The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 10, Issue 4, October- December, 2022
DIP: 18.01.061.20221004, DOI: 10.25215/1004.061
https://www.ijip.in

Research Paper

An Insight into Sexual Dysfunction: The Past and Present

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ABSTRACT

Sex and sexuality have always been very important parts of the human personality. With the coming of age, we are realising its importance in our lives and how much it is essential for overall well-being and healthy personality development and functioning. Since the introduction of psycho-sexual disorders, there has always been an extra effort to describe and classify them due to the stigma attached to these problems. The nosological system of psycho-sexual disorders has come a long way. Mental health professionals now work together toward reducing the stigma of these disorders in society. With the latest developments in the ICD-11 and DSM-5, sexual dysfunctions are now easily diagnosed and treated.

Keywords: *Sexual dysfunctions, Sexual health, History of sexual disorders, Sexuality*

Sexual health is an integral part of our overall health and well-being, which is inseparable from human rights. The definition and meaning of sexual health have evolved, to include the interlinking of physiological, social, psychological, and epidemiological dimensions that give shape to our experiences and health outcomes related to sexuality.

Sexual health and reproductive health are two very different concepts, but still, we find many similarities between them, making them overlap to an extent. Yet, the former has the most scope of them (National Human Rights Commission, 2008). Sexual health has evolved through links with AIDS and other STIs, pregnancies and abortions, infertility and sterility, discrimination of sexual minorities, and gender-based violence.

One of the first definitions of sexual health is "… *the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love*." (World Health Organization, 1975). This definition was later revised by WHO stating that,
"… *it is a state of physical, emotional, mental and social well-being concerning sexuality; it is not merely an absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationship, as well as the*

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Received: May 08, 2022; Revision Received: November 20, 2022; Accepted: November 28, 2022

possibility of having pleasurable and safe experiences, free of coercion, discrimination and violence." (2)

People suffering from HIV/AIDS are stigmatized. Sex workers, transgender people, and those indulging in homosexual behaviour are deprived and marginalized in our society. Many people, including them, lack access to resources and knowledge about sexual health, making them at risk for sexual dysfunction and sexual illness. (3)
Sexuality is described *as "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.*" Sexuality is much more psychological than physiological and is influenced by the interactivity of socio-economic, cultural, legal, ethical, educational, religious, and historical domains. Sexuality is much more related to our identity, who we are, what we feel and what we desire, and is therefore considered an essential part of our personality and an important aspect of our human life.

No discipline, philosophy, religion, or textbook chapter is sufficient to properly comprehend and cover the multitude of forms of human sexuality. (4)

History of Sexual Dysfunctions
The DSM I was published in 1952 in which Sexual Deviation (Standard Nomenclature was 000-x63) was categorised under Sociopathic Personality Disturbances. It included the vast majority of cases previously classified as "psychopathic personality with pathologic sexuality" which required a specific type of pathological behaviour such as paedophilia, transvestism, fetishism, homosexuality and sexual sadism (including rape, sexual assault, and mutilation). (5)

The DSM – II was published in 1968, in which Sexual Deviations were explained in major subdivision V, covering "Personality Disorders and Certain Other Non-Psychotic Mental Disorders". (21) It is intended for those individuals whose sexual interests are primarily directed toward objects other than people of the opposite sex, sexual acts not normally associated with copulation, or copulation performed under unusual circumstances, such as necrophilia, paedophilia, sexual sadism and fetishism. Although many individuals find these activities repulsive, they are unable to replace them with regular sexual conduct. This diagnosis was not for people who engage in deviant sexual behaviour since they do not have access to normal sexual objects. The DSM II included Homosexuality as a Sexual Orientation Disturbance, Fetishism, Paedophilia, Transvestitism, Exhibitionism, Voyeurism, Sadism, Masochism, Other sexual deviation, and unspecified sexual deviation. (6). Even though homosexuality was not considered an illness, the diagnosis of sexual orientation disturbance legitimatised the use of sexual conversion therapy for those with same-sex desires who were distressed and wanted to change. (13) (14).

During the 1960s and 1970s, the direct observation of anatomical and physiological responses in human subjects, William Masters and Virginia Johnson pioneered research into understanding the human sexual response cycle, and the dysfunctions and disorders related to it. The human sexual response cycle has four stages: desire, arousal, orgasm, and resolution. (7). Masters and Johnson launched a short-term, rapid treatment model of psychotherapy in which individuals and their partners place themselves in social isolation to focus on obstacles that interfere with heterosexual unfolding. It was a reversion therapy to convert homosexuals to heterosexuals, but just after that, the DSM-III eliminated homosexuality as a disorder or dysfunction. (8) (9).

Soon after DSM-III was published in 1980 and DSM-III-R in 1987, which had a heavy impact on the diagnostic criteria for mental disorders. From Kraepelin to Neo-Kraepelin, from psychoanalytic-based psychiatry to medical-based psychiatry, the DSM-III marked a paradigm shift in the mental health field. (10) (11) (12). The chapter "Psychosexual Disorders" in the DSM-III detailed sexuality and sex-related problems. The psychosexual disorders were divided into four main groups: Gender Identity Disorders, Paraphilias, Psychosexual dysfunction and Other psychological disorders, which had two sub-groups, including Ego Dystonic Homosexuality and Psychosexual disorders not elsewhere classified.(17).

In December 1973, APA's Board of Trustees (BOT) agreed to remove homosexuality from the DSM. However, psychoanalytic community psychiatrists were not happy with the BOT decision and asked APA to organise a referendum in which the whole membership would vote for or against the BOT decision. A 58% majority of 10,000 voting members backed the 'removal of homosexuality' decision. (15) (16). However, homosexuality was still included in DSM-III as Ego Dystonic Homosexuality, but later in DSM-III-R (1987), it was completely removed. (18). But the ICD published by WHO still listed homosexuality as a disorder. With the publication of ICD-10 in 1992, the WHO removed homosexuality from its ICD classification. However, the description of F66 categories remained as "psychological and behavioural disorders associated with sexual orientation and development". Although ICD-10 states that "sexual orientation alone is not to be regarded as a disorder".

Table 01: F66 categories named "Psychological and behavioural disorders associated with sexual development and orientation" included in ICD-10 are:

Code	Category name
F66.0	Sexual Maturation Disorder
F66.1	Ego-Dystonic Sexual Orientation
F66.2	Sexual Relationship Disorder
F66.8	Other Psychosexual Development Disorders
F66.9	Psychosexual Development Disorders, unspecified.

(ICD 10: International Statistical Classification of Disease and Related Health Problems, tenth revision; adapted from the World Health Organization; NA: Not applicable).

Table 02: The five-character codes under the F66.1 Ego-Dystonic Sexual Orientation are given in ICD-10 to indicate sexual development and orientation variations that may be problematic for individuals.

Codes	Sub-Category description
F66.x0	Heterosexual
F66.x1	Homosexual
F66.x2	Bisexual
F66.x8	Other, including Pre-pubertal

(ICD 10: International Statistical Classification of Disease and Related Health Problems, tenth revision; adapted from the World Health Organization; NA: Not applicable).

Currently, the WHO and APA classifications, ICD-11 and DSM-5, do not have a single category for individuals that could be applied to their sexual orientation. (22).

The DSM-IV was published in 1994 and, subsequently, the DSM-IV-TR (Text Revision) came in 2000. The sexual disorders were described under Axis I of the chapter titled,

"Sexual and Gender Identity Disorders." For the first time, specifiers or sub-types were included for all primary sexual dysfunctions – lifelong/acquired, generalised/situational, and psychogenic/combined factors. For the first time, a concrete definition of sexual dysfunction was included,

"*A Sexual Dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse.*"
DSM-IV-TR (2000, p. 535)

Each sexual dysfunction is defined by three criteria (A, B, and C) in the DSM IV edition. The first criteria (A) is concerned with the psychophysiological deficit, such as lack of desire, arousal, or orgasm. For each dysfunction, the second (B) and third (C) criteria were the same; the impairment causes significant distress or interpersonal difficulty; the problem is not better explained by another Axis I disorder or is not due solely to the direct physiological effects of a substance or a general medical condition. (4).

Table 03: Showing all the types of psycho-sexual disorders mentioned in DSM-IV-TR (2000).

Characteristic/Type	Code	Disorder
Desire	302.71	Hypoactive Sexual Desire Disorder (Male)
	302.79	Sexual Aversion Disorder (Female)
Arousal	302.72	Erectile Dysfunction (Male)
	302.72	Female Sexual Arousal Disorder
Orgasmic	302.73	Female Orgasmic Disorder
	302.75	Premature Ejaculation (Male)
	302.74	Male Orgasmic Disorder
Sexual Pain (Not due to a general medical condition)	302.76	Dyspareunia (Female)
	306.51	Vaginismus (Female)
Sexual Dysfunction due to a general medical condition		Due to Neurological conditions, endocrine conditions, vascular and genitourinary conditions or post-surgery complications.
Substance-Induced Sexual Dysfunction		Alcohol, Amphetamine, Cocaine, Opioid, Sedative, Hypnotic, Anxiolytic or other unknown substances.
Sexual Dysfunction not otherwise specified	302.70	Sexual dysfunctions that do not meet any criteria for specified sexual disorder.

(DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision; reproduced from the American Psychiatric Association, 2000).
**NA – Not applicable, currently the following criteria are replaced by DSM-5.*

The DSM-5 was published in 2013 and its most awaited revision, the DSM-5-TR is expected to come out in March 2022. According to the current fifth edition of the DSM, a sexual dysfunction is described as "*a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure*" (p. 423).

In addition to the subtypes included in DSM-IV-TR, several factors must be examined during the evaluation of sexual dysfunction because they may be significant to causation, therapy, or treatment and may contribute to various degrees among individuals.

Table 04: Factors that must be essential for the assessment of sexual dysfunction in individuals.

Factors	Example
Partner related	Partner's sexual problems, partner's health status, partner's support for treatment
Relationship related	Poor communication, discrepancies for sexual desire, incongruence, lack of romantic attachment
Related to Individual's vulnerability	Poor body image, sexual abuse history, emotional abuse history, substance abuse, lack of information, poor sleep routine
Comorbidity related	Depression, anxiety, PTSD, hypothyroidism, genital mutilation
Cultural or Religion related	Prohibitions, certain biases, stereotypes
Medical-related	Prognosis, course and treatment

(DSM-5: Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision; adapted from the American Psychiatric Association, 2013).

The major differences between DSM-5 and DSM-IV-TR are:

i. It includes the duration criteria, which is a minimum of six months (except for substance/medication-induced sexual dysfunction).
ii. The current edition of the DSM also indicates that 75-100% of the time, dysfunction is present.
iii. Sexual Aversion Disorder, Sexual Dysfunction due to a general medical condition, and Sexual Dysfunction not otherwise specified are eliminated.
iv. Female Sexual Arousal Disorder is renamed as Female Sexual Interest/Arousal Disorder because research has not satisfactorily proven that sexual interest and arousal are distinct in women. (26).
v. Substance/Medication-Induced Sexual Dysfunction replaces Substance-Induced Sexual Dysfunction.
vi. Dyspareunia and Vaginismus, which came under Sexual Pain Disorders are now renamed Genito-pelvic pain/penetration disorders. Because the scientific study could not justify the differentiation between Dyspareunia and Vaginismus, they were merged into DSM-5.

There is no scientific evidence that women with vaginismus have vaginal-related spasms or that vaginismus can be diagnosed accurately. Women with vaginismus, on the other hand, frequently, complain of discomfort during penetration, the anticipation of anxiety before and then the experience of anxiety during sexual activity with a partner. (27). This made the diagnosis of dyspareunia and vaginismus difficult. Vaginal spasms, the chief symptom of vaginismus, do not always occur, although genital discomfort during penetration, which is the chief symptom of dyspareunia, often occurs in women diagnosed with vaginismus. (28). As a result, dyspareunia and vaginismus are combined in the DSM-5 as one Genito-pelvic pain/penetration disorder.

Some of the major changes that happened in ICD-11 from ICD-10 are:

i. The Sexual Disorders, which were mentioned under "Behavioural syndromes associated with physiological disturbances and physical factors" in ICD-10, are now shifted to a separate section on "Conditions related to sexual health" in ICD-11.

The present evidence suggests that physiological and psychological variables interact with each other to cause and maintain sexual dysfunction, and the justification for this

modification in ICD-11 is congruent with today's more integrative approaches to the treatment of sexual dysfunction, which may help to reduce the stigma attached to these conditions. (29) (30).

ii. Sexual dysfunctions are divided into groups: hypoactive sexual desire dysfunction, sexual arousal dysfunction, orgasmic dysfunction, ejaculatory dysfunctions, sexual dysfunction associated with pelvic organ prolapse, other specified, unspecified, and sexual pain disorders.
iii. Because of anatomical differences in males and females, ICD-11 provides a distinct category for female sexual arousal disorder and erectile dysfunction, which earlier in ICD-10 were under the category of "failure of genital response". (29).
iv. The ICD-11 category of Orgasmic Dysfunction is now gender-neutral, which will be helpful in diagnosis in both males and females.
v. ICD-11 also employs the etiological specifiers used in DSM-5 (lifelong/acquired, generalized/situational).
vi. These etiological specifiers will be used in ICD-11 for the classification of sexual disorders, which earlier in ICD-10 were divided based on "organic" and "non-organic" disorders. (31) (29).
vii. Sexual aversion disorder is eliminated and would be classified either as a sexual pain/penetration disorder or under a specific phobia of Anxiety and fear-related disorders based on the symptomatology. (29).
viii. Like in DSM-5, in ICD-11, dyspareunia and vaginismus are categorized as one under sexual pain disorder.

In ICD-11, under Impulse-control Disorder, diagnostic guidelines for Compulsive sexual behaviour disorder (6C72) were given. It is characterised by a persistent failure to control intense and repetitive sexual urges, resulting in repetitive sexual behaviour. Any such disorder related to hyper-sexuality does not have its diagnostic criteria in the DSM-5. However, the fifth edition of the DSM explains hyper-sexuality as a stronger than usual urge to engage in sexual activity which can be diagnosed by the certified practitioner as a sub-category of another mental disorder such as behaviour addiction, or impulse control disorder. Very little research is conducted in this domain, and therefore more accurate scientific results and evidence are needed to draw a clear demarcation between expressing sexuality and hyper-sexuality and making a diagnosis out of it.

The ICD-10 also classifies culture-bound syndromes. The diagnostic guidelines for Dhat syndrome (code F48.8) were detailed under the heading of "Other nonpsychotic mental disorders" (code F48), which is viewed as both, a neurotic disorder and a cultural-specific disorder in India, Sri Lanka, Bangladesh, Nepal, and Pakistan. (32). The classification of Dhat syndrome remains vague and unclear. Dhat syndrome is a psychological as well as a physical condition caused by semen loss. The loss of semen is generally through nocturnal emission, urine, and masturbation, which are associated with the symptoms of fatigue, weakness, sleeplessness, and guilt. Many past studies have discovered significant rates of comorbidity with other psychiatric disorders like depression and anxiety (33), sexual dysfunction (32) (36), and psychosomatic disorder (34), leading to the hypothesis that maybe it is just a culturally determined symptom of depression rather than a distinct dysfunction. (34) (35).

However, the question of whether it should be classified as a distinct diagnostic entity continues to be debatable.

The latest developments in ICD-11 and DSM-5 are somewhat accurate for making diagnoses of sexual dysfunctions, but there is still a debate among mental health professionals in the Indian sub-continent regarding the criteria set for FSAD. Are the guidelines mentioned in DSM-5 for FSAD applicable to women in India? The same applies to males too. Are the guidelines mentioned in the DSM-5 for HSDD applicable to males in India? As we see in the Indian subcontinent, the culture is very different. Sex and sexuality are not openly discussed in this country, and if one of the spouses is perceived to have little or no desire for the partner, then it is not seen as a part of some "disorder or dysfunction". Most Indians have no access to sexual education and have very strong presumptions about sex-related things. And in such a culture, the diagnosis guidelines for HSDD and FSAD become even more difficult in the clinical setting.

CONCLUSION

Satisfactory sex and sexual functioning are important aspects of a healthy relationship as well as of an individual's overall health. Every day, the concept of sexuality and sexual health are becoming more complex, and the disorders associated with them are becoming more diverse and tougher to analyse, describe, and diagnose. With changes in society and more scientific research and awareness, there have been numerous changes in both the DSM and ICD since their initial publications. The DSM-5 and ICD-11 both view sexual dysfunction as persistent and recurrent sexual problems that prevent an individual from enjoying sexual activity and cause distress. The disorders are classified based on sex response cycle phases: Desire, Arousal, Orgasm as well as sexual pain. Multiple factors like comorbidity, religion and cultural factors are also taken into consideration before diagnosing someone, and once diagnosed, suitable treatment and therapy should be followed.

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Acknowledgement

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interest.

How to cite this article: Piyush, A. (2022). An Insight into Sexual Dysfunction: The Past and Present. *International Journal of Indian Psychology*, *10(4)*, 638-646. DIP:18.01.061.20221004, DOI:10.25215/1004.061