Sexual dysfunction or sexual malfunction (see also sexual function) refers to a difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including desire, arousal or orgasm.

To maximize the benefits of medications and behavioral techniques in the management of sexual dysfunction, it is important to have a comprehensive approach to the problem. A thorough sexual history and assessment of general health and other sexual problems (if any) are very important. Assessing (performance) anxiety, guilt (associated with masturbation in many Indian men), stress and worry are integral to the optimal management of sexual dysfunction. When a sexual problem is managed inappropriately or sub-optimally, it is very likely that the condition will subside immediately but re-emerge after a while. When this cycle continues, it strongly reinforces failure that eventually makes clients not to access any help and suffer it all their life. So, it is important to get a thorough assessment from professionals and therapists who are qualified to manage sexual problems. Internet-based information is good for gaining knowledge about sexual functioning and sexual problem but not for self-diagnosis and/or self-management.

Sexual desire disorders:
Hypoactive Sexual Desire Disorder:
Sexual desire disorders or decreased libido are characterized by a lack or absence for some period of time of sexual desire or libido for sexual activity or of sexual fantasies. The condition ranges from a general lack of sexual desire to a lack of sexual desire for the current partner. The condition may have started after a period of normal sexual functioning or the person may always have had no/low sexual desire.

The causes vary considerably, but include a possible decrease in the production of normal estrogen in women or testosterone in both men and women. 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 has been called PSSD; however, this is not a classification that would be found in any current medical text. While a number of causes for low sexual desire are often cited, only some of these have ever been the object of empirical research. Many rely entirely on the impressions of therapists.

Sexual arousal disorders:
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 themselves as an aversion to,
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. Unlike disorders of orgasm, as the success of Viagra (sildenafil citrate) attests, most erectile disorders in men are primarily physical conditions.

Erectile dysfunction:
Erectile dysfunction or impotence is a sexual dysfunction characterized by the inability to develop or maintain an erection of the penis. There are various underlying causes, such as damage to the nerve regents which prevents or delays erection, or diabetes, which simply decreases blood flow to the tissue in the penis, many of which are medically reversible. The causes of erectile dysfunction may be psychological or physical. Psychological impotence can often be helped by almost anything that the patient believes in; there is a very strong placebo effect. Physical damage is much more severe. One leading physical cause of ED is continual or severe damage taken to the nerve regents. These nerves course besides the prostate arising from the sacral plexus and can be damaged in prostatic and colon-rectal surgeries.

Due to its embarrassing nature and the shame felt by sufferers, the subject was taboo for a long time, and is the subject of many urban legends. Folk remedies have long been advocated, with some being advertised widely since the 1930s. The introduction of perhaps the first pharmacologically effective remedy for impotence, sildenafil (trade name Viagra), in the 1990s caused a wave of public attention, propelled in part by the news-worthiness of stories about it and heavy advertising.

The Latin term impotentia coeundi describes simple inability to insert the penis into the vagina. It is now mostly replaced by more precise terms.

Orgasm disorders (Anorgasemia):
Orgasm disorders are persistent delays or absence of orgasm following a normal sexual excitement phase. The disorder can have physical, psychological, or pharmacological origins. SSRI antidepressants are a common pharmaceutical culprit, as they can delay orgasm or eliminate it entirely.

Sexual pain disorders:
Sexual pain disorders affect women almost exclusively and are known as dyspareunia (painful intercourse) or veganismâ€™s (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 veganismâ€™s, 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.

Uncommon sexual disorders in men:
Erectile dysfunction from vascular disease is usually seen only amongst elderly individuals who have atherosclerosis. Vascular disease is common in individuals who have diabetes, peripheral vascular disease, hypertension and those who smoke. Any time blood flow to the penis is impaired, erectile dysfunction is the end result.

Hormone deficiency is a relatively rare cause of erectile dysfunction. In individuals with testicular failure like klinefelter’s syndrome, or those who have had radiation therapy, chemotherapy or childhood exposure to mumps virus, the testes may fail and not produce testosterone. Other hormonal causes of erectile failure include brain tumors,
hyperthyroidism, hypothyroidism or disorders of the adrenal gland. Structural abnormalities of the penis like Peyronie’s disease can make sexual intercourse difficult. The disease is characterized by thick fibrous bands in the penis which leads to a deformed-looking penis. Drugs are also a cause of erectile dysfunction. Individuals who take drugs to lower blood pressure, uses antipsychotics, antidepressants, sedatives, narcotics, antacids or alcohol can have problems with sexual function and loss of libido. Priapism is a painful erection that occurs for several hours and occurs in the absence of sexual stimulation. This condition develops when blood gets trapped in the penis and is unable to drain out. If the condition is not promptly treated, it can lead to severe scarring and permanent loss of erectile function. The disorder occurs in young men and children. Individuals with sickle-cell disease and those who abuse certain medications can often develop this disorder. Causes: There are many factors which may result in a person experiencing a sexual dysfunction. These may result from emotional or physical causes. Sexual dysfunction may arise from emotional factors, including interpersonal or psychological problems. Interpersonal problems may arise from marital or relationship problems, or from a lack of trust and open communication between partners, and psychological problems may be the result of depression, sexual fears or guilt, past sexual trauma, sexual disorders, among others. Sexual dysfunction is especially common among people who have anxiety disorders. Ordinary anxiousness can obviously cause erectile dysfunction in men without psychiatric problems, but clinically diagnosable disorders such as panic disorder commonly cause avoidance of intercourse and premature ejaculation. Pain during intercourse is often a comorbidity of anxiety disorders among women. Sexual activity may also be impacted by physical factors. These would include use of drugs, such as alcohol, nicotine, narcotics, stimulants, antihypertensive, antihistamines, and some psychotherapeutic drugs. For women, almost any physiological change that affects the reproductive system—premenstrual syndrome, pregnancy, postpartum, menopause—can have an adverse effect on libido. Injuries to the back may also impact sexual activity, as would problems with an enlarged prostate gland, problems with blood supply, nerve damage (as in spinal cord injuries). Disease, such as diabetic neuropathy, multiple sclerosis, tumors, and, rarely, tertiary syphilis may also impact on the activity, as would 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. Treatment for males: Since in many men the cause of sexual dysfunction is related to anxiety about performance, psychotherapy can help. Situational anxiety arises from an earlier bad incident or lack of experience. This anxiety often leads to development of fear towards sexual activity and avoidance. In return evading leads to a cycle of increased anxiety and desensitization of the penis. In some cases, erectile dysfunction may be due to marital disharmony. Marriage counseling sessions are recommended in this situation. Lifestyle changes such as discontinuing smoking, drug or alcohol abuse can also help in some types of erectile dysfunction. Several medications like Viagra, cialis and Levitra have become available to help people with erectile dysfunction. These medications do work in about 60% of men. In the rest, the medications may not work because of wrong diagnosis or chronic history. Another type of medication that is effective in roughly 85% of men is called intracavernous pharmacotherapy used by companies such as Boston Medical Group, Performance Medical Centers and independent doctors and involves injecting a vasodilator drug directly into the penis in order to stimulate an erection.
Treatment for females:
Although there are no approved pharmaceuticals for addressing female sexual disorders, several are under investigation for their effectiveness. A vacuum device is the only approved medical device for arousal and orgasm disorders. It is designed to increase blood flow to the clitoris and external genitalia. Women experiencing pain with intercourse are often prescribed pain relievers or desensitizing agents. Others are prescribed lubricants and/or hormone therapy. Many patients with female sexual dysfunction are often also referred to a counselor or therapist for psychosocial counseling.

A manual physical therapy, the Wurn Technique, which is designed to reduce pelvic and vaginal adhesion, may also be beneficial for women experiencing sexual pain and dysfunction. In a controlled study, increasing orgasm and decreasing intercourse pain by a manual physical therapy technique, twenty-three (23) women reporting painful intercourse and/or sexual dysfunction received a 20-hour program of manipulative physical therapy. The results were compared using the validated Female Sexual Function Index, with post-test vs. pretest scores. Results of therapy showed statistically significant improvements in all six recognized domains of sexual dysfunction. A second study to improve sexual function in patients with endometriosis showed similar statistical results.

Behavioral Definitions for Couples Experiencing Sexual Dysfunction Problems:

Consistent very low desire for or no pleasurable anticipation of any sexual activity.

Strong avoidance or repulsion to any and all sexual contact even in the existence of mutual caring and respect.

Lack of usual physiological response of sexual excitement and arousal (erection, vaginal lubrication etc.).

Lack of subjective sense of enjoyment and pleasure during any sexual activity.

Delay in or absence of reaching orgasm after achieving arousal, despite the use of sensitive sexual pleasuring by a caring spouse or partner.

Genital pain before, during, or after sexual intercourse.

Consistent involuntary spasm of the vagina (veganismâ€™s) that stops penetration for sexual intercourse.

Expressions and feelings of general relationship dissatisfaction.

Verbalizations of a lack of love or caring by one or both spouse or partner.

Avoidance of communication about any sexual matters.

Critical comments about the spouse or partner’s lack of sexual responsiveness.

Statements or feelings of low self-esteem by spouse or partner with sexual dysfunction.

Statements or feelings of low self-esteem by spouse or partner who perceives the sexual dysfunction of other spouse or partner to be his or her fault.
Depressed mood in one or both spouse or partners.

Long Term Goals for Couples Experiencing Sexual Dysfunction Problems:

Increase desire for enjoyment of sexual activity.
Increase physiological arousal during sexual intercourse.
Maintain physiological arousal during sexual intercourse.
Help spouse or partner reach orgasm on a regular basis.
Eliminate or reduce any pain associated with any aspect of the sexual interaction.
Eliminate or reduce spasms that prevent intromission.
Increase communication about sexual matters.
Increase relationship satisfaction.
Reduce depressive behaviors or symptoms.
Increase both spouses or partners’ self-esteem.
Help couple develop an accepting attitude toward variety in normal sexual activity.
Help couple develop an accepting attitude toward changes in the intensity and frequency of sexual activity across a life stages.

Short Term goals for Couples Experiencing Sexual Dysfunction Problems:

Explore the history of the sexual relationship and identify and define where conflicts about sexual matters originated.
Identify and list any positive aspects of the nonsexual portion of the relationship.
Describe and define any positive aspects of the sexual relationship.
Help couple learn to communicate openly and without criticism, especially about sexual matters.
Help couple understand and identify sexual expectations in the relationship and how they have changed across time.
Explore any past traumatic experiences that may be impacting on the sexual interaction.
Identify and define any religious beliefs that may be interfere with experiencing pleasure.
Encourage couple to stop any activity that triggers memories of past traumatic experiences until the feelings related to that activity can be resolved.

Explore sexual attitudes in family of origin, identifying those experiences which enhance and those that diminish experiencing sexual pleasure.

Express and define any emotional detachment from early family experiences that deter current experience of pleasure.

Identify and define any physical disorder or medication that is inhibiting sexual desire.

Verbalize and define any feelings regarding body image and how it may relate to sexual functioning.

Express and define a new improved body image due to increased exercise, improved dress, and more healthy diet.

Identify and define causes for and remedies to low self-esteem within the relationship.

Identify and define any perceived or real emotional creates continuing resentment or jealousy.

Verbalize and define any homosexual activity that may interfere with sexual functioning and help couple openly acknowledging plans for future direction of sexual interest.

Help couple openly acknowledging plans for future direction of sexual interest.

Report and explore an increase in sexual thoughts or fantasy in regular daily activities.

Encourage couple to read books or watch educational videos on sexual functioning and sexuality.

Encourage couple to engage in sensate focus activity alone and with spouse or partner.

Discuss and explore sensate focus activities with spouse or partner in therapy sessions, and modify sexual stimulation activities based on feedback from the couple.

Interventions or Strategies for Couples Experiencing Sexual Dysfunction Problems:

Assess and explore the frequency of sexual interactions across the history of the relationship.

Assess and explore the spouse or partners' enjoyment of sexual interactions across the history of the relationship.

Encourage spouse or partners to describe the perceived causes of decline in sexual activity and enjoyment thereof.

Encourage spouse or partners to describe the positive nonsexual aspects of the beginning of their relationship.
Encourage spouse or partners to describe the positive nonsexual aspects of their current relationship.

Encourage spouse or partners to describe the positive sexual aspects of the beginning of their relationship.

Encourage spouse or partners to describe the positive sexual aspects of their current relationship.

Encourage spouse or partners to communicate with each other about a nonsexual matter. Encourage listener not to use interruptions and demonstrate understanding.

Encourage couple to communicate with each other about a sexual matter. Using good listening skills and empathy.

Give constant feedback and interpretation to spouse or partners about their communication styles.

Encourage couple to describe initial expectations about his or her sexual life.

Encourage couple to describe how expectations about his or her sexual life have changed.

Help couple interpret the frequency and satisfaction of their sexual encounters as compared to that of others of their ages.

Encourage to each discuss any past traumatic sexual experiences.

Help couple probe about thoughts during sexual activities and assess if the traumatic sexual encounter triggers negative emotions during sexual activity.

Resolve past traumas that impact current sexual pleasure.

Explore how religious beliefs or training interferes with engaging in sexual activity.

Assess how religious beliefs interferences, and attempt to neutralize current impact, or define acceptable sexual practice.

Recommend couple to stop any sexual activity that triggers memories of traumatic events, until traumatic memories are properly resolved.

Help couple identify family of origin experiences that may influence current positive and negative sexual experiences.

Assess and explore any feelings related to early family experiences that have a negative impact on current sexual experience.

Encourage couple to make a differentiation between the past and the here and now.

Assess and explore the role of any known or possible existing physical condition that could interfere with sexual functioning (diabetes, substance abuse, depression, anxiety disorders, etc.).

Assess and explore the role of any medication that might interfere with sexual functioning.
Explore and assess the decrease and range of sexual activities due to a decline in body image (increased body weight, lack of muscle tone, or the residual effects of surgery, etc.).

Encourage and explore a positive change in attitude about body image.

Encourage couple engage in exercise, change dress style, or diet to enhance client’s body image.

Assess and explore the role of self-esteem in sexual functioning, and identify any factors in the relationship that lead to positive and negative feelings.

Explore feelings that relate to suspected or actual extramarital affairs, and make sure that such relationships have stopped.

Assess in an individual therapy session whether there are homosexual thoughts or activities that interfere with present heterosexual functioning.

If there are homosexual activities or fantasies that interfere with the sexual relationship, explore the sexual identity and its implication for the future of heterosexual relationships.

Encourage the couple to indulge in sexual fantasies that increase sexual desire toward spouse or partner.

Request that clients read material on sexual fantasies.

If couple’s views permit, encouraged couple to purchase educational videos of sexual activities to teach enhancement of fantasy, masturbation, and a variety of heterosexual sexual behaviors.

Suggest t reading on sexual behavior and sexual functioning.

Instruct couple in use of sensate focus to learn how to touch each other.

Obtain feedback from couple about the sensate focus exercises, and assist in minimizing any behaviors that affect negatively.

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