Sexual dysfunction

Sex is among the most basic and fundamental concept of human beings. To say that a man has problems sexually is just like saying that a part of him is inadequate or incomplete. According to surveys, one man in ten suffers sexual dysfunctions yet the “ embarrassment” prevents a number of men with these problems from consulting medical and psychological help. There are various sexual dysfunctions and among them are male erectile dysfunction and female orgasmic disorder. Despite the rising prevalence of these disorders, underdiagnosis occurs often thus leading to fewer numbers of treatments.

Male erectile dysfunction (ED), may be defined as the consistent inability to achieve or maintain an erection sufficient to permit satisfactory sexual intercourse. The word " consistent" is included in the definition because most men experience transient episodes of ED that are temporary and usually associated with fatigue, anger, depression or other stressful emotions. The use of the formerly used term " impotence" has been virtually abandoned because of its inherent stigma of weakness and lack of power.

Accordingly, since Erectile Dysfunction is found to be age-related, it is expected that the number of men who has this problem will double worldwide by 2025. Causes and Symptoms Several studies indicate that the problem of male erectile dysfunction is not only psychologically caused. Majority of the leading causes of ED is said to be physical. Sadly though, treatment has not been consistent compared to other diseases for fear of being ridiculed. Moreover, a precise identification and identification of the cause of male ED is difficult to pinpoint because of various factors.

The complicated nature of the human sexual response and complex physiology of penile erection and relaxation may be among the consequences of the difficulties in determining precisely the cause of male ED. In the past, psychological and psychiatric causes were said to be the origins of the rising number of ED among men, it was found out that this has not always been the case. Organic, non-psychological causes of ED play a much more significant role in the development of ED.

Researchers agree that among the reported cases of ED, 15-20 percent of these are psychologically caused while 80 percent are with organic causes, although in many cases, the causes are somewhat “ mixed” or a combination of organic and psychological origins. The causes of male Erectile dysfunction may be grouped into endogenous and exogenous factors. Endogenous factors or those that arise within the individual include endocrine imbalances, cardiovascular and other medical conditions, and emotional causes.

On the other hand, exogenous factors are those that come from outside sources of the body such as trauma, medication, surgery, substance abuse or smoking. Current theorists and practitioners believe that many cases involve some partial organic or substance induced impairment of the erection response that initially causes an erectile problem. This then predisposes the man to increased vulnerability to the psychological factors that inhibit erection, which then serve to maintain the erectile dysfunction (Comer, 1995).

Substances that can cause erectile dysfunction include alcohol, cigarettes, high blood pressure medication, anti-anxiety medication, antidepressants,

cocaine, and major tranquillisers such as Melleril (Davidson & Neale, 1996). On the instances that psychological factors play in the causes of male Erectile dysfunction, the causes involved are very complex since there are various factors in play. Among them is the patient’s “ performance anxiety” and the “ spectator role”.

When a man experiences erectile problems, he ultimately becomes anxious of this “ dilemma” and during sexual intercourse, instead of focusing on the act itself, he focuses on his penis thereby distancing himself and making himself a “ spectator”. Prevalence As it is common among men who have erectile problems to hide their condition, prevalence rate of ED is not really conclusive, extreme caution is taken in interpreting figures as to the number of men who have male ED. In the American population, the prevalence of erectile failure is between approximately 8 and 10 percent of the male population (Comer, 1995).

Among the studies conducted for male ED, the Massachusetts male aging study was a cross-sectional random sample community-based survey of 1, 290 men ages 40 to 70 years and was conducted from 1987 to 1989 in areas around Boston. (Feldman HA, Goldstein I, Hatzichristou DG, Krane RJ, McKinlay JB 1994). The cases in this study were self-reported and ranged from being mild, moderate and complete ED. Furthermore, the study also showed that prevalence of male ED rose or increased with age.

At age 40 there was an approximately 40% prevalence rate increasing to close to 70% in men age 70. The prevalence of moderate erectile dysfunction increased from 17% to about 34% with that of complete erectile dysfunction increasing from 5% to 15% as age increased from 40 to 70.

(Lakin) Despite the initial conclusion that among the consequences of aging is male Erectile Dysfunction, other factors play in the prevalence of this condition. These factors increase the probability of men with ED when they have diseases such as hypertension, heart diseases and diabetes.

In another study conducted by the National Health and Social Life Survey, wherein it looked at sexual function of men and women, it found out that there was an increased number of erectile dysfunction and decreased sexual desire among aging men. The study surveyed 1, 410 men aged 18-59. In this study there was a higher prevalence of sexual dysfunction in men who had never married or were divorced. Experience of sexual dysfunction was more likely among men with poor physical and emotional health.

This study also concluded that sexual dysfunction is an important public health concern and added that emotional issues were likely to contribute to the experience of these problems. (Lakin) Treatment Among the essential steps for the treatment of male erectile dysfunction is to take a thorough sexual, medical and psychosocial history of the patient. The sexual history must have information regarding the frequency of social intercourse, its duration, the quality and degree of penile erection, the presence or absence of nocturnal erections, and the success or failure of penetration.

Gathering such information would lead to the exact identification of the dysfunction. Once the medical history of the patient is documented, laboratory and physical examinations may be conducted on the patient in order to find out evidences of hypogonadism or congenital conditions where there is defective testicular function. Other diagnostics methods may also be performed as soon as the routine physical examination is finished in order to

determine levels of hormones. As soon as these are done, treatment may be started. The first step is to eliminate or alter modifiable risks that may hamper proper treatment of ED.

Such risks include lifestyle or psychosocial factors like smoking, obesity, substance and alcohol abuse. Among the treatments that may be sought by the patient are oral therapy, withdrawal of offending medication and the use of vacuum constriction device. Oral therapy is among the first treatment that most patients seek after the diagnosis of ED. Currently, there are three drugs that are approved by the FDA. These are Sildenafil Citrate (Viagra approved March 1998) and Vardenafil Hydrochloride (Levitra approved September 2003) and Tadalafil (Cialis approved November 2003).

All three drugs reversibly inhibit the penile-specific phosphodiesterase (type 5; PDE-5) and enhance the nitric oxide-cyclic GMP pathway of cavernous smooth muscle relaxation (ie, all three prevent breakdown of cyclic GMP by PDE-5). In several double-blind, placebo-controlled studies of patients with erectile dysfunction of varied etiology, all three drugs demonstrated improvement in erectile function, with success rates varying between 70% and 90% depending on the populations studied. (Lakin)

The withdrawal of offending medication may likely be undertaken particularly be patients who have histories of hypertension, diabetes, psychological diseases such as depression, anxiety, or psychosis. Drugs that are used for these disorders may be substituted in order to alleviate the problem of male ED. On the other hand, vacuum constriction device therapy involves a mechanical device used in order to increase penile blood flow and erection may also be recommended. Psychosexual therapy is also

recommended so that any psychological causes for ED can be detected and therapy can be instituted.

Individual psychotherapy or couples therapy may be helpful. These various treatment methods can be used alone or in combination. (Myerson) Female Sexual Dysfunction In problems of sexual dysfunction among men and women ages 19-59, the percentage of women having problems sexually is higher compared to men. Statistics gathered by the Epidemiology/Risk Factors Committee revealed that 40% to 45% of adult women have problems sexually compared to the 20-30 percent of men who do.

Sexual dysfunction among women include persistent or recurrent disorders of sexual interest or desire, disorders of subjective and genital arousal, orgasmic disorder, and pain and difficulty with attempted or completed intercourse. (Kaplan 2004). Female orgasmic disorder is said to be among the most prevalent female sexual dysfunctions. Female orgasmic disorder (FOD) is defined as the persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. (Meston).

Moreover, FOD cause marked distress or discomfort and despite adequate stimulation fails to have sufficient orgasmic response as assessed by a competent clinician. Normally, women display a wide range or types of stimulation in order to achieve orgasm. Research indicates orgasms in women can be induced via erotic stimulation of a number of genital sites including the clitoris and vagina (the most usual sites), the periurethral glans, breast/nipple or mons. Non-genital forms of stimulation reported to induce orgasm include mental–imagery or fantasy and hypnosis. (Meston)

In the studies conducted, FOD is said to be either primary orgasmic dysfunction or secondary orgasmic dysfunction. Primary orgasmic dysfunction refers to women who fails to achieve an orgasm despite all the stimulation induced including masturbation. On the other hand, secondary orgasmic dysfunction refers to problems by women who do meet situational, acquired and lack of orgasm. These women may have experienced orgasmic previously but has failed to achieve it frequently later on. Causes and Symptoms The problem of female orgasmic disorder stems from various causes and factors.

Among the causes of FOD are religious orthodoxy, psychosexual trauma, homosexual inclinations, inadequate counselling, excessive intake of alcohol, biological causes, and sociocultural factors as playing a role. (Masters and Johnson, 1986). Like in the cases of men who have male Erectile Disorders, women who have FOD also play the role of a spectator. The role of a spectator entails that the woman fears about her performance in the sexual act itself, communicates poorly with her partner which ultimately leads to the misinterpretation of the partner to anticipate what the partner wants.

Aside from these causes, there are other factors as well which is linked to FOD. Endogenous factors like medical or biological and neurological conditions of the patient also play part in FOD. Diseases such as diabetes and hypertension are among the factors that could lead to female orgasmic disorder. Prevalence In a study conducted by the National Health and Social Life survey, more than 40 million women in the United States have female sexual dysfunctions. Moreover, according to the National Health and Social

Life Survey, female orgasmic disorder is the second most frequently reported sexual problems among women in the United States.

Based on the results, among the 1, 749 women ages 18-59, 24 percent reported a lack of orgasm in the past year or so. The random sampling also suggested that women who are not married or who are not active sexually may have greater risks of developing orgasm problems. Treatment There are various means adopted in the treatment of female orgasmic disorder. Such treatments range from self-exploration, cognitive-behavioural, medical or pharmacological and systems theory perspectives. Cognitive-behavioural approach centers on promoting changes of attitudes and thoughts related sexually.

This kind of therapy also aims at decreasing anxiety in relation to sex while increasing orgasmic stimulation and pleasure. On the other hand, Direct Masturbation (DM) is used primarily on women who have primary anorgasmia. This kind of treatment aims at training a woman in finding or locating manually the genital areas that bring stimulate sexual pleasure. Normally, the process starts with visual exploration of the body using a mirror, and educational materials depicting the female genital anatomy.

After identifying the regions which stimulate pleasure, the woman is then directed and trained manually in finding orgasmic pleasure in these areas. Another method directed in treating female orgasmic disorder is the reduction of anxiety technique wherein anxiety is reduced if not eradicated since anxiety could potentially impair a woman’s orgasmic functions. It disrupts the woman’s erotic cues instead of focusing on the performance of the sexual act itself. Because the patient focuses on the performance, guilt

or embarrassment, the woman thus monitors her sexual performance and acting out her “ spectator role”.

Such technique however, is often difficult to assess as there are various techniques that are used as well such as sex education, Kegel exercises and direct masturbation. Unlike erectile dysfunction in men which may be treated pharmacologically, female orgasmic disorder has no proven pharmacological agents which can treat this disorder although placebo is used in enhancing organic function in women who are diagnosed with Female Orgasmic Disorder. More research is needed in order to link the effectiveness of such agents.