Sexual Dysfunction

Sexual Dysfunction or **Sexual difficulties** can begin early in a person's sex life or they may develop after an individual has previously experienced enjoyable and satisfying sex. A problem may develop gradually over time, or may occur suddenly as a total or partial inability to participate in one or more stages of the sexual act. The causes of sexual difficulties can be physical, psychological, or both.

Emotional factors affecting sex include both interpersonal problems such as marital/relationship problems, or lack of trust and open communication between partners and psychological problems within the individual (depression, sexual fears or guilt, past sexual trauma, sexual disorders, and so on).

Physical factors include drugs (alcohol, nicotine, narcotics, stimulants, antihypertensives, antihistamines, and some psychotherapeutic drugs); injuries to the back, problems with an enlarged prostate gland, problems with blood supply, nerve damage (as in spinal cord injuries); or disease (diabetic neuropathy, multiple sclerosis, tumors, and, rarely, tertiary syphilis); failure of various organ systems (such as the heart and lungs); endocrine disorders (thyroid, pituitary, or adrenal gland problems); hormonal deficiencies (low testosterone, estrogen, or androgens); and some birth defects.

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

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 (such as the SSRIs) or psychiatric conditions, such as depression and anxiety. Loss of libido from SSRIs usually reverses after SSRIs are discontinued, but in some cases it does not. This is known as PSSD.

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, for example, desire or arousal.

For both men and women, these conditions can manifest as an aversion to, and avoidance of, sexual contact with a partner. In men, there may be partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity.
There may be medical causes to these disorders, such as decreased blood flow or lack of vaginal lubrication. Chronic disease can also contribute, as well as the nature of the relationship between the partners. As the success of sildenafil (Viagra) attests, most erectile disorders in men are primarily physical, not psychological conditions.

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 SSRI 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 (painful intercourse) and vaginismus (an involuntary spasm of the muscles of the vaginal wall that interferes with intercourse). Dyspareunia may be caused by insufficient lubrication (vaginal dryness) in women.

Poor lubrication may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause, pregnancy, or breast-feeding. Irritation from contraceptive creams and foams can also cause dryness, as can fear and anxiety about sex.

It is unclear exactly what causes vaginismus, but it is thought that past sexual trauma (such as rape or abuse) may play a role. Another female sexual pain disorder is called vulvodynia or vulvar vestibulitis. In this condition, women experience burning pain during sex which seems to be related to problems with the skin in the vulvar and vaginal areas. The cause is unknown.

Sexual dysfunctions are more common in the early adult years, with the majority of people seeking care for such conditions during their late twenties through thirties. The incidence increases again in the geriatric population, typically with gradual onset of symptoms that are associated most commonly with medical causes of sexual dysfunction.

Sexual dysfunction is more common in people who abuse alcohol and drugs. It is also more likely in people suffering from diabetes and degenerative neurological disorders. Ongoing psychological problems, difficulty maintaining relationships or chronic disharmony with the current sexual partner can also interfere with sexual function.

Symptoms

Psychological sexual disorders

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders lists the following psychological sexual disorders:

* Hypoactive sexual disorder (see also asexuality)
* Sexual aversion disorder (avoidance of or lack of desire for sexual intercourse)
* Female sexual arousal disorder (failure of normal lubricating arousal response)
* Male erectile disorder
* Female orgasmic disorder (see Anorgasmia)
* Male orgasmic disorder (see Anorgasmia)
* Premature ejaculation
* Dyspareunia
* Vaginismus
* Secondary sexual dysfunction
* Paraphilias
* Gender identity disorder
* PTSD due to genital mutilation or childhood sexual abuse

Other sexual problems

* Sexual dissatisfaction (non-specific)
* Lack of sexual desire
* Anorgasmia
* Impotence
* Sexually transmitted diseases
* Infidelity
* Delay or absence of ejaculation, despite adequate stimulation
* Inability to control timing of ejaculation
* Inability to relax vaginal muscles enough to allow intercourse
* Inadequate vaginal lubrication preceding and during intercourse
* Burning pain on the vulva or in the vagina with contact to those areas
* Unhappiness or confusion related to sexual orientation
* Transsexual and transgender people may have sexual problems before or after surgery
* Persistent sexual arousal syndrome
* Post SSRI Sexual Dysfunction
* Sexual addiction
* Hypersexuality
* Female genital cutting has occurred more in the USA than previously thought
* Male circumcision alters the natural sexual function for both partners

Other related problems

* Infertility
* Paraphilias

Clinical studies

Since people tend not to talk to one another about their sexual problems, many people imagine that they are "abnormal", or that their sexual problems are unique or shameful. Images of sexuality presented by society and the media often present people with unrealistic ideals of sexual behavior, whether of the ideals of chastity and sexual fidelity presented by religion, or the ideal of sexual inexhaustibility and promiscuous availability presented by pornography. Neither image appears to be representative of human behavior in real life: this has been summed up in the phrase "everyone lies about sex".

The genuine clinical study of sexual problems is usually dated back no further than 1970 when Masters and Johnson's Human Sexual Inadequacy was published. It was the result of over a decade of work at the Reproductive Biology Research Foundation in St. Louis, involving 790 cases. The work grew from Masters and Johnson's earlier Human Sexual Response (1966).

Prior to Masters and Johnson the clinical approach to sexual problems was largely derived from the thinking of Freud. It was held with psychopathology and approached with a certain pessimism regarding the chance of help or improvement. Sexual problems were merely symptoms of a deeper malaise and the diagnostic approach was from the psychopathological. There was little distinction between difficulties in function and variations nor between perversion and problems. Despite work by psychotherapists such as Balint sexual difficulties were crudely split into frigidity or impotence, terms which too soon acquired negative connotations in popular culture.

The achievement of Human Sexual Inadequacy was to move thinking from psychopathology to learning, only if a problem did not respond to educative treatment would psychopathological problems be considered. Also treatment was directed at couples, whereas before partners would be seen individually. Masters and Johnson saw that sex was a joint act. They believed that sexual communication was the key issue to sexual problems not the specifics of an individual problem. They also proposed co-therapy, a matching pair of therapists to the clients, arguing that a lone male therapist could not fully comprehend female difficulties and vice versa.

The basic Masters and Johnson treatment program was an intensive two week program to develop efficient sexual communication. Couple-based and therapist led the program began with discussion and then sensate focus between the couple to develop shared experiences. From the experiences specific difficulties could be determined and approached with a specific therapy. In a limited number of male only cases (41) Masters and Johnson had developed the use of a female surrogate, an approach they soon abandoned over the ethical, legal and other problems it raised.

In defining the range of sexual problems Masters and Johnson defined a boundary between dysfunction and deviations. Dysfunctions were transitory and experience by the majority of people, dysfunctions bounded male primary or secondary impotence, premature ejaculation, ejaculatory incompetence; female primary orgasmic dysfunction and situational orgasmic dysfunction; pain during intercourse (dyspareunia) and vaginismus. According to Masters and Johnson sexual arousal and climax are a normal physiological process of every functionally intact adult, but despite being autonomic it can be inhibited. Masters and Johnson treatment program for dysfunction was 81.1% successful.

Despite the work of Masters and Johnson the field in the US was quickly over-run by ethusiastic rather than systematic approaches, blurring the space between enrichment and therapy. Although it has been argued that the impact of the work was such that it would be impossible to repeat such a clean experiment.