Chapter

7

Identify, Address and Treat Sexual Concerns, Dysfunctions and Disorders

*Since sexual concerns, dysfunctions and disorders all have an impact on quality of life, general and sexual health; they should be recognized, prevented and treated.**

Introduction

Sexual health is increasing recognized as a fundamental component of overall health and well-being and adequate sexual functioning must therefore be seen as a legitimate and central aspect of health. Yet, nearly all, if not all, cultures around the globe have been reluctant to openly recognize sexual function as a legitimate health issue, even as our medical/scientific understanding of health and sexuality has progressed enormously, particularly over the last century. In other words, while our understanding of sexual function and its role in overall individual and relationship functioning and happiness has evolved, our integration of sexual function into the broader rubric of health has lagged at the level of social and public health policy and political discourse.

Although the identification and treatment of sexual dysfunction and disorders has not been at the top of the health policy agenda, it is important to recognize the necessity of addressing sexual concerns, sexual dysfunction and disorders in a broadly-based initiative aimed at meaningfully improving the health and well-being of a population.

*This chapter was informed by the WAS Expert Consultation in Oaxaca, Mexico, a thorough review of the literature, and the background paper written by Emil Ng (see Appendix IV and V).

Increasingly, public health institutions are recognizing not only the importance of integrating sexual health into overall health programming but they are also realizing that sexual health entails more than HIV/STI prevention and reproductive health and includes aspects such as sexual function. For example, the World Health Organization (WHO, 2004) Department of Reproductive Health and Research has begun to focus on sexual health and this new emphasis is based, in part, on the public health importance of sexual dysfunction.

It has been commonly thought that sexual dysfunction has been primarily an issue of concern in North American and Western European countries and was less of a concern in other parts of the world.

This perception has, historically, been reinforced by the fact that most of the research investigating the prevalence and impact of sexual dysfunction has been conducted in Western countries. However, in recent years research on sexual dysfunction has expanded dramatically to cover diverse populations from around the world.

For example, The Global Study of Sexual Attitudes and Behaviors assessed sexual function among adults from 29 countries around the world including non-Western countries such as Algeria, South Africa, Turkey, Morocco, China, Indonesia, Malaysia, Philippines and Thailand. This study concludes, along with other considerations, that despite considerable cultural variation among the countries studied, a consistent finding was that sexual well-being was correlated with overall happiness in both men and women (Laumann, Paik, & Glasser, 2006).

The Connection between Sexual Function and Overall Health and Well-being

It is clear that sexual dysfunctions are strongly correlated with other health conditions. That is, there are common risk factor categories associated with sexual dysfunction for men and women (Lewis, Fugl-Meyer, Bosch, 2004). The directionality of cause and effect between sexual dysfunctions and other health conditions has, with many categories of sexual dysfunction, yet to be fully elucidated but it is clear that there is a close interactive association. In effect, people suffering with sexual dysfunctions are more likely to develop other conditions (e.g., depression) and people with other conditions such as cardiovascular disease are more likely to develop sexual dysfunction (e.g., erectile dysfunction). In any case, there is a close association and it illustrates that adequate sexual functioning is properly seen as an important component of not only sexual health but overall health and well-being. According to Sadovsky and Nusbaum (2006):

> Sexual problems have a clear negative impact on both the quality of life and emotional state regardless of age. Learning about specific sexual dysfunctions among men can reveal a variety of as-yet-diagnosed co-morbid pathologic conditions such as: (i) depression and other emotional illnesses; (ii) psychosocial stress; (iii) actual cardiovascular disease as well as related risk factors such as hypertension, diabetes, and/or hyperlipidemia; (iv) hyperprolactinemia; and low serum testosterone. Specific sexual dysfunctions among women can reveal pathologic conditions such as: (i) depression and other….psychosocial conditions; (ii) low serum estrogen or testosterone; and/or (iii) vaginal or pelvic disorders (p. 3).

Given the role of sexuality in fundamental aspects of life including reproduction and relationships, it is not surprising that problems with sexual functioning are correlated with reduced subjective well-being. Sexual problems have been linked to and cause diminished quality of life, low physical satisfaction, low emotional satisfaction, and low general happiness (Sadovsky & Nusbaum, 2006). The National Health and Social Life Survey in the United States found significant associations between sexual dysfunction feelings of general well-being (Laumann, Paik, & Rosen, 1999). The authors conclude from the data that "With the strong association between sexual dysfunction and impaired quality of life, this problem warrants recognition as a significant public health concern" (p. 544).

The precise relationship between sexual satisfaction and relationship satisfaction is complex; however research does indicate that people with greater relationship satisfaction also report greater sexual satisfaction (Byers, 2005; Yeh, Lorenzo, Wickrama, et al. 2006). Yeh et al. concluded from their longitudinal study of 283 American married couples that "Those who were satisfied with their sexual relations tended to be satisfied and happy with their marriages, and better marital quality, in turn, helped reduce marital instability" (p. 342). This linkage between sexual satisfaction and relationship satisfaction is not limited to couples in North America. The Global Study of Sexual Attitudes and Behaviors found that 82% of men and 76% of women agreed with the statement "satisfactory sex is essential to maintain a relationship" (Nicolosi, Laumann, Glasser et al., 2004). As West, Vinikoor, and West (2004) suggest from their review of research on the prevalence and predictors of female sexual dysfunction,

> For the individual with sexual dysfunction, there is a personal cost to her and her partner with respect to their relationship. But there may be societal costs as well, as reflected in divorce rates, domestic violence, single-parent families, and future relationships. These ancillary costs are rarely measured, but without a better understanding of their magnitude,

> female sexual dysfunction, as a health outcome, will continue to be underappreciated, to the detriment of the individual or society (p. 167).

The Prevalence of Sexual Concerns, Problems and Dysfunctions

Determining the prevalence of sexual concerns, problems, and sexual dysfunctions is very much dependant on the definition used and the methodologies used to assess them.

Sexual Concerns

There is a severe lack of data to indicate the number of individuals who have questions and concerns about their sexual functioning. However, questions and concerns are ubiquitous. People of all ages often perceive that they lack accurate and comprehensive information on a wide range of sexuality related issues including::

- HIV and STI transmission
- Sexual orientation and identity
- Gender roles
- Sexual function
- The appropriate frequency and normalcy of different sexual behaviors
- Infertility
- Contraception and abortion
- Sexual violence and abuse
- Sexuality related aspects of mental and physical illness
- Medical treatments for sexual problems and dysfunctions
- The impact of medications on sexual function
- The impact of physical and developmental disabilities on sexuality and relationships
- Masturbation
- Sexual/reproductive anatomy
- Body image
- Breast and genital size and appearance

Often, the lack of accurate information on these and other aspects of sexuality lead to concerns or uncertainty and anxiety that can have severe impact on self esteem, identity, well-being and the capacity to be involved in intimate relationships.

Most of these concerns could be could be addressed through comprehensive sexual education or other forums for providing basic information that dispels myths and

misinformation. In some cases, the provision factual information is not enough as such concerns may be symptomatic of deeper underlying anxieties and fears.

Unfortunately, many people do not feel comfortable addressing these concerns with their health care provider nor do they feel that their health care provider would be sensitive or comfortable enough to address these issues (Marwick, 1999).

Sexual Dysfunctions

A number of definitions for both sexual function and sexual dysfunction can be found in the medical sexological literature and a variety of definitions have been used in their measurement.

Nevertheless, there is a general consensus that adequate sexual functioning consists of the three basic stages of desire, arousal, and orgasm. There are also sexual pain disorders.

Thus, sexual dysfunction can be defined, at least in part, as an impairment or disturbance in one of these stages (Winze & Carey, 2001). The most common sexual

CLASSIFICATION OF SEXUAL DYSFUNCTIONS

- Sexual interest/desire dysfunctions (men and women)
- Female Sexual Dysfunctions:
  - Sexual arousal disorders
  - Genital sexual arousal dysfunctions
  - Subjective sexual arousal dysfunction
  - Combined genital and subjective sexual arousal dysfunction
  - Persistent sexual arousal disorder
  - Orgasmic dysfunction
  - Dyspareunia
  - Vaginismus
  - Sexual aversion disorder
- Male Sexual Dysfunctions
  - Erectile dysfunction
  - Early ejaculation
  - Delayed Ejaculation
  - Orgasmic dysfunction
  - Anejaculation

2ND International Consultation on Sexual Dysfunction Lewis, R.W., Fugl-Meyer, K.S., Bosch, R. Fugl-Meyer, A.R., Laumann E.O., Lizza, E., Martín-Morales, A. (2004).

dysfunctions are as follows (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza, & Martín-Morales, 2004):

Most population studies have asked respondents if they have experienced problems related to these stages. The results of these studies indicate problems with sexual functioning are very common within adult populations.

A review of the existing epidemiological data indicates that about 40-45% of adult women and 20-30% of adult men have at least one sexual dysfunction (Lewis, Kersten, Fugl-Meyer, et al., 2004). The Global Study of Sexual Attitudes and Behaviors found that among sexually active people aged 40 to 80 years, 28% of men and 39% of women reported at least one problem with sexual functioning in the previous year. For men, the most common problems were early ejaculation (14%), erectile difficulties (10%) while for women the most common were lack of sexual interest (21%), inability to reach orgasm (16%), and lubrication difficulties (16%) (Nicolosi et al., 2004).

It should be noted that participants were sexually active and it is likely that reported sexual dysfunction rates would have been higher if people who were not sexually active were included. The occurrence of sexual dysfunction is often age related with prevalence increasing as people grow older. However, this is not always the case. For example, in the National Health and Social Life Survey in the United States, problems such as inability to reach orgasm and pain during sex were more common among younger women (18-39) than older women (40-59) (Lauman, Paik & Rosen, 1999). Recent studies have found high levels of sexual dysfunction among women in Nigeria (Ojomo, Thacher, & Obadofin, 2006), Malaysia (Sidi, Puteh, Abdullah, & Midin, 2006) and Ecuador (Yanez, Castelo-Branco, Hidalgo, & Chedraui, 2006) showing that problems with sexual function are truly a global phenomenon that transcend culture.

Sexual Disorders

Sexual disorders are usually classified into paraphilic and non-paraphilic types (Coleman, 1991). The paraphilias are clearly classified in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA) (DSM-IV). Eight paraphilias are listed.

Money (1986) has identified more than 40 different types of paraphilias, including zoophilia (bestiality), asphyxiophilia (cutting off oxygen to enhance arousal or orgasm), and necrophilia (sex with dead people). Paraphilias are marked by an obsessive preoccupation with a socially unconventional sexual behavior that involves nonhuman objects, children or other nonconsenting persons, or the suffering or humiliation of oneself or one's partner.

These behaviors are also considered by the majority of people to be socially deviant.. It is important to note that to meet clinical criteria for having a paraphilia, the person must have sexually arousing fantasies, sexual urges, and behaviors that cause clinically significant distress in social, occupational, or other important areas of functioning. Many men and women, for example, cross-dress to varying degrees but do not experience sexual arousal that causes distress.

CLASSIFICATION OF PARAPHILIAS

- Pedophilia
- Exhibitionism
- Voyeurism
- Sexual masochism
- Sexual sadism
- Transvestic fetishism
- Fetishism
- Frotteurism

Diagnostic and Statistical Manual of the American Psychiatric Association (APA) (DSM-IV)

They have been able to integrate their activities into their overall identity and interpersonal relationships. By nature, paraphilic behavior interferes with a person's feeling of well-being and ability to have or form reciprocal love relationships.

There is a lack of epidemiological data on the prevalence of the paraphilic disorders, however they are well recognized as clinical syndromes and some of them are root causes of sexual violence, abuse, and interference in intimate relationships. Many more men than women suffer from paraphilic disorders (APA, 2000). The lack of epidemiological data is due in part to the absence of a clear definitions and clinical criteria. In addition, many people may have problematic sexual behaviors but do not meet the clinical threshold for paraphilic disorders. Even many sexual offenders, who have violated norms and laws of their societies, do not necessarily meet clinical criteria for paraphilia, although they may be suffering from and need treatment for some other type of psychiatric disorder, (Miner & Coleman, 2001).

While not classified per se in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2000), there has been growing recognition that there are another set of sexual disorders which are similar to the paraphilias but involve normative or conventional sexual behavior but in a similar manner they involve sexually arousing fantasies, sexual urges, and behaviors which cause clinically significant

distress in social, occupational, or other important areas of functioning (Coleman, Raymond & McBean, 2003).

There is even poorer epidemiological data on this type of disorder but have been extensively described in the literature. This type of sexual disorder has been called hypersexuality, hyperphilia, erotomania, perversion, nymphomania, satyriasis, and, more recently, compulsive sexual behavior (CSB) or sexual addiction (Coleman, 1991). While some of these are exotic terms and the nosology and etiology is highly debated among professionals in the area, there is no question that this is a serious mental, sexual, and physical health problem. Nonparaphilic CSB can be impulsive, obsessive and compulsive, driven, out of control, and distressing. No clear category exists for this type of CSB in the DSM nomenclature, but an example is given under Sexual Disorder Not Otherwise Specified (NOS): "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (APA, 1994). There are at least 7 subtypes of nonparaphilic CSB (Coleman, Raymond & McBean, 2003).

SUBTYPES OF NONPARAPHILIC COMPULSIVE SEXUAL BEHAVIOR

- compulsive cruising and multiple partners
- compulsive fixation on an unattainable partner
- compulsive autoeroticism (masturbation)
- compulsive use of erotica
- compulsive use of the Internet for sexual purposes
- compulsive multiple love relationships
- compulsive sexuality in a relationship

Coleman, Raymond & McBean, 2003

There is a growing body of literature suggesting an association between CSB and HIV and STI risk behaviors (Kalichman & Rompa, 1995; 2001; Miner, Coleman, Center, Ross,& Rosser, 2007; Reece, Plate, & Daughtry, 2001).

Whether paraphilic or nonparaphilic compulsive sexual behavior, these problems are associated with many other comorbid psychiatric disorders and are linked to sexual health problems – particularly sexually transmitted infections, sexual violence and abuse (Black, Kehrberg, Flumerfelt, & Schlosser, 1998; Kafka, & Prentky, 1994; Raymond, Coleman, Ohlerking, Christenson & Miner, 1999). In order to effectively address the MDGs, it is critical that these types of sexual disorders are identified, assessed, and given proper treatment. Beyond structural factors, these individual psychiatric factors can be responsible for a large number of negative sexual health consequences.

Comfort with ones gender is a necessary requisite for sexual health and well-being. Individuals who are uncomfortable with their gender identity or suffer from gender identity disorders are at high risk for negative sexual health consequences. Gender identify disorders are defined as an incongruence between one's physical phenotype (male or female) and one's gender identity that is, the felt and self identification as man or woman (APA, 1994). The experience of this incongruence is termed gender dysphoria. In the most extreme form of gender dysphoria, individuals wish to make their body congruent with their gender identity and this is called transsexualism.

The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females (WPATH, 2001). Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized (WPATH, 2001).

Between the publication of APA's DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender variance. Transgender is not a formal diagnosis, but many professionals and members of the public find this to be a preferred term because of its inclusiveness and lack of assumed pathology (WPATH, 2001). When the wide variety of gender identities and expressions are taken into account, there are no good estimates on the prevalence of individuals who might be defined as transgender.

What is most important is to recognize that not all people identify as either male, female, boy or girl, man or woman. Depending on cultural norms, individuals who do not fit into the binary face varying challenges in developing positive sexual identities, being granted sexual citizenship, healthy relationships and well-being. It is important that these individuals be identified and assisted in their process of positive sexual identity development (Bockting & Coleman, 2007).

Effective Education and Treatment for Sexual Concerns, Problems and Dysfunctions

Many difficulties that people experience related to sexual concerns, problems and dysfunctions can be effectively addressed with the provision of factual information to counter misunderstandings, myths, and ignorance. A lack of scientifically valid information concerning sexual function within the general population is pervasive and the negative impact of this ignorance is felt around the world. In addition, many instances of sexual difficulties can be satisfactorily resolved through the provision of short-term solution focused therapy delivered by a sufficiently trained counselor, therapist, or front line health care provider.

Physicians and other primary care health providers are ideally placed to inquire about sexual concerns, problems and dysfunction in a non-judgmental and professional fashion that is welcomed by patients (Nusbaum & Hamilton, 2002). Brief assessment of sexual concerns, problems and dysfunction can and should become a standard component of the general health assessment and people should be invited and encouraged by the health care provider to ask questions concerning these issues. For example, individuals experiencing difficulties with sexual function will benefit from factual information on sexual anatomy, the sexual response cycle of both sexes, psychosocial factors (e.g., relationship function, stress) affecting sexual function as well as sexuality related changes associated with aging, pregnancy, menopause, medical conditions, illnesses, and medications. However, data from the Global Study of Sexual Attitudes and Behaviors showed that few physicians in the 29 countries surveyed routinely assess the sexual health of their patients (Moreira, Brock, Glasser, et al., 2005). Although nearly half of the men and women in the survey reported sexual problems, less than 20% sought help from their physicians and only 9% of both men and women reported that their physician had inquired about their sexual health in the previous three years.

Numerous studies have found that physicians are often uncomfortable talking to their patients about sexuality or taking a sexual history, that most medical school curricula do not train them to do so, and that even brief training interventions designed to increase and improve physician-patient communication about sexuality can be effective (Council on Scientific Affairs, 1996; McCance, Moser, & Smith, 1991; Ng & McCarthy, 2002; Rosen, Kountz, Post-Zwicker, T. et al., 2006; Solursh, Ernest, Lewis, et al., 2003; Tsimtsiou, Hatzimouratidis, Nakopoulou, et al., 2006). Barriers to physician-patient communication includes lack of provider comfort, bias, fears of offending the patient, lack of training, and time constraints (Maheux, Haley, Rivard & Gervais, 1999). These findings indicate that physicians and other primary health providers require more and better training to effectively communicate with and educate their patients about sexuality.

Evidence-based recommendations for the treatment of sexual dysfunctions in women (Basson, Althof, Davis, et al., 2004) and men (Lue, Giuliano, Montorsi, et al., 2004) are available. With respect to clinical sexual dysfunctions diagnosed by a health professional, there is growing evidence that medical interventions to treat sexual dysfunctions among men can be effective and can have a meaningful positive impact on health and well-being. For example, research has demonstrated that medical treatment for erectile dysfunction can result in improved long-term psychosocial quality of life for men including increased self-esteem, sexual relationship satisfaction, and relationship satisfaction (Althof, O'Leary, & Cappelleri, et al., 2006a; Althof, O'Leary, & Cappelleri, et al., 2006b). In comparison to men, for women, understanding of the bio-physiology and psychology of sexual function and research on sexual dysfunction including effective treatment is less well developed (Verit, Yeni, & Kafali, 2006). Although safe and effective pharmacologic therapies for female sexual dysfunction have not been firmly established, recommendations for treatment include cognitive-behavioral therapy aimed at changing maladaptive thoughts and unreasonable expectations, correcting misinformation about sexuality, and exploring strategies to improve couple emotional closeness and communication (Basson, 2006). Among some guidelines issued by medical associations, there is support for local estrogen therapy for dyspareunia associated with vulval atrophy and cautious support for selective use of low dose testosterone provided the patient understands the risks involved (for review see Basson, 2006). There is a clear need for more research on the management of female sexual dysfunction that includes long-term treatment outcome studies (Basson et al., 2004).

Evidenced-based treatment for sexual disorders is not as well established. However, there is guidance based upon extensive clinical experience (Bradford, 2000; Coleman, Raymond & McBean, 2003). Combinations of psycho- and pharmacotherapy are often helpful. However, there is clear need for further research to support various types of treatments.

Treatment of gender identity disorders has been carefully outlined by the Standards of Care of the World Professional Association for Transgender Health (Meyer, Bockting, Cohen-Kettenis, Coleman, DiCeglie, Devor, Gooren, Hage, Kirk, Laub, Lawrence, Menard, Monstrey, Patton, Schaefer, Webb, & Wheeler, 2001) and international experts in this field (Ettner, Monstrey, & Eyler, 2007). As with sexual disorders, there is still much research and work to be done to develop evidenced-based treatments.

Necessary Actions

7.1 Given the importance of adequate sexual functioning for general sexual health, overall health and well-being, and the health of interpersonal relationships, the assessment and treatment for sexual concerns, problems, and dysfunction should be specifically noted and included in national and international programs and agreements to promote sexual health.

7.2 Sexual function and gender identity are increasingly recognized as key components of overall health and problems with sexual dysfunction and gender dysphoria are associated with other medical conditions and individual and relationship well-being. Therefore, comprehensive sexual health assessment that includes evaluating basic sexual function and gender identity should become a standard component of health care.

7.3 Many sexual concerns, disorders and dysfunctions are rooted in a lack of information about sexuality. Information on sexual functioning should be included as an integral component of the comprehensive sexuality education available to all people. Schools, through their sexual health education curricula, and the health sector (physicians, nurses, and other health workers) must play key roles in educating their students and patients about sexual functioning.

7.4 Training programs for teachers, community workers, and health care workers must include, as a standard component, training in sexual dysfunction, disorders and gender problems. Such programs should include specific training on educating clients about sexual function and gender identity development. Physician and nursing training should go beyond providing education to include a specific focus on addressing and treating sexual problems/dysfunctions.

7.5 Optimal treatment approaches for sexual concerns, dysfunction, disorders and gender identity problems are in development, and more research is needed to develop evidence-based guidelines for the majority of these conditions. Allocation of funds for the conducting of this research is necessary and justified by the considerable impact that these problems have in the individual, the couple, and the family and ultimately in the society at large.

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