

# Psychosexual Disorders-Really?

Psychosexual disorder simply refers to a sexual problem that is psychological, rather than physiological, in origin. These can be divided in two main categories:

- a. **SEXUAL DYSFUNCTION:** when physiologically normal function fails eg inability / difficulty to respond to erotic stimulation with arousal, erection or orgasm, or when desire in sex is diminished or absent that prevents the individual or couple from enjoying sexual activity. In males, erectile failure accounts for 60% of sexual dysfunction, premature ejaculation for 15%, and failure of ejaculation for 5%. In women, infrequent orgasm is most often complained of, with impaired sexual interest having a similar prevalence. Dyspareunia is also common.
- b. **SEXUAL DEVIANCE:** When a sexual behaviour violates the laws or norms of the society eg exhibitionism, paedophilia

Neither sexual dysfunction nor deviance indicates illness or pathology, though in a small proportion of cases this may be so, eg loss of sexual response with diabetes mellitus or exhibitionism with dementia.

Stupendous success of Viagra and other related compounds as well as ongoing research has shown that most of the conditions categorized as psychosexual disorders can also result from several organic causes. These must be eliminated, by careful history and necessary investigations, before labeling a patient and subjecting him/ her to counseling.

Sexual dysfunction disorders are generally classified into four categories: sexual desire disorders, sexual arousal disorders, orgasm disorders and sexual pain disorders.

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1. **Sexual desire disorders** or decreased libido can be caused by a decrease in normal estrogen (in women) or testosterone (in both men and women) production. Other causes may be aging, fatigue, pregnancy, medications — the anti-depressants group of drugs are well known for reducing desire in both men and women — or psychiatric conditions, such as depression and anxiety. Reduced desire may also be partner specific
2. **Sexual arousal disorders** were previously known as frigidity in women and impotence in men, though these have now been replaced with less judgmental terms. Impotence is now known as erectile dysfunction, and frigidity has been replaced with a number of terms describing specific problems with desire or arousal.
3. **Orgasm disorders** are a persistent delay or absence of orgasm following a normal sexual excitement phase. The disorder can occur in both women and men. Again, the antidepressants are frequent culprits — these can delay the achievement of orgasm or eliminate it entirely
4. **Sexual pain disorders** affect women almost exclusively, and are known as dyspareunia and vaginismus. Dyspareunia may be caused by insufficient lubrication. A very small percentage of men also may experience dyspareunia.

**Accepted norms of sexual behavior and attitudes:** These vary greatly within and among different cultures.

5. **Masturbation:** Once widely regarded as a perversion and a cause of mental disorders, is now recognized as normal sexual activity throughout life; it is considered a symptom only when it inhibits partner-oriented normal sexual behavior, is performed in public or is sufficiently compulsive to cause distress. Its incidence is about 97% in males and 80% in females. Although masturbation is harmless, in our society guilt created by the disapproval and disciplinary attitudes of others causes considerable

distress and may impair sexual performance. We, the Primary Care Physicians, owe it our patients to impart proper sex education and save them from the clutches of *Babas & their bhasmas*.

6. **Homosexuality:** About 4 to 5% of the population is preferentially homosexual for their entire lives. Since 1973, the American Psychiatric Association has not considered homosexuality a disorder. Like heterosexuality, homosexuality results from complex biologic and environmental factors leading to an almost inevitable preference in the selection of a sexual partner. For them, it is not a matter of choice. Still, many people, including physicians, regard homosexuality as immoral, and a physician's intense aversion to homosexuality may interfere with appropriate care of homosexuals.
7. **Frequent sexual activity** with several partners, one-night encounters, indicate a diminished capacity for bonding. Most cultures discourage extramarital sexuality but accept premarital coitus as normal. Today, most people have intercourse before marriage, as part of the trend toward more sexual freedom. The effect of satellite TV/ page 3 kind of titillating journalism is obviously eroding Indian cultural values. Well-informed Primary care physicians can offer sensitive, disciplined advice on sexual matters and should not miss opportunities for helpful intervention, keeping in mind that sexual practices differ by culture and that the strength of the sexual drive, individual needs, and the frequency of sexual contact vary greatly.

#### COMMONLY SEEN CONDITIONS

##### 1. ERECTILE DYSFUNCTION IN MALE

Erectile dysfunction is the repeated inability to initiate or maintain an erection firm enough for sexual intercourse until ejaculation.

##### Physiology of an erection

Specific steps during producing and sustaining an erection:

- Ø **Arousal:** The first step is sexual arousal, which men obtain from the senses of sight, touch, hearing, smell and from thoughts.

- Ø **Nervous system response:** Erection requires an intact parasympathetic reflex at S2 and S3. Ejaculation requires an intact sympathetic L1 root. The brain communicates the sexual excitation to the nervous system leading to increased blood flow to the penis.

- Ø **Blood vessel response:** A relaxing action occurs in the blood vessels that supply the penis, allowing more blood to flow into the shafts that produce the erection.

The penis contains two chambers full of spongy tissue called the corpora cavernosa. When a man becomes sexually aroused, impulses from the brain and local nerves cause muscles in the corpora cavernosa to relax, allowing blood to flow in and fill the spaces. This creates pressure in the corpora cavernosa, making the penis expand. A membrane called the tunica albuginea helps trap the blood in the corpora cavernosa, thereby sustaining erection. The erection is lost when the muscles contract to stop blood flowing into the penis, and open outflow channels.

##### What causes erectile dysfunction?

A successful, sustained erection requires a sequence of events to occur in a precise fashion. Anything which disrupts this sequence can lead to problems either getting, or keeping an erection. The most common cause of erectile dysfunction is damage to the tissues, either the nerves, arteries, muscles or fibrous tissue. This is often linked either to disease. Conditions such as diabetes, kidney disease, chronic alcoholism, multiple sclerosis and cardiovascular disease account for around 70% of cases of erectile dysfunction.

In some cases the condition is caused by damage to the nerves and arteries near the penis which can occur during surgery, particularly for prostate and bladder cancer. Physical injury to the penis, spinal cord, prostate, bladder or pelvis can also be a factor.

Psychological factors such as problems within a relationship, stress, anxiety, guilt, depression, low self-esteem and fear of sexual failure cause up to 20% of cases. Many cases of erectile dysfunction are partner specific. Smoking, which affects blood flow, has also been linked to the condition.



**HISTORY TAKING IN IMPOTENCE:** History is most valuable in deciding whether we should resort to detailed investigation and find the cause or accept it as psychosexual. Important features include:

- £ when, how and who is erectile dysfunction specific to
- £ early morning erections - if present, then organic causes are unlikely
- £ any anxieties about sexual matters
- £ ruling out organic causes
  - o diabetes
  - o alcohol
  - o drugs being taken which might influence potency - antihypertensives, antipsychotics, metastatic disease
- £ relationships
  - o conflicts
  - o conflict resolution - eg do they end rows by getting into bed?
  - o partner reaction – disgust at physical attribute or ridicule at lack of performance
  - o contextual threats “If you won’t give me that dress, I’m leaving”
  - o lack of proper communication
  - o depression
  - o sexual (masturbatory) fantasies - and the comparison with actual activity

**INVESTIGATIONS:** All patients should have a random plasma glucose or urinalysis for glucose to exclude diabetes. Further investigations to consider depending on history include:

- serum testosterone, prolactin, LH
- CBC
- LFTs, GGT, renal function, lipid profile

**COPING SKILLS**

Whether the cause of erectile dysfunction is physical factors or psychological factors or a combination of both, it can become a source of mental and emotional stress for a man — and his partner. If one experiences erectile dysfunction only on occasion, make him understand that it is not a permanent problem and not to expect it to

happen again during the next sexual encounter. One episode of erectile dysfunction should not be taken as a lasting comment on a person’s health, virility or masculinity

**TREATMENT**

Treatment depends on the cause.

Anxiety induced erectile failure is treated using a therapeutic regimen based on the sexual history, a period of abstinence from sexual activity for several weeks and then the onset of therapy. The general principle of the therapy is a process of patient re-education so that sex is approached without anxiety and the partner is told not to react in a rejecting and unhappy way if erection is not achieved but gradually to build up sexual activity without aiming at complete penetration by more and more time spent in foreplay. Getting an erection and knowing that there has to be NO penetration makes a patient realize that erection can be sustained well enough.

The process is designed to reduce the patient’s anxiety and increase his confidence until normal erectile function is regained, and thus normal sexual intercourse can resume.

**2. SEXUAL DYSFUNCTION IN WOMEN**

When men and women become sexually aroused, their genitals become engorged with blood. In women this normally results in:

- Enlargement of the clitoris and surrounding tissues (comparable to a male erection)
- Secretion of vaginal lubrication
- Relaxation and widening of the vaginal opening to permit intercourse.

FSAD patients have the desire to have sex but their genital area fails to respond in the normal way, making sex painful or impossible.

Although some cases of Female sexual dysfunction may be due to side effect of anti-hypertensives, it is usually linked to psychological causes. These can include:

- § Inadequate or ineffective foreplay
- § Depression
- § Poor self-esteem

- § Sexual abuse or incest
- § Feelings of shame or guilt about sex
- § Fear of pregnancy
- § Stress and fatigue

### 3. PREMATURE EJACULATION

Premature ejaculation is said to occur when a man ejaculates, with/ without an orgasm, too quickly for his sexual partner to achieve enjoyment from the act of love-making. Thus, the term premature is a very subjective one.

In addition allaying anxiety, firm compression of the glans penis just before ejaculation will inhibit the process. If this is then followed by a period of rest, intercourse may be recommenced and ejaculation delayed. This technique, as any other, relies on practice, but the practice may be fun, and the method provides a ready treatment procedure for this psychosexual disorder

### 4. DYSPAREUNIA

Dyspareunia is pain on intercourse, and is a potent cause of marital discord. It should be investigated swiftly. A relaxed atmosphere is essential (extremely rare in our clinics); the patient should be encouraged to discuss her symptoms in her own words and with plenty of time.

Dyspareunia may be classified as:

**SUPERFICIAL** - pain confined to the introitus

**DEEP** - pain experienced deep in the pelvis during intercourse

**ORGASMIC** - pain during orgasm

**POST COITAL** - pain follows coitus

#### CAUSES:

##### SUPERFICIAL

a. Infection - Trichomonas, vaginal candidiasis

b. Vaginal atrophy - Postmenopausal shrinkage; infrequent intercourse, inadequate or over-enthusiastic perineal repair following childbirth

**PSYCHOLOGICAL** - Vaginismus, fear, ignorance, previous painful intercourse, poor sexual stimulation

**DEEP:** Pelvic inflammatory disease, endometriosis, cervicitis, retroverted and retroflexed uterus - unlikely to cause significant dyspareunia unless associated

endometriosis

**PSYCHOSEXUAL** - Only diagnosed once organic causes excluded

#### ASSESSMENT:

##### HISTORY

~ Onset of pain - any relationship to life events, menstrual cycle; sudden or chronic problem - an acute onset suggests an organic cause whilst a chronic problem is more suggestive of a psychosexual disorder

~ Obstetric, menstrual, contraceptive and sexual histories assess woman's attitude towards sex

##### EXAMINATION

~ Abdominal examination

~ Speculum examination - swabs if infection suspected

~ Vaginal examination

**TREATMENT** Superficial dyspareunia - the cause is often apparent on examination. Treatment is dependent on cause. If vaginismus +/- other psychosexual disorder is the cause then treatment is via psychosexual counseling and the use of devices such as vaginal dilators.

Deep dyspareunia - treatment is dependent on cause

### 4. DYSPAREUNIA (MALE)

Yes, even males complain of Dyspareunia. In males it is usually the result of genital or prostatic infection. In some cases, however it may be used as a ploy to avoid sexual intercourse

### 5. VAGINISMUS

Vaginismus is a painful or spastic contraction of a woman's pelvic floor muscles that occurs with attempted penetration of the vagina, preventing successful sexual intercourse. It is most commonly caused by psychological problems but it may sometimes be due to vaginal inflammation. Women who have been raped, molested, sexually abused or examined roughly by a physician also may develop secondary vaginismus. In most cases the woman in question is affected by a past, painful (physical and/or mental) experience or has heard too many bad experiences of friends, relatives etc.

In general, women who have vaginismus are strongly

motivated to change. Many of them can learn to break their cycle of spastic contractions even with one limited pelvic exam performed with extreme gentleness. This shows that a finger can enter the vagina without causing any/ much pain. Female primary care physician can do this with attention to privacy and confidentiality. Allow the woman to be in charge of the exam; do nothing without her knowledge and permission and explain all parts of the examination in detail in advance. As the exam progresses, reassure the woman that her pelvic findings are normal (if they are normal). A partner can be counseled to show the woman the same degree of gentleness and communication.

Some women may require vaginal dilation as part of the treatment of vaginismus. The best vaginal dilator is the woman's own finger, which she can insert with the aid of a little lubricant. Artificial dilators are also available. Psychological causes of vaginismus can usually be treated effectively by counseling. Young women may be unable to begin having intercourse without pain. Some women with vaginismus shun sexual contact for fear that it may lead to attempted penetration. Other affected women have otherwise normal sexual response, and can reach orgasm through some form of masturbation.

**6. ORGASM FAILURE:** The female orgasm is brought about mainly as a result of clitoral stimulation and may not occur only via vaginal stimulation by the erect penis. If the individual has failure of orgasm then a careful history of the complaint must be taken. Often additional clitoral stimulation, ie manual, oral or mechanical, may be sufficient for the female to achieve orgasm. Failure to achieve orgasm is a problem that may have a significant psychological contribution as well as one of inadequate technique.

Well-informed physicians can offer sensitive, disciplined advice on sexual matters and should not miss opportunities for helpful intervention, remembering that sexual practices differ by culture and that the strength of the sexual drive, individual needs, and the frequency of sexual contact vary greatly. Psychological counselling can also play an important part in treating men/ women with

sexual problems, as can coaching in sexual foreplay and stimulation techniques.

#### SEXUAL DEVIATIONS

**Exhibitionism** -As a psychiatric term - refers to the exposure of genitals to unprepared persons, usually strangers, of the opposite sex, for the purpose of sexual gratification. Exhibitionists also desire to elicit shock in the victim and are almost exclusively males

**Fetishism** is a condition where the person may only achieve orgasm after being stimulated by various inanimate objects including items such as shoes, rubber raincoats.

**Paedophilia** is the repeated sexual activity - or fantasy of such activity - with prepubertal children. This is the sole or preferred means of an individual realizing sexual excitement. It is almost exclusively a disorder of men.

**Transvestism** is the practice of wearing articles of clothing of the opposite sex. It occurs more often in males. An individual may dress up in order to obtain sexual relief or before having heterosexual intercourse.

**Voyeurism** is characterized by recurrent, intense sexual urges or sexually arousing fantasies involving watching unsuspecting people who are naked, disrobing, or engaging in sexual activity. It is a normal reaction for an individual to become excited when observing others engaged in sexual intercourse. However in voyeurism an individual prefers repeatedly watching others involved in sexual activity as a means of sexual arousal. The voyeur may also watch women undressing or without clothes himself but will not attempt any sexual activity with them. The act of observation is usually accompanied by masturbation. This is a disorder of heterosexual men, whose sexual activities are usually inadequate.

Sexual deviation are for psychiatrists to handle.

