# AN OVER VIEW- SEXUAL DYSFUNCTIONS

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## Dr. Anita Shyam MD, FECSM

- Integrative Psychiatrist; Sexual Medicine specialist;
- ABS-Clinical Sexologist. Relationship , Intimacy & Sex Coach.
- Founding member and CMO at Rxmen (Qurex)
- NLP, Hypnotherapy, Spiritual & Pranic Healing Practitioner.
- Educator; Speaker; Researcher and Mentor
- Volunteer and Community Enthusiast

## Awards and Achievements

- University topper.
- India's first Clinical Sexologist and Sex Coach (since 2002).
- India's first and the only one Certified Surrogate Partner Therapist (STP)
- Privileged to be India's first and only Psychiatrist to write a thesis on Hijra community; loves to works with LGBTQ group.
- Author and Co-author for medical text books.
- National & International speaker.
- Publications in National & International Journals.
- Member & Fellow of National & International organizations.

# Goal of the Presentation

Over View of Sexual Dysfucntion in Males and Females

Assesment and Management of Sexual Dysfucntion in Males and Females

## Average Sexual Frequency

**Average adult**: 54 times per year (about 1 per week)

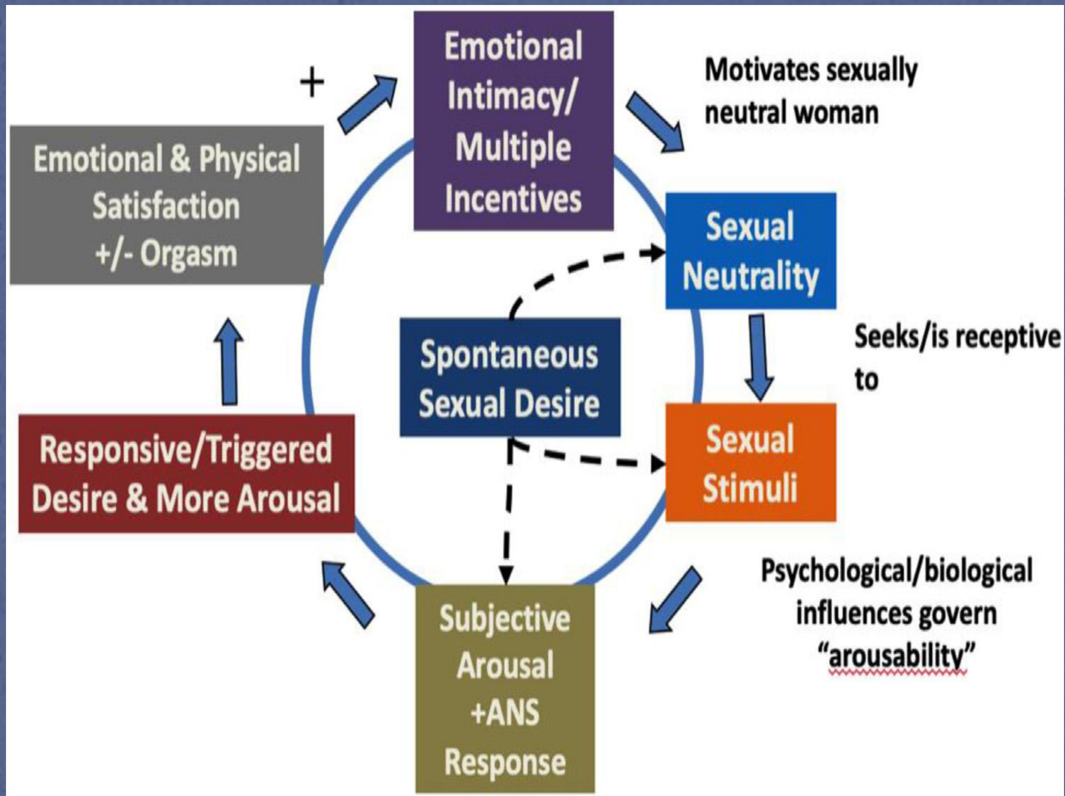
**Adults in their 20s**: Around 80 times per year

**Adults in their 60s**: 20 times per year

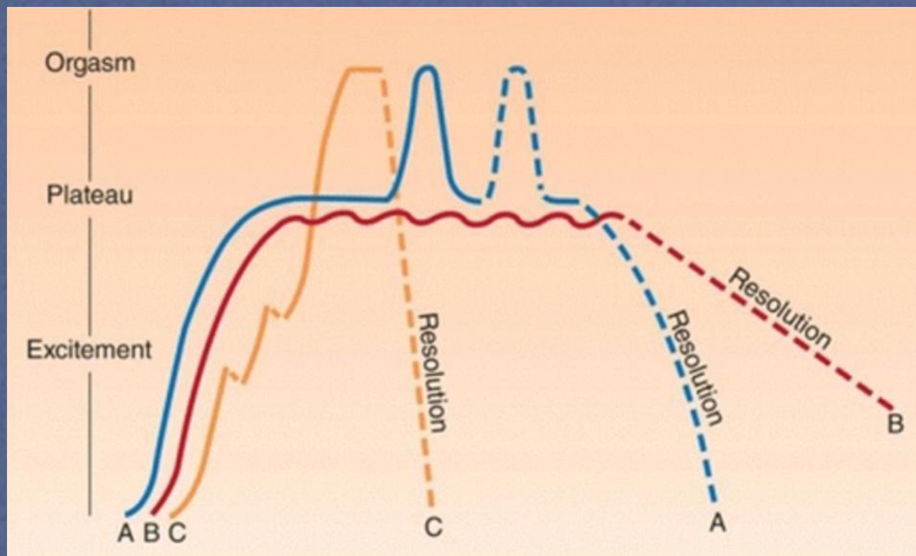
## Sexual Response Cycle

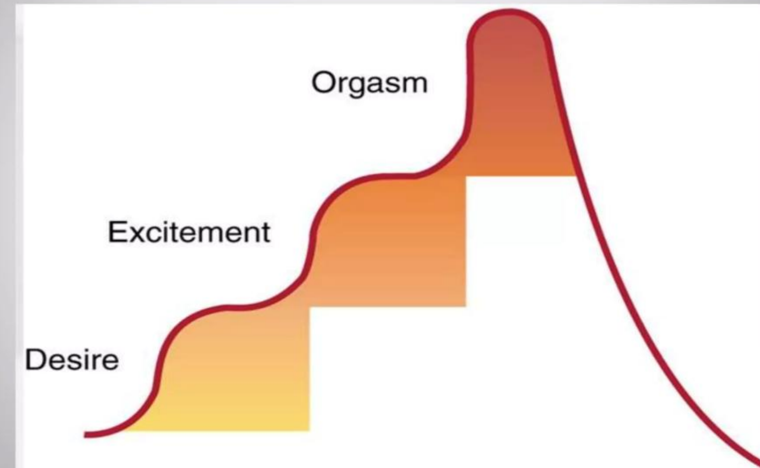
**The sexual response cycle refers to the sequence of physical and emotional changes that occur as a person becomes sexually aroused and participates in sexually stimulating activities, including intercourse and masturbation.**

Male

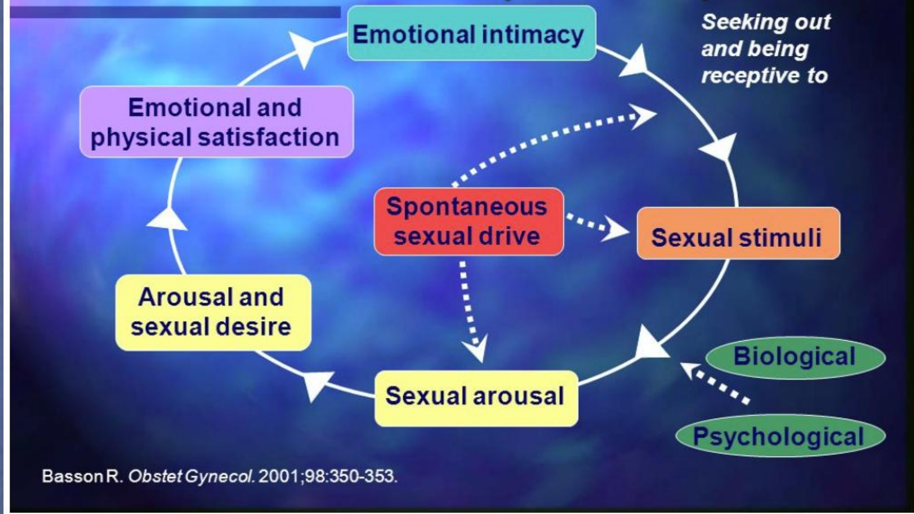



Female




Masters and Johnson's female sexual response cycle



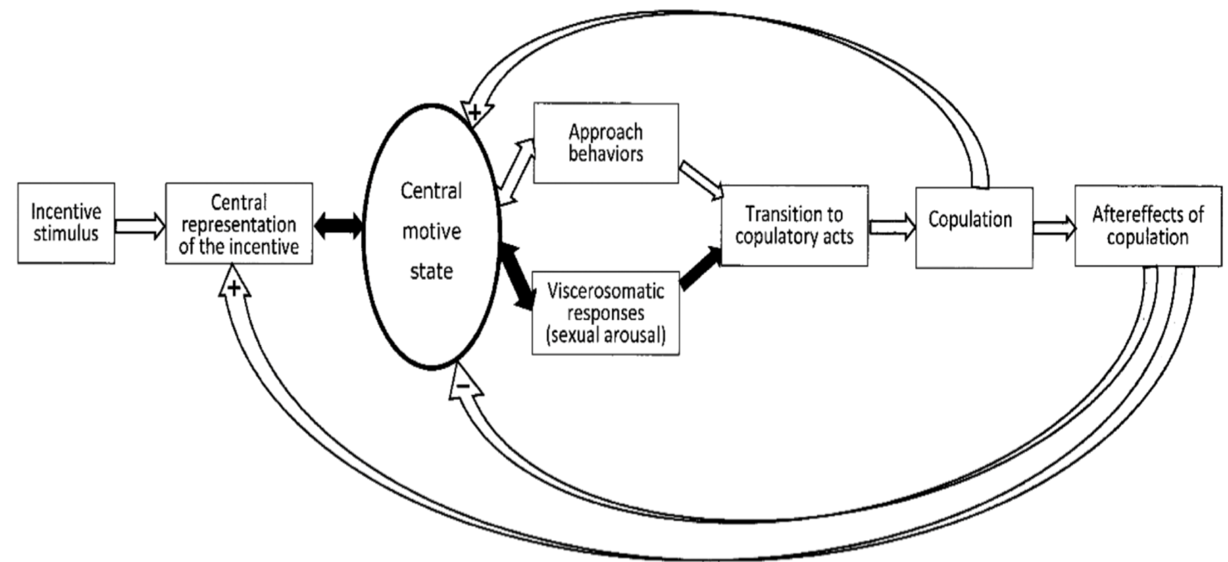
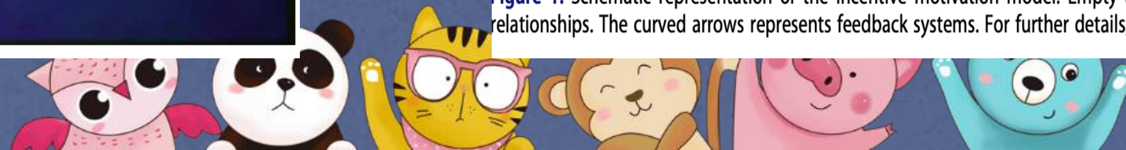




Figure 1. Schematic representation of the incentive motivation model. Empty arrows show unidirectional relationships, whereas filled arrows illustrate reciprocal relationships. The curved arrows represents feedback systems. For further details, see text. +, excitation. -, inhibition.



# Three main take-home messages from studying sexual response cycles-

1) Sexual pleasure and satisfaction aren’t reliant on orgasm, though orgasm may certainly be a nice bonus.

2)Sexual desire doesn’t always have to come before sexual activity or arousal. Sometimes getting physical and experiencing arousal will elicit desire.

3) External factors such as relationship dynamics, intimacy, and weighing rewards and costs of sexual experience may play an important role in sexual response.

4) Pleasure base not goal oriented

5)Shift the focus to you and your partner’s sexual response; communicate your needs both inside and outside the bedroom.

Biological

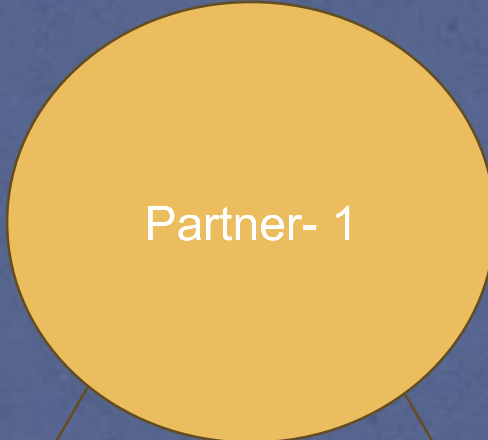
Social

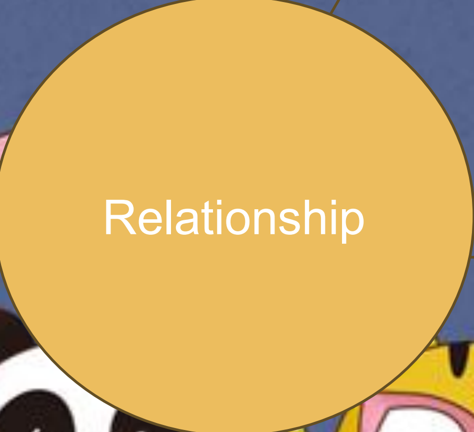
Psychological

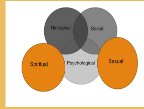
Spiritual

Sexual

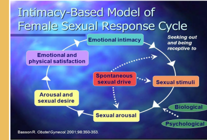
# Relationship triangle



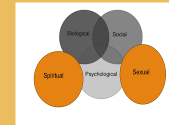





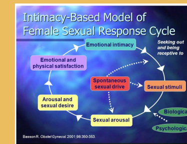

## Partner- 1




## Relationship



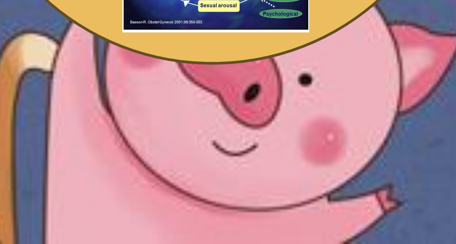

## Partner-2




Hi ~

Nice ~

Love



**Sexual dysfunction** is a difficulty/challenge experienced by an individual or a couple during any stage of normal sexual activity, including physical pleasure, desire, arousal or orgasm.

Causing extreme Distress to self and in the relationship;

Have a profound impact on an individual's perceived quality of sexual life.

DSM-5 also includes subtypes for all sexual disorders,
Specifier-
lifelong vs. acquired
generalized vs. situational

due to psychological factors vs. combined factors

**One or more conditions can co-exist in an individual at a given time.**

## Prevalence

43% of women and 31% of men have one or other kind of sexual dysfunction.

**Table 1: Comparison of diagnostic categories of ICD-10 & DSM-5 of sexual disorders**

| Disorders according to sexual cycle | ICD-10 | DSM-5 |
|---|---|---|
| **Sexual desire disorders** | Lack or loss of sexual desire | Male hypoactive sexual desire disorder |
| | Sexual aversion | Female sexual interest/arousal disorder |
| | Excessive sexual drive | |
| **Sexual arousal disorders** | Failure of genital response | Male |
| | | Erectile disorder |
| **Orgasm disorders** | Orgasmic dysfunction | Male |
| | Lack of sexual enjoyment | Premature (early) ejaculation |
| | Premature ejaculation | Delayed ejaculation |
| | | Female |
| | | Orgasmic disorder |
| **Sexual pain disorders** | Nonorganic dyspareunia | Female |
| | Nonorganic Vaginismus | Genito-pelvic pain/penetration disorder |
| | | Substance/Medication induced sexual dysfunction |
| **Other sexual disorders** | | |
| | Paraphilias | Paraphilic disorders |
| | Gender identity disorders | Gender Dysphoria |
| | | Gender Dysphoria in children |
| | | Gender Dysphoria in adolescent and adults |
| | | Other specified Gender Dysphoria |
| | | Unspecified Gender dysphoria |
| | Other sexual dysfunction, not caused by | |

# Assessment and evaluation

# Why Sexual Complaints Confuse Clinicians

- Sexual response is state-dependent, not trait-based

- Strong influence of context, relationship, meaning

- Risk of over-pathologising vs dismissing

## Evaluation and Intervention models used in clinical practice.

1) **ALLOW (Ask, Legitimize, Limitations, Open up, Work together).** Evaluation Systems of Female Sexual Function
2) **PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy**) by Jack S. Annon
**3) MEBES (Mind, Emotions, Body, Energy, Spirit)** by Dr. Britton

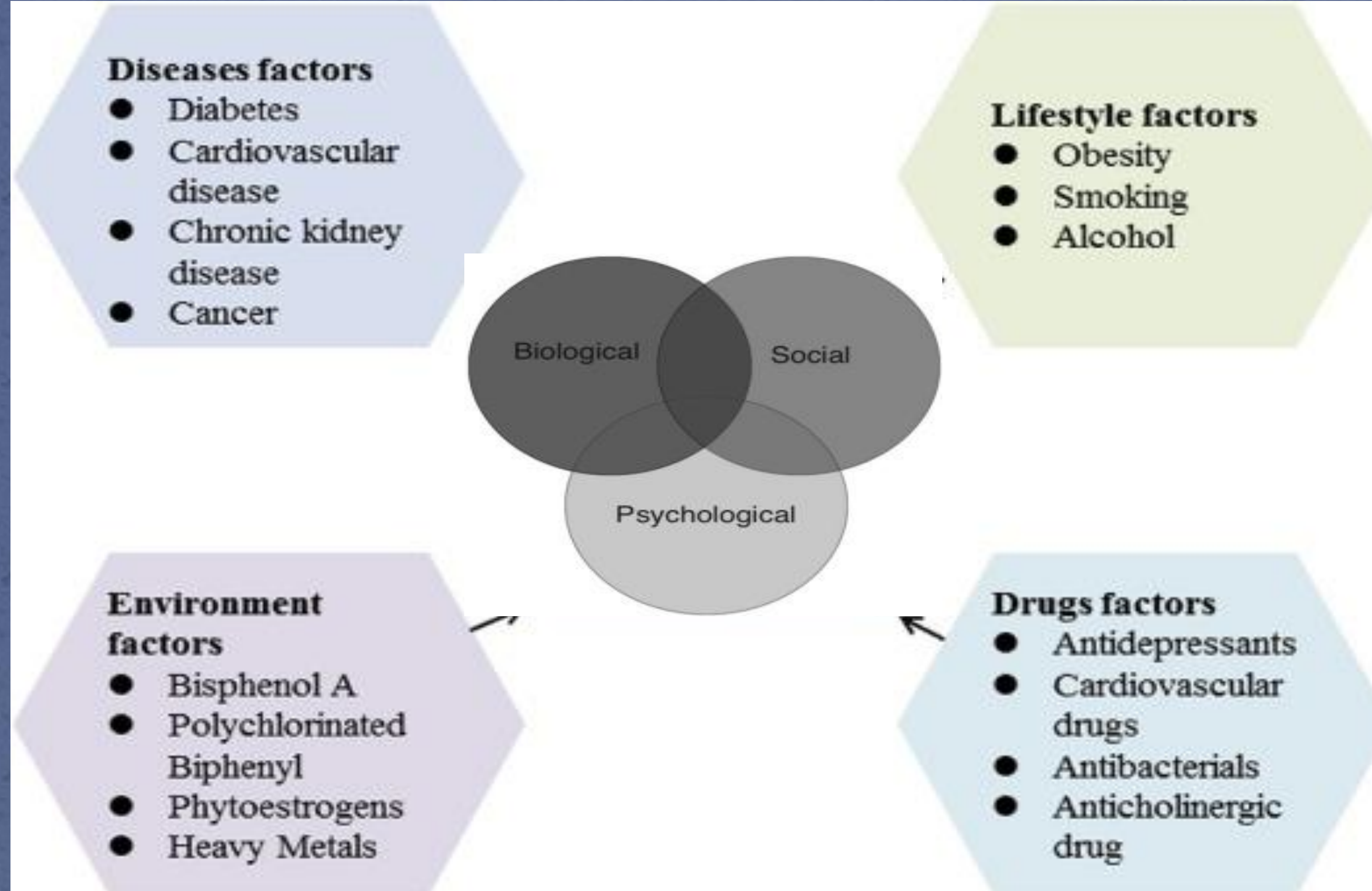
## Goals of Treatment-

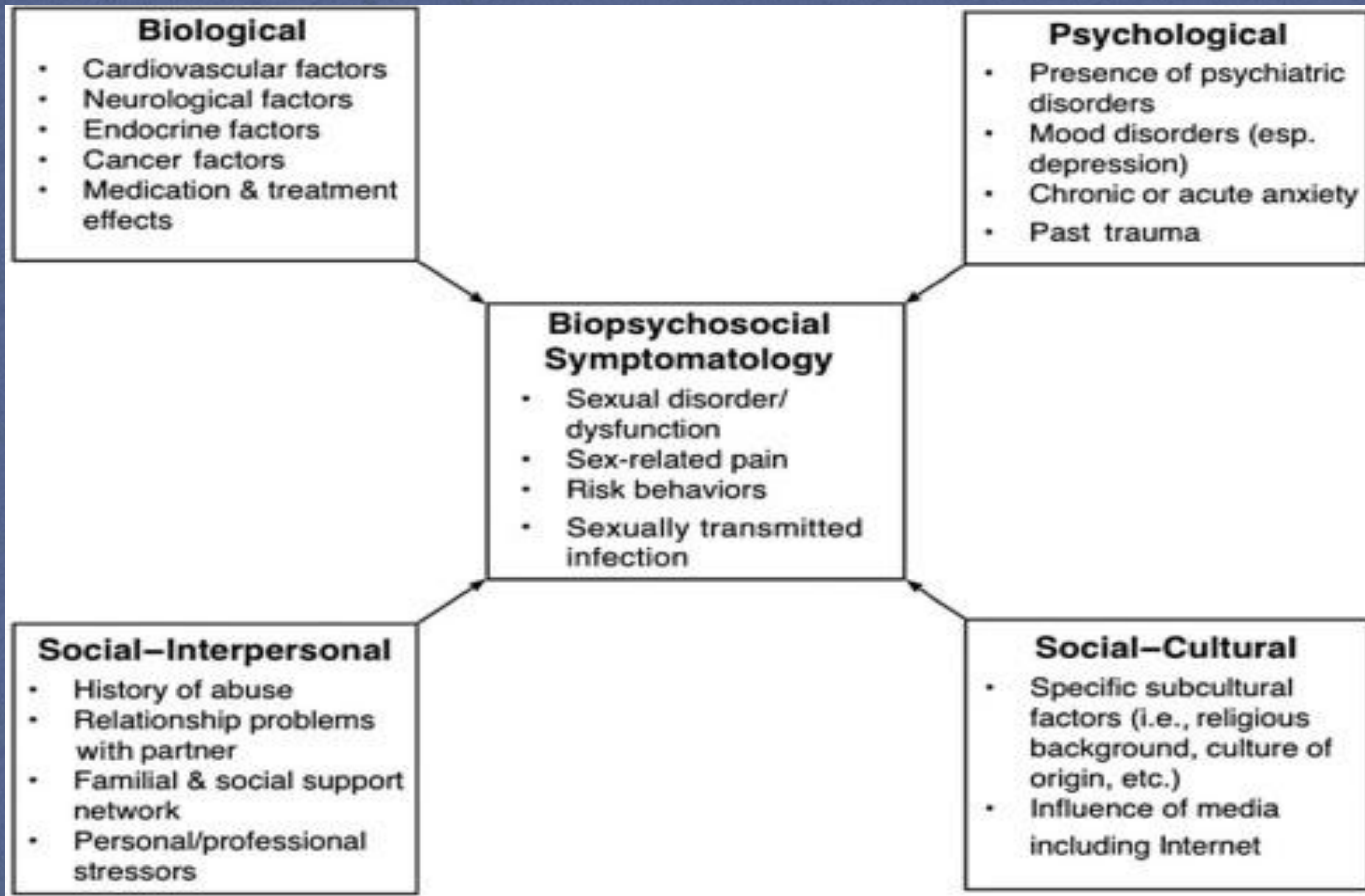
**Creating sex positive, open minded, body-based approach, client centered and goal oriented and result driven.** psychological counseling and adopting treatment procedures so as to improve the quality of their marital life and prevent disorders and mental diseases in women.

**Assessing potential causes and exacerbating; predisposing, precipitating; and maintaining factor. Working together as a team with Behavioral health clinician or sexual medicine expert who is experienced in Psychotherapeutic, Cognitive & Behavioral, and Sex Therapy Interventions**

Patient/client presenting with sexual dysfunction/ difficulty
Treating doctor
Psychosocial health provider
Step 1
Basic psychosocial evaluation
• Brief sexual history
• Psychosocial history
Psychosocial evaluation
• Comprehensive sexual history
• Psychosocial history
+
Comprehensive medical history
Mandatory
• Sexual history
Highly recommended
• Focused physical exam
• Laboratory investigations
Step 2
Findings indicate physiogenic etiology
Findings indicate combined biopsychosocial etiology
Findings indicate psychosocial etiology
Step 3
Patient/partner education & shared decision making
Step 4
Medical treatment
Combined medical & psychosocial treatment
Psychosocial treatment
Step 5
Biopsychosocial evaluation of sexual well-being

Sexual functioning is a complex bio-psycho-social process, coordinated by the neurological, vascular and endocrine systems.




Biological
Cardiovascular factors
Neurological factors
Endocrine factors
Cancer factors
Medication & treatment effects
Psychological
Presence of psychiatric disorders
Mood disorders (esp. depression)
Chronic or acute anxiety
Past trauma
Biopsychosocial Symptomatology
Sexual disorder/ dysfunction
Sex-related pain
Risk behaviors
Sexually transmitted infection
Social–Interpersonal
History of abuse
Relationship problems with partner
Familial & social support network
Personal/professional stressors
Social–Cultural
Specific subcultural factors (i.e., religious background, culture of origin, etc.)
Influence of media including Internet

## Table 3: Important aspects in evaluation of sexual dysfunctions

- Conduct the evaluation in a comfortable surroundings and ensure privacy
- Be empathic, non-judgmental, and understanding
- Preferably use the language in which patient is comfortable
- Use neutral terms (as opposed to vulgar terms) and proper medical terms as long as these are in common usage (e.g., use `penis' and `vagina', bu `lips' rather than `labia')
- Use anatomical drawings to understand patients knowledge and explain sexual issues to the patient
- Reassure the patient that sexual dysfunction or adjustment problems are common and treatable. For example, "It is common for some people to .'
- Explain things in simple, clear and specific terms. Some patients may not be able to understand the language which is commonly used by clinicia may feel embarrassed to admit this. Hence, whenever new terms are used, provide alternatives or explanations. Check with the patients that they the terms used.
- Start with general, non-threatening questions first (e.g., "Do you have a regular partner?") then ask more specific and potentially embarrassing questions (e.g., "Do you also experience this problem when you masturbate, that is, when you touch or stimulate yourself?").
- Assumptions must be avioded (e.g., sexual orientation, number of partners, sexual practices)
- If a couple has presented together, gather the information for a sexual history from each individual separately (i.e., not in each other's presence).
- Conduct the evaluation in presence of a female attendant/relative while examining patients of opposite gender.
- Make sure that the `problem' does not just reflect a lack of knowledge or unrealistic expectations on the part of the presenting individual or their
- Understand the cultural and religious factors which influence sexual issues
- Although sexual dysfunction may occur in isolation, but in many cases there may be co-existing problems contributing to the dysfunction (e.g., r difficulties, psychiatric or physical illness) - prioritize the treatment goals in such situations
- Assess psychological sophistication and motivation of the patient/couple

**Table 5: Differentiating features between psychogenic and organic sexual dysfunction**

| Characteristics | Predominantly Organic | Predominantly Psychogenic |
|---|---|---|
| **Age** | Older | Younger |
| **Onset** | Gradual (except trauma or surgery) | Acute |
| **Circumstances** | Global | Situational |
| **Symptom Course** | Consistent or progressive | Intermittent |
| **Desire** | Normal to start with | Decreased |
| **Organic risks** | Present | Absent, variable |
| **Partner problem** | Usually Secondary | Usually at the onset |
| **Anxiety and fear** | Usually Secondary | Usually Primary |

## Psychological factors associated with sexual dysfunctions

### Predisposing factors

- Restrictive upbringing
- Disturbed family relationships
- Traumatic early sexual experience
- Inadequate sexual information
- Insecurity in the psychosexual role
- Distraction

### Maintaining factors

- Performance anxiety
- Guilt
- Poor communication
- Loss of attraction between partners
- Impaired self-image
- Restricted foreplay
- Poor emotional intimacy
- Depression or anxiety
- Expectation of negative outcome
- Fear of intimacy
- Sexual myths and misconceptions
- Poor communication

### Precipitating factors

- Unreasonable expectations
- Random failure
- Discord in the relationship
- Dysfunction in the partner
- Infidelity
- Reaction to organic disease
- Pregnancy/Childbirth
- Poor emotional intimacy
- Expectation of negative outcome
- Depression or anxiety

Avasthi et al

## Table 2: Subtypes of sexual dysfunctions according to DSM-5

| | Subtypes | |
|---|---|---|
| Onset | **Lifelong:** present since the onset of sexual functioning | **Acquired:** develops after a period of normal functioning |
| Context | **Generalized :** not limited to certain types of stimulation, situation or partner | **Situational:** limited to certain types of stimulation, situation or partner |

## Psychophysiological Models

- Desire Discrepancy
- Dual control of sexual interest and response:
- Excitatory processes or Inhibition of sexual interest or response.
- Inhibition of sexual interest or response- adaptive response. (a distressing relationship or life circumstances that serves to help; avoid risky, distressing, or threatening sexual situations and behavior).

- **Psycho Sexual Education Model**
- **Desire is made up of 3 different elements.**
- **Libido or Drive –** is only one of those elements. Biological Mechanism.
- The other two elements are
- **Erotic script or cognitive component-** individual's expectations, beliefs, and values about sex.
- **Intimacy** or **"motivation,"-** the emotional and interpersonal factors that influence the individual's willingness to engage in sexual activity.

# Causes & factors

## Psychological & relational

- Stress, anxiety, depression, and performance pressure
- Past trauma or sexual abuse
- Negative body image & low self-esteem

Relationship conflict and poor communication

Guilt or shame about sexuality

## Medical & physiological

- Ageing, menopause & hormonal shifts
- Chronic illnesses (e.g., diabetes, hysterectomy, cardiovascular disease)
- Medications: SSRIs, antihypertensives and others

Hormonal disorders & endocrine issues

Pelvic pain, nerve damage, or vaginal dryness

## Situational & cultural

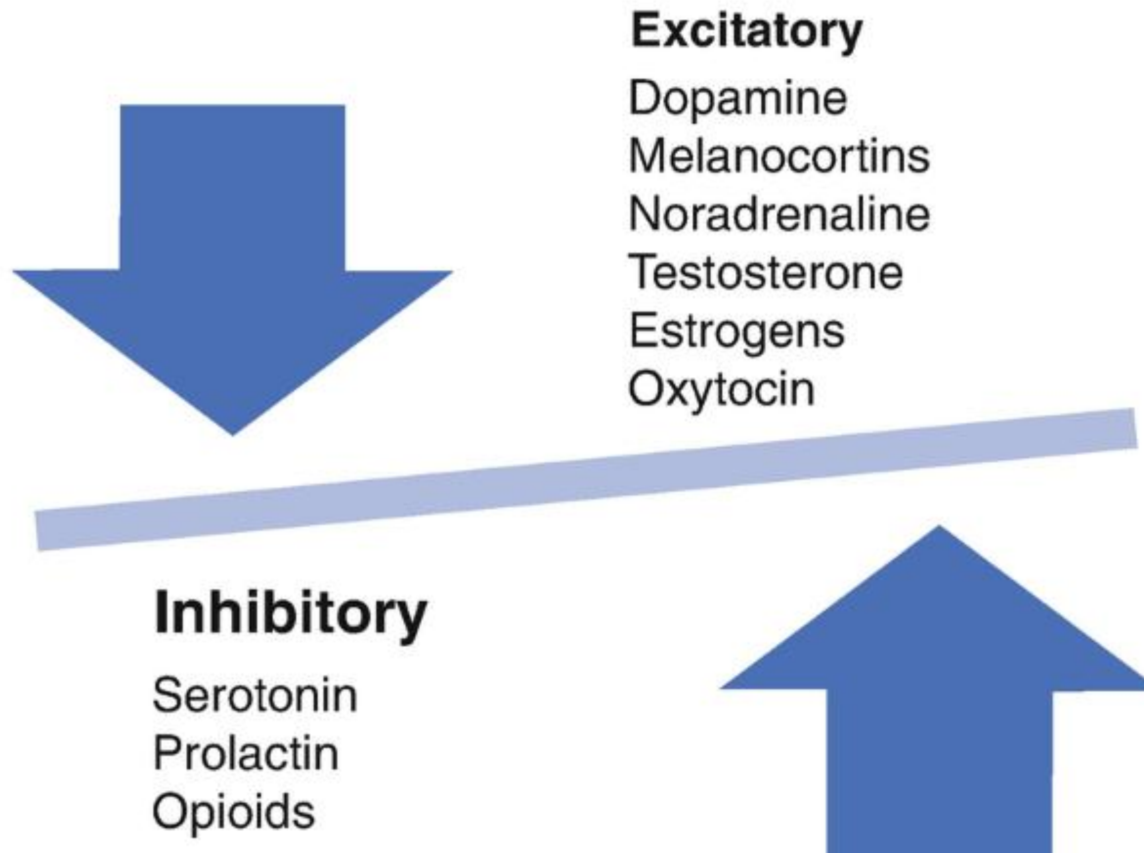
- Insufficient stimulation of the clitoris or boredom with routine
- Performance pressure or unrealistic expectations from media
- Cultural, religious or familial attitudes limiting sexual expression

Lack of sex education or anatomical knowledge

Time constraints, stressors and lack of privacy

“Responsive desire.”

“an Adaptive responses”



Excitatory and inhibitory central factors
Excitatory
Dopamine
Melanocortins
Noradrenaline
Testosterone
Estrogens
Oxytocin
Inhibitory
Serotonin
Prolactin
Opioids

# Management & Interventions

## A Psycho-Education and Psycho-sexual Therapy

Treatments for sexual pain disorders are time-consuming, and they require great patience and empathy, sensitivity to non-verbal signals and insight into relational interactions.

**Teaching about Sexual Response Cycle in .**

**Anatomy and Physiology**

**Educating about the factors causing the sexual challenge**

**Build a Plan with the client and partner involved.**

**Benefits and importance to sex in a relationship.**

## *Tempo- Go slow and low…*

The specific ***non-pharmacological*** ~~management~~ involves the following stages:

1. Sex therapy; Individual and Couples therapy – Experimental; Exploratory and Experiential and Enhancing. Masturbation protocol and communication skills and sexual communication skills.
Sex Map, Sex Diary and Sexual Calendar.

2. Body Image- Self acceptance. Positive psychology and Supportive therapy, Encouragement. Develop more positive attitudes towards body and genitals.
Open Communication

3. Focus on Pleasure and Satisfaction, non- goal-oriented approach – Sensate focusing( both Non genital and Genital), guided imagery. **A mainstay of sex therapy, "sensate focus" or "non-demand" or "sensual touching," can decrease the inhibitory effects of performance anxiety with exercises that employ a graded transition from nonsexual to sexual touching.**

4. CBT and MBCBT approach-
5. Behavioral tech- Systematic desensitization to reduce the symptoms of anxiety/fear.

a) **Vaginal penetration**- slowly and Graded- using fingertips start with touch and then finger insertion.
b) **Vaginal containment**- Encourage, Re-enforcement, Persistence and reassurance.
c) **Movements during containment:** Woman in charge.
d) **PME techniques**
e) **ED - Pelvic exercises**

**Body mapping (Sensation Play & Pleasure Mapping)** is a mindfulness-based intervention tool that supports and encourages participant-

1) self-reflection
2) self-expression
3) self-awareness
4) exploring and developing sexual pleasure from new areas of your body
5) introspection
6) personal connection
7) processing difficult emotions
8) reduces verbal communication barriers
9) facilitates personal experiences

**Instruction- Do the exercise in a comfortable and private space and time.**

**The Masters and Johnson method- is relatively brief, problem-focused and directive.**

Includes –

1) **Sexual therapy and education** provides information about human sexual anatomy and functional aspects, sexual reproduction and sexual intercourse. In vaginismus therapy the goal of sexual education is to describe biological and psychological mechanisms held responsible for the origin and maintenance of the condition.

2) **Sensate Focus-** direct behavioral exercises, including prescription of non-demand pleasuring, or 'sensate focus', wherein the objective was to (re)experience sexual pleasure in the absence of anxiety from perceptions of performance demand or excessive self monitoring of sexual performance.

Melnik T, Hawton K, McGuire H. Interventions for vaginismus. Cochrane Database Syst Rev. 2012 Dec 12;12(12):CD001760. doi: 10.1002/14651858.CD001760.pub2. PMID: 23235583; PMCID: PMC7072531.

## Steps of the sensate-focused therapy-

(1) communication about the couple's sexual desires and non-genital touching,
(2) genital and breast touching,
(3) mutual touching,
(4) using lubricants, and
(5) sexual intercourse/penetration.

https://journals.lww.com/njcp/Fulltext/2023/01000/Successful_Management_of_Penetration_Disorder__A.18.aspx

**Mainstay of sex therapy, “sensate focus” or “nondemand” or “sensual touching,”** can decrease the inhibitory effects of performance anxiety with exercises that employ a graded transition from nonsexual to sexual touching. This technique simultaneously increases excitatory processes by focusing attention on the sensuality of touch.
cognitive behavioral therapy program that combined communication and sexual skill training, sensate focus exercises and other strategies to lower sexual and performance anxiety showed improvement in women, most of whom had more than 1 sexual disorder.

The program had greatest impact on anorgasmia and arousal problems and less on low interest in sex. There is additional evidence that cognitive behavioral therapy, psychoeducational and mindfulness techniques may be of benefit to women with sexual distress and dysfunction.

Developed by Master and Johnson
Stage 1
Stage 2
Stage 3 and
Stage 4

Outcome
2/3 times a week
Assessment done by clinician
Relapse rate is less
Failure is low

# Sex Toys and Pleasure accessories

Saucy Spooning

Miraculous Missionary

69 Me to the Moon

Carefree Cowgirl

Danger-Free Doggy

Cosmic Chair Action

# COITAL TECHNIQUE (CAT)

Encourage
Explore
Experiment
Enhance
Embrace
Evolve

Pharmacological

Hormonal

Injectables

and

Surgical options

# 'Sexual health' means having consenting, pleasurable and safe sexual experiences

**Different kinds of sex**

Sex can mean different things to different people.

When most people talk about 'having sex' they are usually referring to sexual intercourse (or penetrative sex). It is also possible to be 'sexual' without actually having sex.

Things like kissing, touching, rubbing and stroking are all things that can make you feel good.

Kissing
Masturbation/self-pleasuring
Mutual masturbation
Fingering
Foreplay
Dry humping or genital rubbing.
Non-penetrative sex
Penetrative sex (also called sexual intercourse)
Vaginal, anal and oral sex are all types of penetrative sex.

https://www.getthefacts.health.wa.gov.au/sex and The Planned Parent hood

# Thank you