Sexual Dysfunction Disorders

Sexual dysfunction is characterized by a disturbance in the sexual response cycle or by pain associated with sexual intercourse and cause marked distress and interpersonal difficulty:

? Sexual desire disorders
? Sexual arousal disorders
? Orgasmic disorders
? Sexual pain disorders

Diagnostic Judgement:

? Age, culture, religion, and experience of the client
? Chronicity and frequency of the symptom
? Subjective distress and the effect on other areas of functioning.
? If sexual stimulation is inadequate in either focus, intensity or duration, the diagnosis of sexual dysfunction involving excitement or orgasm is not made.

A: Sexual Desire Disorders

Hypoactive sexual desire disorder
Persistent or recurrently deficient (or absent) sexual fantasies and desire for sexual activity.

The disturbance causes marked distress or interpersonal difficulty.

The sexual dysfunction is not better accounted for by another disorder and is not exclusively due to the direct physiological effects of a substance or a general medical condition.
Sexual aversion disorder*

Persistent or extreme aversion to, and avoidance of, all (or almost all) genital

sexual contact with sexual contact.

The disturbance causes marked distress or interpersonal difficulty.

Sexual dysfunction is not accounted for by another mental disorder except by another sexual dysfunction.

B. Sexual Arousal Disorder

Female sexual interest/arousal disorder

Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.

The disorder may result in painful intercourse, sexual avoidance, and the disturbance of marital or sexual relationships.

The disturbance causes marked distress or interpersonal difficulty.

Male erectile disorder

Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

Is associated with sexual anxiety, fear of failure, concerns about sexual performance, and decreased subjective sense of sexual excitement and pleasure.

The disturbance causes marked distress or interpersonal difficulty.

C: Orgasmic Disorders

Female orgasmic disorder.

Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. This is based on the age, sexual experience and adequacy of
sexual stimulation a woman receives.

The disturbance causes marked distress or interpersonal difficulty.

Premature/Early Ejaculation Disorder

Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.

psychological factors - newly married, fear about performance, stressful relationships etc.
Physical factors- some men may be tactilely sensitive, responding more intensely to stimulation.
Genito-pelvic pain/penetration Disorder
Dyspareunia (not due to a general medical condition)
Recurrent or persistent pain associated with sexual intercourse in either male or a female.
Vaginismus (not due to a general medical condition) ? Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes
with sexual intercourse.

General Treatment

Medication

Hormone shots, pills, or creams
Viagra
Mechanical aids
Penile implants, dilators
Sex therapy
Behavioral treatments
Avoid smoking, drinking, or drug use
Psychotherapy
Manage stress, anxiety, and concerns
Education and communication
About sex and sexual behaviors
Create an open dialogue
Management of sexual dysfunction disorders

Assessment

The following are some of the factors to be covered during the assessment interview:

Adopt Annon’s PLISSIT model

The nature and development of the sexual problem

Family attitudes towards sexuality – “taboo” element

Sexual knowledge: how and from where was it gained

Gender identity and role: did the individual feel safe with the gender identity or role during childhood or adolescent

Puberty: When did this occur, was it early or late compared with peers, was it traumatic, for the female; ask about the onset and early understanding of menstruation and subsequent patterns.

Masturbation: if it occurred, was it associated with guilt? Does the individual masturbate now? Enquire about masturbatory fantasies.

Interest in the opposite sex: when did it develop and what was the nature of the first heterosexual relationship?

Homosexuality: any early homosexuality, but more importantly, is there any current homosexual interests?

Relationships and sexual contacts prior to meeting the current partner: have there been partners; has sexual activity occurred in these relationships, and if so, were their problems

Current relationships: when did the couple meet; what attracted them to each other and how did the relationship develop; is there any general discord in the relationship of which sexual difficulty may be merely a symptom; (if so, general marital therapy might be indicated); has the sexual problem undermined general relationship?

How did the current sexual relationship develop:- was there a problem initially or it suddenly appear?

Are there any physical (e.g diabetes, neurological diseases, pelvic pathology, medicines) or psychiatric factors (mood and anxiety disorders) that could account for the problem?

Physical examination: if indicated to exclude organic causes of the dysfunction.

Therapeutic intervention

The treatment of sexual dysfunctions altered drastically following Masters and Johnson’s work in 1970. until then, more attempts at RX had involved lengthy psychoanalysis or psychotherapy of an

individual; producing only fair outcomes.

Principles of Masters and Johnson approach:

The couple is helped to communicate both verbally and nonverbally about and during sexual behavior.

Education is provided concerning sexual anatomy and physiology: the couple should concentrate on the uninhibited giving and receiving of sexual stimulation and allow spontaneous physiological reactions (e.g. erections, orgasm) to take care of themselves.

The “give to get principle” i.e. partners are encouraged to give pleasure to receive it.

Couples are engaged in a very intensive program of 2 – 3 weeks in which the

couple is encouraged to carry out a graduated series of “homework” assignments aimed at establishing a rewarding sexual relationship.

Therapists work in pairs (one male and one female).

Plan of psychosexual therapy:

Formulation: the couple together is given an explanation of their sexual difficulty in terms of past causes and current factors serving to perpetuate the problems.

Agreed ban on sexual intercourse and intimate touching in the early stages of treatment. Instead, the couple engages in:

Sensate focus: involves exploration of each other’s bodies in order to give and receive pleasurable sensations with emphasis on communication and giving pleasure in order to receive it.

Genital sensate focus: the couple moves to involve the genital and breast areas in their caressing and exploration.

Education: a very important part of therapy that involves providing information on sexual physiology and anatomy and how to engage in effective sexual stimulation. Visual aids are often

helpful.

Specific techniques: may be used aimed at correcting specific problems e.g. the “squeeze technique” for premature ejaculation or the use of graded dilators for vaginismus.

Gradual return to sexual intercourse: occurs usually through an intermediate stage of “vaginal containment” with no movement using the female superior or lateral positions. These positions are encouraged because they facilitate continuing use of such techniques as the “squeeze” and maybe effective stimulation of the female partner.

Biological treatment: Viagra (sildenafil), Cialis

Sexual disorders

1. **Paraphilias**

Paraphilias are recurrent and intense sexual urges or sexually arousing fantasies involving either nonhuman objects, children, or nonconsenting adults.

Types of paraphilias

1. **Frotteurism**: recurrent and intense sexual urges to touch and rub against non-consenting adults.

Common in men who rub their genitals against nonconsenting women esp when getting into and out of car. They can also rub their thighs and breast and achieve maximum satisfaction by doing so.

2. **voyeurism**: recurrent and strong sexual desire to observe unsuspecting people in secret as they undress or to spy on couples engage in intercourse. The person normally go near bedrooms at the outside of rooms and listen to the ongoing activities and if possible watches it.

3. **Exhibitionism**: recurrent sexually arousing fantasies or urges of exposing genitals (male) to another person, Their sexual relationships with their spouses are not satisfactory because they just expose to them without engaging them in an act

4. **Fetishism**: recurrent intense sexual urges, sexually arousing fantasies, or behaviors that involv