, the woman is directed to masturbate, sometimes using a vibrator. The shaft of the clitoris is the masturbatory site usually preferred by women, and orgasm depends on adequate clitoral stimulation. Cyproheptadine can reverse drug induced anorgasmia.

**Vaginismus**: Vaginismus is a severe psychophysiological syndrome severely affecting
women’s sexual response adversely, if not totally, and impeding coital function. The musculature investing the perineum and the outer third of the vagina contracts spastically due to a completely involuntary reflex, stimulated by imagined, anticipated or real attempts at vaginal penetration. It is a classical example of psychosomatic illness. A definite diagnosis of vaginismus cannot be established without the specific clinical support that only direct pelvic examination can provide.

Religious orthodoxy, psychological traumas, dyspareunia and homosexual orientation are the aetiological factors which produce vaginismus. Anxiety due to any other sexually related issue can also lead to vaginismus. Treatment consists of sex education, relaxation exercises and use of graded dilators.

**Dyspareunia:** Dyspareunia refers to recurrent and persistent pain occurring before, during, or after intercourse in either men or women. It is much more common in women and is often accompanied by vaginismus. An intact hymen or the bruised remnants of the hymenal ring, episiotomy scars, Bartholin’s glands infection and various forms of vaginitis or cervicitis are the usual causes. Insufficient lubrication and thinning of vaginal mucosa are often responsible in postmenopausal women. Cause should be treated.

**Dhat Syndrome:** Dhat syndrome is a culture bound syndrome of sexual dysfunction. Culture bound syndromes refers to a group of symptom clusters seen in a particular culture. Dhat syndrome is common in the Indian subcontinent. Patients often present with complaints of passage of a whitish discharge with urine, described as ‘Dhat’, believed to be semen by the patient, although there is no objective evidence of such discharge. The word ‘Dhat’ has been derived from the Sanskrit word Dhatu’, meaning the elixir that constitutes the body. Semen is known by the name ‘Viria’ in Hindi in India, derived from a Sanskrit word meaning bravery, power, or strength, or that which generates power and greatness. Charak Samhita, another ancient treatise on Indian medicine, describes a disorder resembling Dhat syndrome by the name ‘Shukrameha’ (spermaturia), in which the patient passes semen resembling urine or urine mixed with semen. In Ayurveda, the Indian system of medicine, loss of semen in any form is considered to lead to depletion of physical and mental energy. This belief is deeply ingrained in the Indian culture and is responsible for the symptoms of Dhat syndrome.

Malhotra & Wig (1975) called dhat a ‘sex neurosis of the Orient’. A typical case presents with multiple somatic complaints along with feelings of physical and mental exhaustion, attributed to the passage of semen in urine. Apart from a whitish discharge with urine there are no other urinary symptoms. Urine examination fails to reveal any abnormality.

Dhat syndrome is commonly seen in young males in the Indian subcontinent, especially in those from the lower socioeconomic strata of India and the subcontinent, as a mixture of neurotic features of asthenia, anxiety, depression, phobia and hypochondria in patients, who are usually young and attribute the myriad of symptoms to loss of semen in urine, in nocturnal emission, ‘bad dreams’, semenuria, masturbation or sexual intercourse. As the misplaced fear and ignorance are the core features of this syndrome, treatment primarily involves sex education and counseling.

**Masturbation:** Masturbation is considered a normal activity and part of sexual development in humans. Though religious institutions look down upon it as a sin, scientific evidence is contrary to it. However guilt associated with it is almost universal. It is considered as a method of releasing sexual tension in teenagers and lays the foundation for a healthy sexual life as adults. A number of misconceptions are associated with masturbation leading to guilt over earlier habits.
- It is bad.
- It causes blindness
- It leads to energy depletion.
- It is not a normal part of sexual development.
- People in relationships do not masturbate.
- Masturbation is not natural.

**Sex Addiction:** Sex addiction, as defined by Ewald, refers to engaging in any sexual activity that eventually transcends beyond any normal sexual practices to the point of losing control. There are broad range of sexual behaviours that may control the person's life; like compulsive masturbation, pornography, ongoing affairs, prostitution and telephone sex to name a few. An addict may spend an excessive amount of time devoted to the arrangement and recoveries of these sexual activities and will have a hard time trying to end the behaviours if they are able to at all.

<table>
<thead>
<tr>
<th><strong>Self Assessment Questions 2</strong></th>
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<tbody>
<tr>
<td>1) Explain the psychological and biological factors associated with sexual dysfunction.</td>
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| 2) Discuss briefly about Dhat syndrome. |
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| 3) Discuss briefly about the misconceptions associated with masturbation. |
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3.3.5 Sexual Dysfunction: Diagnostic Evaluation

Clinicians and patients both find themselves uncomfortable while working up through the sexual history. Developing rapport followed by a very sensitive history taking is important; the clinician should be empathic and non-judgmental. A physical examination is a must in all the cases. Both recent and past sexual history should be covered.

Patient’s current complaint, sexual practices, fantasies and goals, intimacy issues with partner, relationship problems, history regarding masturbation, sexual orientation and past history of sexual abuse need to be noted. The development of sexual identity from childhood and the effect of family members, other significant individuals and life events on the sexuality of the individual should be discussed. The effect of children, professional commitments and extramarital or premarital relationships if any, on the sexual life of the couple needs discussion. It is necessary to understand relationship difficulties among the couple, whether partner is sympathetic towards the problem, their expectations and motivation for treatment. High risk sexual behaviours should be enquired into.

Differences in socio-economic level, age, gender and culture between the clinician and the patient can be barriers towards adequate history taking. Females are usually reluctant to express their sexual problems, more so in the Indian context. Men with erectile dysfunction may have normal libido and ejaculatory function. Usually, psychogenic impotence begins suddenly, may be situation specific and is accompanied by normal nocturnal and early morning tumescence. Desire disorders and aversion disorders are encountered far more frequently in practice than expected earlier. However, organic erectile dysfunction starts gradually, presents consistently and there would be loss of early morning erections.

Laboratory studies should include blood tests for complete blood count, blood urea, serum creatinine, lipid profile, blood sugar, urine analysis, thyroid function and other endocrinal tests as required. Nocturnal penile tumescence, intracavernous pharmacologic injection using a vasodilating agent like papaverine, phentolamine & prostaglandin E1, Doppler studies may be indicated. In cases of organic causes, the patient should be referred to a urologist.

Differentiating features between psychogenic and organic sexual dysfunctions are given in Table-2. Areas to be covered in history taking of sexual disorders is given in Table-3.

**Table 2: Differentiating features between psychogenic and organic sexual dysfunction**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Organic</th>
<th>Psychogenic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Older (except trauma or surgery)</td>
<td>Younger</td>
</tr>
<tr>
<td>Onset</td>
<td>Gradual</td>
<td>Acute</td>
</tr>
<tr>
<td>Circumstances</td>
<td>Global</td>
<td>Situational</td>
</tr>
<tr>
<td>Symptom Course</td>
<td>Consistent or progressive</td>
<td>Intermittent</td>
</tr>
<tr>
<td>Desire</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Organic risks</td>
<td>Present</td>
<td>Absent, variable</td>
</tr>
<tr>
<td>Partner problem</td>
<td>Secondary</td>
<td>At onset</td>
</tr>
<tr>
<td>Anxiety and fear</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
</tbody>
</table>

*Adopted from Clinical Practice Guidelines for Management of Sexual Dysfunctions published by Indian Psychiatric Society (2006)*
Table 3: History taking for sexual disorders

<table>
<thead>
<tr>
<th>Identification</th>
<th>• Includes age, sex, education, profession, address, ethnicity, relationship status, sexual orientation, religion, social class, current stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current sexual functioning</td>
<td>• Type of sexual problem; onset, course, duration, aggravating and relieving factors; generalized or situational; with a particular partner only or multiple partners • Details of current sexual functioning-frequency, communication, foreplay</td>
</tr>
<tr>
<td>Past sexual history (from childhood to being an adult):</td>
<td>• Family attitude towards sex; family environment and parental attitudes; obtaining information/ misinformation about sex: at what age; masturbation, experiences related to any sexual interaction. Adult sexual activities: premarital and post marriage (frequency, first experience, masturbation, conflict with spouse)</td>
</tr>
<tr>
<td>Other issues</td>
<td>• Sexual abuse, chronic illness, paraphilic disorder, gender identity dysphoria, psychiatric history (anxiety, depression), substance abuse, poor general medical condition</td>
</tr>
</tbody>
</table>

3.3.6 Management of Sexual Dysfunction

Individual psychotherapies were the most common intervention for sexual dysfunction before 1970. The classic psychodynamic theories stressed on the early developmental conflicts as the core issue for sexual dysfunction. Hence resolution of these conflicts would lead to acceptance of sexual impulses to the ego and resolution of the problem. However, in actual practice behavioural techniques and other pharmacological therapies are often required for the management:

**Sex therapy (Dual Sex Therapy)** ideally includes involvement of both the patient and the partner for satisfactory outcome. Therapy should emphasize that there is no use blaming one’s partner or oneself, that sex is a mutual act between two individuals, and it is not something a man does to a woman or woman to a man. It can be a form of interpersonal communication at a highly intimate level; enhanced social communication benefits the relationship. Educating the couple, improved communication, heightening sensory awareness, and sensate focus exercises are taught to the couple. The assessment and treatment need to be tailored depending upon one’s setting, profession, specialty and most important of all, the type of the problem encountered in the client.

**Behavioural techniques**

Sexual dysfunction is considered as a maladaptive behaviour by behavioural therapists. Using a hierarchy of anxiety provoking sexual interactions, the client is systematically desensitized.
Annon (1974) proposed a graded intervention popularly called as PLISSIT MODEL wherein the individual letters stand for: P = Permission giving; LI = Limited information; SS = Specific suggestion; IT = Intensive sex therapy.

The therapy involves primarily sensitization, desensitization techniques. The general principles are applicable to majority of the inadequacies encountered in clinical practice. The major guide-lines to be followed are:

i) **Educating the couple/client:** The couple is advised to talk on issues bothering them in a nonjudgmental way, encourage partners to see, hear and understand each others’ perception and teach verbal and non verbal communication skills, in general and during sexual activity in particular.

ii) **Setting the framework for the therapy:** Inform ground rules of the therapy, dispel negative and sensational images of sex therapy and allow the couple to recognize and take responsibility for much of their treatment. The treatment has to be tailored towards the couple which acts as a marital unit, focusing in particular on the problems associated with the marital unit.

iii) **Proscribe sex:** It is recommended not to indulge in sexual activity till specifically asked so as to take off performance anxiety and pressure.

iv) **Sensate focus exercises:** These are structured exercises, about 3-5 sessions assigned between the visits. Help couple recognize that sexual activity is not limited to sexual intercourse and that “Pleasuring” and “Receiving Pleasure” can be enjoyable without being regarded as foreplay or a preliminary to sexual intercourse. The couple may progress slowly from non-demanding pleasure i.e. pleasing to explore one’s own feelings about the experience from non-genital area to breasts and then to penile pleasuring. Various stimulation methods are taught and the couple is advised to try different intercourse positions which may not necessarily lead to completion of sexual intercourse. One of these stimulation methods is using fantasies for stimulation, to avoid obsessive concerns termed ‘spectatoring’.

v) **Systematic Sensitization and Desensitization:** ‘Start-Stop Sensitization’ technique used for premature ejaculation is one of the most common and useful techniques under this heading. Here one partner provides manual stimulation to the other and is stopped at a signal from him when orgasm becomes imminent. Repeating this activity for certain duration of time, leads to some degree of control over ejaculation. Further the partners are advised to try intra vaginal containment, usually in female superior position. Partners should increase the rhythmic movements until the man gives the signal to stop. After a pause, they should repeat the act. With repeated attempts, the partners learn how to prolong the pleasure of intercourse while containing the urge to ejaculate. Similar desensitizing and sensitizing techniques are utilized in treating psychogenic erectile and orgasmic dysfunctions in men, and arousal and orgasmic dysfunctions in women. In women, with progressive stimulation of clitoral and other genital areas by partner, arousal is experienced without demand or pressure of intercourse.

**Integrated Sex Therapy**

Usually sex therapy is integrated with other treatment modalities when it is better termed as “Integrated Sex Therapy”. Supportive, psychodynamic (in certain cases), insight orientated psychotherapy and particularly behaviour therapy form part of the sex therapy program and lead to better results.
In “syndyastic sexual therapy” the focus is more on attachment dimension of sexuality. This improves intimacy and bonding in the couple and improves sexual functioning. Thus, the concept of syndyastic sexual therapy puts fulfilment of psychosocial fundamental needs into the focus of therapy, which makes it quite different from all other treatment methods.

**Self Assessment Questions 3**

1) Describe history taking in sexual disorders.

2) What do you mean by dual sex therapy?

3) What does PLISST stand for?

**Pharmacotherapy for sexual dysfunction**

**Pharmacological Management**

In recent years, a number of drugs have been introduced for treatment of impotence and premature ejaculation. These drugs improve inflow of blood into the penis and improve erection. These include sildenafil, tadalafil and vardenafil. These drugs are effective irrespective of the etiology of the erectile dysfunction. Patients who have benefited are those who have had erectile dysfunction due to psychogenic causes, spinal cord injury, diabetes mellitus and prostate surgery. Patients also benefit irrespective of age or baseline severity of erectile dysfunction. The magnitude of the benefit however varies. This means it does not produce a magic erection; rather it improves the strength of the erection, the duration of the erection, and the number of occasions on which the erection is satisfactory.

Selective Serotonin Reuptake Inhibitors (SSRIs) and dapoxetine have got efficacy in delaying ejaculation in patients with premature ejaculation.

**Testosterone** is definitively effective only in cases of hypogonadism. It can increase the desire but has no effect on erectile functioning. Female low sex drive and anorgasmia can be tried under careful monitoring. **Hormone Replacement Therapy (HRT)** with estrogen in case of menopausal women as vaginal function, particularly lubrication is determined by them.
In some selected cases when psychotherapy, behaviour techniques and drugs fail or seen to be not very effective, vacuum devices, injections and implants, vibrators are found to be relatively effective. Ultimately, the success of sex therapy depends on a host of factors. Therapy duration ranges from 6 weeks to more than a year in occasional cases. More than half of the cases of erectile dysfunction and almost all the cases of premature ejaculation respond to combination of therapies.

### 3.4 GENDER IDENTITY DISORDERS (GENDER DYSPHORIA)

The term gender refers to the public lived role as male or female. Gender identity refers to social identity of an individual; an individual’s identification as male, female or some other category.

In DSM-5, the term gender identity disorder has been removed and replaced by gender dysphoria. **Gender dysphoria** refers to distress that accompanies the incongruence between one’s experienced and expressed gender and one’s assigned gender.

**Intersexuality:** Develops where there was ambiguity at birth regarding child’s external genitalia. Examples include androgen sensitivity syndrome or congenital adrenal hyperplasia.

**Sexual maturation disorder:** Here the person suffers from uncertainty about his or her gender identity or sexual orientation which causes anxiety or depression.

**Dual role transvestism:** The subject wishes to lead a double role, spending part of his time as a male and part as a female.

**Transexualism:** is a gender identity disorder characterized by a persistent belief to be of the opposite sex. A male transsexual believes that he will grow up to be woman and lose his genitals. A female transsexual tends to present masculine appearance and behaviour. These individuals are characterized by behaviour of cross dressing before the age of 4 years in 75% of the individuals. No specific factor has been established conclusively. Early upbringing, lack of proper parental identification etc, are the causes. Treatment involves psychotherapy, behaviour modification, family therapy and in some selected cases sexual reassignment surgery.

### 3.5 PARAPHILIAS (SEXUAL DEVIATIONS OR PERVERSIONS)

The term ‘paraphilia’ is derived from the Greek words “para” which means next to and “philia” meaning love. Paraphilias are characterized by intense and persistent sexual interest in an object (may be inanimate) other than the genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”.

DSM-5 has further described Paraphilic Disorders as disorders based on,

1) anomalous activity preferences: further subdivided into (i) courtship disorders (voyeuristic disorder, exhibitionist disorder and frotteuristic disorder) & (ii) algolagnic disorders which involve pain and suffering (sexual masochism disorder and sexual sadism disorder); and

2) anomalous target preferences: (i) towards humans (pedophilic disorder) & (ii) directed elsewhere (fetishistic disorder and transvestic disorder)
Paraphilias are rare and occur mostly in men. They are characterized by recurrent intense sexual urges and sexually arousing fantasies generally involving either non-human objects, suffering or humiliation of oneself or one’s partner or children or other non-consenting persons. For the paraphilic patient, the imagery is persistent, the fantasies evoked are necessary for erotic arousal, for the relief from non-erotic tension and for sexual excitement and orgasm. Many paraphilics feel no distress and show impairment in the capacity for reciprocal affectionate sexual activity. No known genetic or biological factors have been implicated in its etiology. Upbringing, problems in mother-child relationship has been implicated. History of being sexually abused as children is common among these groups.

Other paraphilias include: bestiality or zoophilia, exhibitionism, fetishism, frotteurism, masochism, sadism, pedophilia, transvestism, and voyeurism.

3.6 HOMOSEXUALITY

The shift in understanding of homosexuality from being pathological to a normal variant of human sexuality occurred in the late 20th century. It was accepted as a normal variant by American Psychiatric Association in 1973 and by World Health Organization in 1992. Research has demonstrated that people with homosexual orientation do not have any psychological dysfunction and there is a distinction between desire, behaviour and identity; hence acknowledging the multidimensional nature of sexuality. Psychiatry uses terms like homosexuality, heterosexuality, bisexuality and trans-sexuality to encompass all related issues; however sociology argues for lesbian, gay, bisexual and transgender (LGBT), which focuses on identities. Research has led to the understanding that homosexuality is not a single phenomenon and that there may be multiple phenomena within the construct of homosexuality. People with homosexual orientation face conflicts in accepting their homosexual feelings (ego-dystonic homosexual orientation), more so in a hostile social environment.

Treatment of gender identity disorders and paraphilias is difficult and time consuming, often needs professional intervention. The recommended treatments are:

- To decrease deviant sexual arousal
- To develop heterosexual arousal
- To develop skills or social interaction with members of the opposite sex
- To provide training in assertiveness
- To provide training in empathy
- To attain sexual knowledge and
- To treat sexual dysfunction with the marital unit

Gay-affirmative psychotherapies help people cope with same-sex orientation. There is no evidence for the effectiveness of sexual conversion therapies; research data has shown very limited success with aversive therapies for homosexual orientation.
Self Assessment Questions 4

1) What do you understand by Gender Identity Disorders?
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2) What is Paraphilia?
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3.7 LET US SUM UP

Human sexuality is a multi-dimensional concept and involves the whole experience of a person’s sense of self. Sexual disorders are often underdiagnosed and undertreated, even when the diagnosis is made. Any of the psychosocial or biological factors may be involved in the etiology of sexual problems. Culture bound syndromes have significant importance particularly in the light of a particular culture; like Dhat Syndrome in the Indian culture. Sexual disorders are underdiagnosed and more-so undertreated, once the diagnosis is made. Recent research in this field has opened new avenues, for the use of novel approaches, in the understanding of sexual disorders.

3.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Love is a strong feeling of deep affection. Sternberg has described three components of love: intimacy, commitment and passion. The characteristics of an intimate relationship include an enduring behavioural interdependence, attachment and need fulfillment. Intimate relationships include friendships, dating and marital relationships and spiritual relationships. Intimacy does not necessarily mean sex. Sex as commonly used in English language, refers to male or female based on biological characteristics.

2) Sexuality is a multi-dimensional concept which includes the desire for sex, the sexual act and values, and beliefs about sex. (Kaiser, 1996). It is an important aspect of the personality of an individual and has physical, intellectual, psychological and social dimensions. Sexuality involves the whole experience of a person’s sense of self, ability to form relationships, and feelings about themselves.

3) Prevalence rates for ejaculatory dysfunction range from 9% to 31%.

Self Assessment Questions 2

1) Psychological factors include a) Socio-cultural factors, b) Individual factors, and c) Relationship and partner factors. Biological factors that explain sexual
dysfunction include general medical disorders such as diabetes, hypertension, neurological disorders (spinal cord lesions), malignancies, traumatic cause, endocrine disorders; and drugs.

2) **Dhat syndrome** is a culture bound syndrome of sexual dysfunction. Dhat syndrome is common in the Indian subcontinent. Patients often present with complaints of passage of a whitish discharge with urine, described as ‘Dhat’, believed to be semen by the patient, although there is no objective evidence of such discharge.

3) Misconceptions regarding masturbation include:
   - it is bad
   - it leads to energy depletion
   - it is not natural
   - it is not a normal part of sexual development

**Self Assessment Questions 3**

1) History taking in sexual disorders includes identification data, current sexual functioning, past sexual history, chronic illness, psychiatric history, substance abuse etc.

2) Dual Sex Therapy ideally includes involvement of both the patient and the partner for satisfactory outcome. The therapy emphasizes that there is no use blaming one’s partner or oneself and sex is a mutual act between two individuals.

3) **PLISSIT** stand for: P = Permission giving; LI = Limited information; SS = Specific suggestion; IT = Intensive sex therapy.

**Self Assessment Questions 4**

1) The term Gender identity disorder has been removed and replaced by gender dysphoria in DSM -5. It refers to distress that accompanies the incongruence between one’s experienced and expressed gender and one’s assigned gender.

2) Paraphilias are characterized by intense and persistent sexual interest in an object (may be inanimate) other than the genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.

### 3.9 UNIT END QUESTIONS

1) Discuss the etiology of sexual dysfunction.

2) Describe the management of sexual dysfunction.

3) Explain behaviour therapy for sexual disorders based on the PLISSIT MODEL.

4) Describe homosexuality with particular focus on India.

5) Discuss the interrelationship between stress, intimacy and sexual disorders in the modern society.

### 3.10 REFERENCES

Specific Issues on Mental Health

disorders. Published by Indian Psychiatric Society :144-32.


3.11 SUGGESTED READINGS


Sathyanarayana Rao TS, Jacob KS. The reversal on gay rights in India. Indian J Psychiatry 2014;56:1-2