INTRODUCTION

The cumulative effect of thousands of years of education, culture and refinement have not had much impact on our knowledge about the genitals. Despite all the frank “for adults only” films and books today. Most people still are ignorant about sex. Most of us are in the uncomfortable position of knowing more about that occurs 238,000 miles away on the surface on the moon than what happens six inches below our own navels. Sexual disorders, however, minor lead to frustration, worry and stress; and have a serious impact on the life and happiness of a couple. The mechanism responsible for the successful sex life is a very complicated and delicate one. It is affected by various environmental, social, psychological and somatic factors, as well as by the higher centres of the central and autonomic nervous system.

MALE SEXUAL DISORDER

Impotence: It can be defined as the persistent inability to develop and/or maintain a penile-erection, sufficient to conclude coitus, to orgasm and ejaculation.

The complex neuro-endocrine system, controlling erection during coitus includes (i) higher psychic centres, (ii) hypothalamus, (iii) sacral spinal cord centres and (iv) androgens playing their role.

Aetiologically speaking the impotence is of 3 types: (a) Constitutional impotence is usually associated with persistent evidence of low sexual drives and responsiveness. Some extreme cases, because of profound sexual indifferences will neither have engaged in self masturbation, nor have sought out hetero or homo-sexual contacts during their entire life i.e., no desire of coitus. There is no demonstrable organic pathology in such cases. (b) Organic impotence develops from previous competency in association with some pathological lesion, unless the constitutional factors are dominant or the condition is congenital. (c) Psychogenic impotence is alleged to be selective and transient, occurring in certain situations and certain times.

These are theoretical differences between 3 postulated aetiological types of impotence, but in practice the distinction is not always easy and even impossible because of aetiological overlapping.

Causes of Impotence: Organic impotence may be either anatomical (or congenital) or symptomatic. Anatomical defeats present genital cause impotence, which may be due to hypo or epi-spedius, ectope vesicae, mumps, genital tuberculosis, trauma tumour and absence of genitals organs.

Symptomatic impotence is little more frequent and may be due to poor health, presence of disease or drugs. Anything that lowers normal body functions can also cause sexual inadequacy. Disorders that may lead to sexual impotence are as follows:

i. Chronic debilitating diseases, e.g. malignancy, tuberculosis, malnutrition, chronic anaemia, cirrhosis liver etc.

ii. Neurological disorders, e.g. organic psychosis, syphilis, multiple-sclerosis, any disorder involving sacral segments of spinal cord, cauda equina or lumber parasympathetic outflow,
which prevents occurrence of erection and is associated with automatic bladder, absent anal reflex and atonic urethral sphincter causing enuresis and ectoparesis.

iii. Cardiovascular disorders, e.g. myocardial infarction, hypertension etc.

iv. Obesity which is said to reduce sexual drive.

v. Endocrine disorders: e.g. acromegaly, chromophobe adenoma, Larich’s syndrome, cranio-phyaryngoma, hyper-thyroidism myxoedema, Addison’s disease, Cushing’s syndrome, infantilism, feminising interstitial cell tumours, and eunuchoiding including Klinfelter’s syndrome.

vi. Metabolic disorders: Diabetes mellitus is the commonest cause. It has been estimated that 30 to 60% of all diabetic men will develop impotence of varying degree at some stage of their sexual life. Possible causes of impotence in such cases may be autonomic neuropathy, arteriosclerotic changes in penile blood vessels which hamper the polling and trapping of blood in corpora of penis or discruption of biochemical and hormonal homeostasis.

vii. Prostatic diseases: Impotence may occur in case of acute prostatitis and also after perineal prostatectomy if lesion produces pain.

viii. Ageing: Here availability of partner is more important than age. In widowers the impotence is more frequent.

ix. Drugs: Hypno-sedatives e.g. morphine, chronic barbiturate poisoning, acute alcoholic intoxication. Tranquillisers e.g. phenothiazines particularly thioridaxine; thio-xanthines particularly chlorprothixine; anti-hypertensives e.g. reserpine, ganglionic blockers, alpha-methyl dopa, quanithidine. Anti depressants e.g. amphetamine, MAOIS, imipramine. Thus any drug causing marked stimulation of sympathetic nervous system can lead to impotence. Miscellaneous e.g. atropine, nicotine, digitalis, ingestion of female sex hormones.

x. Post-radiation: The effect depends upon dose and duration of exposure. It is by virtue of its effect on spinal cord and interstitial cells of testes.

xi. Castration: It can be surgical as in crushing injuries to testes, chronic haematoma, malignant testes, chronic haematoma, malignant testes, or therapeutic in prostatic malignancy. It can also be conservative by giving heavy doses of female sex hormones in cases of prostatic malignancy.

Psychogenic Impotence: May be due to the following:

i. Psychiatrical disorders, e.g. endogenous depression, neurasthenia, paranoia, schizophrenia and anxiety — neurosis, anxiety perse is unlikely to inhibit creation because of its peripheral sympathetic effect but do so by increasing arousal above optimum level, which in some individuals may be very low.

ii. Inexperience — Impotence of inexperience occurs in a person whenever did coitus and/or masturbation and is not knowing about these things.

iii. Honeymoon — It is frequently associated with impotence. Both partners are tired, excited, anxious, self conscious and usually have some ignorance and inexperience. No infrequently these factors combine to render a man impotent on this occasion. On the next night
honeymoon, he approaches sexual situation with anxiety which itself is sufficient to render him impotent or causing premature ejaculation. After this, secondary anxiety increases in snow-falls fashion until the man is convinced that he is impotent or sexually abnormal.

iv. Post-vasectomy impotence is very common. Ordinarily it has no effect on sex-mechanism or endocrine interrelationship, but the social and emotional feelings associated with it and its intimate relationship to sex lead to a psychosomatic disturbance by producing a feeling of weakness.

v. Impotence only with wife — It is a selective impotence and may be due to hostile feelings towards wife, feeling of excessive respect or distrust for the partner, lack of attraction towards the partner, masculine partner, who uses male just for sex and for her penis is important and rest of the body is just an appendage and so it may decrease sex feeling in male, causing impotence. Unconscious and conflicting loves due to persistent infantile attachment to mother, sister, or some other women in early life may also cause impotence.

vi. Impotence prior to orgasm and ejaculation i.e., penis becomes flaccid after penetration which may occur in cases of multiparous women with lax vagina which does not afford frictional grip, fear of pregnancy, fear of being caught.

vii. Impotence associated with sexual deviation as seen in cases of latent homo-sexual attachment.

viii. Masturbation anxiety i.e., guilt around masturbation is a frequent cause of impotence.

ix. Miscellaneous cause e.g. castration anxiety, fear of losing independence, fear of contracting V.D. or pregnancy or death, when coitus environment is threatening and distracting, unconscious hostilities towards women stemming from childhood experiences in which opposite sex is perceived as critical, punitive and capable of damaging the male genitals.

Diagnosis of psycho-sexual impotence is made only after thorough somatic and psychic examination. While taking history female partner should also be invited. In order to arrive at an accurate diagnosis, the patient is first of all physically examined to find out physical disorders if any. Then history of taking any drug is enquired and hormonal assays are done to assess any hormonal deficiency.

Psycho-sexual exploration includes family background, moral training and education and details of sexual development. If married, the patient is enquired about history of marriage relationship, duration of dysfunction, absolute or relative impotence, details about first erection, emission and sexual desire details of first failure, frequency of intercourse, postcoital reaction, history of nocturnal emissions and masturbation, and his own theory regarding the disorder and accompanying fantasies. The partner should be explored for personality, either she loves him or not details about her first intercourse and if unsuccessful what was her reaction to it.

**Prognosis:** A better outcome in therapy is associated with (1) late onset impotence, (2) impotence of short duration, (3) hetero-sexual drive, (4) a good relationship between sexual partners and (5) willingness and ability of wife to co-operate fully in treatment.

If there is no improvement in impotence after six months of technically satisfactory treatment, then further practical measures, however prolonged are likely to fruitless (Master and Johnson claim 65% improvement).
MANAGEMENT
Man is most potent if he is well relaxed and least suspicious. Best way to preserve normal potency upto old age is to retain healthy attitudes towards sex and to practice sex relations regularly at a relatively short intervals. Thus management includes:

1. General measures viz. advice regarding disturbing conditions, initially avoiding intercourse and its failure, removal of fantasies regarding sex, treatment of depression.

2. Psychotherapy — (a) Supportive psychotherapy aimed to help the sufferer by encouraging noncoital stimulation, e.g. masturbation to reduce his tension and to provide a measure for sexual satisfaction, reassurance to wife regarding her husband’s disability, supporting the males ego during the adjustment period, promoting the frank communication between sexual attitude, performance and inhibition. (b) Psycho-analytic psychotherapy — it is needed only in resistance cases.

3. Drugs (a) Testosterone — Role of testosterone in impotence is highly disputed. At present there is no conclusive evidence that potency once established in man depends on the testosterone. It is probably much more importantly concerned with fertility and anabolism. It is more likely that a rise in blood level of testosterone is secondary to sexual arousal and response. Hence, the reduction in plasma testosterone level found in chronic impotent man probably reflects sexual apathy rather than its cause. Thus, the administration of testosterone is unlikely to succeed. It is said that latent cancer of prostate is present in 25% of all males over the age of 40 years (Boyd). So testosterone administration release the trigger mechanism so as to spring the tumour activity in such cases.

b. Tentex and Himcolin — It increases desire and improves performance by acting on hypothalamus and limbic system. It is given in doses of two tablets per day for 1-2 days but in severe cases and in elderly patients the treatment should be continued for 45 to 50 days and repeated every 6 months. It can be combined with local application of Himcolin, once or twice a day. It should not be given in cases hypertension, cardiac failure, chronic renal failure.

4. Sex education: It should be given to both partners who should be encouraged to ask any question they like. It may be necessary to provide information regarding coital techniques, female sex anatomy, physiology, so as to rectify false impression resulting from misinformations derived from other during adolescence. It should be emphasised to both that any type of stimulation which is mutually pleasurable and acceptable is perfectly normal and can be indulged without fear of guilty.

5. Impotence and marriage: Impotence must be treated before marriage but marriage should never become therapy.

Pre-mature Ejaculation: It is the persistent occurrence of ejaculation and orgasm against the wish of the male, before or after penetration.

Causes — There is nothing like a normal duration of coitus. It depends upon circumstances and varies from person to person and in the same person from occasion to occasion. It may be due to —

i. Anxiety, which in turn may be due to masturbation in past, guilt regarding citus in mind, when coitus is attempted first time in life e.g. during honeymoon, when coitus is attempted at a situation where there is a fear of being caught by somebody.

ii. Intercourse at long intervals.

iii. Excessive fore play.
iv. Coitus with a very beautiful lady.

v. Judicious use of alcohol or hypnosedative or use of anaesthetic cream locally.

Types — it may be two types —

1. Sexually hyper-excitable where sexual arousal and excitement is high, hence arousal reducing
drugs, e.g. melleril and anxiolitics are helpful.

2. Sexually hypo-excitable, where sexual arousal is low and often associated with impaired erection.
Hence Seaman’s technique (1956) is helpful in such cases, since anxiety does not appear to play
an important role.

Treatment —

i. Psychotherapy to relieve anxiety.

ii. Drugs — Melleril-26 mg daily or B.D.
Diazepam — 2.5 to 5 mg. T.D.S. Speman forte 2 tabs. T.D.S. These drugs are commonly used.

iii. Attention diversion at the time of ejaculation will help prolonging duration of coitus.

iv. Seaman’s technique — It consists of extra-vaginal, manual stimulation of penis by the woman
and should be interrupted when patient feels that orgasm and ejaculation is imminent. It is
then again continued, when the feeling has faded away. This procedure is repeated as to delay
ejaculation as much as possible. Once mastered this procedure can be transferred to actual
coitus.

If there is no improvement even after 10 to 15 sessions it is unlikely to improve.

v. Master and Johnson’s Technique — It is needed when Seaman’s technique has failed. It is
aimed to eliminate the interval between the husband and wife orgasm. It consists of measures
to slow-down the man speed-up the semen.

Impotentia-Ejaculandi: It is the persistent absence of orgasm and ejaculation during coitus, despite
the normal desire and erection. Types and causes include (i) Dry run orgasm and (ii) Delayed
orgasm. Dry run orgasm is normal orgasm without ejaculation. It is commonly due to drugs e.g.
phenothiazines and anti-hypertensive drugs — particularly guanethidine, alpha methyl dopa, and also
ganglionic ejaculation which follows prostatectomy in some cases. The reasons in some are very
deep seated e.g. fears of pregnancy, bilateral lumber sympathectomy below 12 e.g. some in cases of
Burgers’ disease.

Delayed orgasm — “Both orgasm and ejaculation are delayed”. It is more common. Causes are (i)
insufficient excitement and arousal, e.g. in some sex diviants who need particularly type of sex-
stimulation; (ii) associated anxiety (why anxiety increases orgasm in some and decreases in other is
not known and unexplainable).

Treatment — should be according to the underline causes.

FEMALE SEXUAL DISORDER

1. Frigidity — “It is a lack of sexual feeling in women and may vary in degree from an intense
feeling of revulsion to any sexual advance, to varying sexual arousal without orgasm”.

It is synonymous with impotence in males.

Types — It may be of two types —

i. Primary frigidity: When the woman has experienced any orgasm. It may be partial or
complete.
ii. Secondary frigidity: When a woman has experienced orgasm in past but is unable to do so now. It may be partial or complete.

Causes:

i. Primary frigidity:
   a. Complete primary frigidity may be due to:
   b. Partial primary frigidity is mainly due to psychological causes — viz. ignorance regarding coitus, fear of coitus, feeling of hostility and envy against males, misconception about feminine arousal, sexual dysfunction. Strong maternal fixation and infantile personality make-up.

   These women have lacked sexual instructions from their parents and very often their husbands are ignorant of their needs and sex-techniques.

i. Secondary frigidity:
   a. Physical causes — causing dysparunia will lead to frigidity.
   b. Physiological causes — are some times responsible for frigidity during lactation.
   c. Psychological causes — includes fear of pregnancy, fear of injury during intercourse, inadequate stimulation due to coitus, interruptus or the husband being weakly potent or suffering from premature ejaculation. In professional women who are financially and socially emancipated it becomes an emotional problem of dependency versus independendency, depression or anxiety symptoms may also be a contributory factor.

   Treatment: Psychoanalytically oriented psychotherapy is the only treatment when psychological factors are responsible for frigidity. It is more likely to prove beneficial in those whose inhibitions are due to unconscious feeling of guilt, disgust or the repressed hostility, then in women with a strong material fixation and infantile personality make-up.

2. Vaginisums: It is an involuntary spasm of the vaginal muscles and is always psychogenic in origin.

Causes:

i. It usually an automatic fear or anxiety reaction, coming after painful past experiences during the intercourse.
ii. In some women it is a difficulty in accepting the full female role and is a manifestation of psychosexual immaturity.

   Treatment — Analytic psychotherapy — same as in case of frigidity.

3. Dyspareunia: It is pain on intercourse.

   It may be present for a short time at the onset of marriage or sexual intercourse. Pain that continues long after marriage or develops later in life suggests local diseases or emotional disturbance. Vaginal and pelvic examination should be made to exclude pelvic inflammatory disease, endometriosis, or tumour. In the absence of demonstrable organic disease, psychological or emotional factors must be considered. Fear of pregnancy, fear of cancer if contraceptives are used and tension between husband and wife can prevent enjoyment of intercourse with consequent spasm of vaginal musculature.
**Treatment:** Explanation of underlying psychological factors with reassurance by an psychiatrist may be followed by appreciable improvement.