# Sexual dysfunction

We understand sexual dysfunctions as **quantitative disorders of sexual performance** . It is a category understood very differently by different authors. In the literature, we can find concepts emphasizing the functional or psychogenic nature of sexual dysfunctions, as well as concepts based on biological etiological factors. However, the largest part of experts advocates the concept of **multifactorial etiology** of these conditions.

Areas that relate to sexual dysfunctions include, in particular:

- **sexual arousal ,**
- **desire for sex** ( *appetence, libido* ),
- **genital reaction** .

Little observed, but certainly important, is the area **of sexual satisfaction** ( *satisfaction* ). This highly psychological quality ultimately determines how the subject evaluates his sexuality and how satisfied he is with it.

The traditional assessment of sexual dysfunctions is based on a purely heterosexual model of human sexual behavior. However, homosexually oriented people can also suffer from the same sexual disorders as the heterosexual majority population.

Sexual dysfunctions are a grateful object of medical care in a wide range of fields. In addition to countless sexologists, gynecologists, urologists and psychiatrists are devoted to them. Many partner problems of sexual dysfunctions as well as partner sexual discord require consistent care by experienced psychologists and psychotherapists. It is important that doctors and other health professionals have enough interest and empathy in relation to the sexual problems of their patients.

## WHO classification

**The WHO International Classification of Diseases** (ICD-10) tries to accurately classify sexual disorders as "functional", i.e. those that are not related to organic causes. Because in this area we are on the ground of typical psychosomatic connections, it is very difficult in practice to follow this classification completely. Disturbances are distinguished:

1. **sexual desire ( *F52.0 (https://mkn10.uzis.cz/prohlizec/F52.0) Lack or loss of sexual desire , F52.1 ( https://mkn10.uzis.cz/prohlizec/F52.1) Resistance to sexuality - sexually aversive disorder* );**
2. **sexual arousal ( *F52.1 (https://mkn10.uzis.cz/prohlizec/F52.1) Insufficient experience of sexuality , F52.2 (https://mkn10.uzis.cz/prohlizec/F52.2) Failure of genital response* );**
3. **orgasm ( *F52.3 (https://mkn10.uzis.cz/prohlizec/F52.3) Dysfunctional orgasm , F52.4 (https://mkn10.uzis.cz/prohlizec/F52.4) Premature ejaculation* );**
4. **sexual pain disorders ( *F52.5 (https://mkn10.uzis.cz/prohlizec/F52.5) Nonorganic vaginismus , F52.6 (https://mkn10.uzis.cz/prohlizec/F52.6) Nonorganic dyspareunia* );**
5. **increased sex drive ( *F52.7 (https://mkn10.uzis.cz/prohlizec/F52.7) Hypersexuality* ).**

## Categorization of sexual dysfunctions

Each sexual dysfunction should be defined in the diagnostic conclusion in particular in the following categories:

### Primary or secondary sexual dysfunction

We speak of **primary** dysfunction if it occurs in the patient from the beginning of his sexual life. **Secondary** are dysfunctions occurring after a certain longer period of trouble-free sexual life.

### Sexual dysfunction complete or partial

**Complete** sexual dysfunction means the practical absence of some physiological sexual quality. That is, lack of lubrication, lack of firm erection , lack of orgasm, etc. **Partial** dysfunctions are those where the relevant sexual function is impaired only to a certain extent (for example, unreliable erection, insufficient lubrication, occasional lack of orgasm, etc.).

### Sexual dysfunction generalized or selective

**Generalized** dysfunction is not tied to the current partner relationship and is autonomous with respect to the specific partner. **Selective** dysfunction is linked to a certain partner relationship and its quality.

### Sexual dysfunction mainly functional (psychogenic) or mainly organic

## Epidemiology of sexual dysfunctions

### Prevalence

of sexual dysfunctions in the population is not precisely known. What is indisputable is that most of these disorders, in their milder form, occur at least sometime in most people's lives. In a survey of the sexual behavior of a representative sample of the Czech population, 17% of women and 19% of men stated that they had suffered from sexual disorders at some point in their lives. In the same survey, 11% of women and 15% of men stated that they currently have sexual problems (DEMA 1998).

### Age at onset of sexual dysfunction

the first peak of occurrence are debutant failures during first sexual intercourse . that is, difficulties in people under the age of twenty. This is followed by difficulties with the course of the partner's sex life. It is often not true sexual dysfunction, but a typical partner mismatch (see the relevant chapter). An important period in terms of decreasing sexual performance is involution, both in men and in women.

## Course and prognosis of sexual dysfunctions

The course of sexual dysfunction is a quality about which we know little. We know dysfunctions with a life-long fatal nature. Most often, however, we observe fluctuations in the intensity of symptoms at different times with shorter and longer remissions.

## Etiopathogenesis of sexual dysfunctions

The causes of sexual dysfunctions are varied. Constitutional, biological, psychological and social factors apply here. Only for a small part of these disorders can a single decisive cause be unequivocally established. For example, a vascular defect in severe erectile dysfunction. **A multifactorial** etiology must be assumed for most dysfunctions .

## Treatment of sexual dysfunctions

### Behavioral therapy

In the therapy of sexual dysfunctions, a psychosomatic approach with an emphasis on the comprehensive analysis of each case has been consistently applied for decades. Specific psychotherapy, behaviorally oriented ( **sex therapy** ), has a dominant role in therapy. It is important that sex therapy also works well for those sexual dysfunctions that are clearly organic in nature.

### Drug treatment

Pharmacotherapy plays an important role in the treatment of sexual dysfunctions. **Medications with central** ( dopaminergic drugs, antidepressants , anxiolytics ) and **peripheral** ( vasodilatation , spasmolytic ) effects are used . Exogenous hormones also have their place in the treatment of sexual dysfunctions , especially androgens (in both men and women) and estrogens (in case of their deficiency in women).

### Life management

The effort to improve the overall mental and physical condition of patients is of great importance for the treatment of sexual dysfunctions. Stresses of all kinds affect the sex life of all people negatively. Already the classic A. Kinsey (https://en.wikipedia.org/wiki/Alfred_Kinsey) emphasized that the best aphrodisiac is plenty of movement in the fresh air and sound sleep .

## Links

### Related Articles

- Sexual dysfunction in men
- Sexual dysfunction in women
- Psychophysiology of human sexuality

### Source

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