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Sexual Assault & Life Beyond

Indian Institute of Sexology Bhubaneswar

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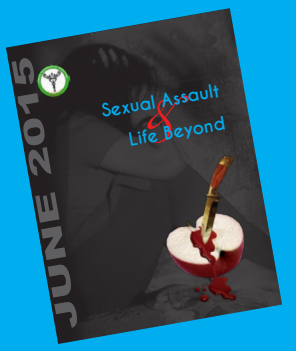

Editorial

Many don't hear that cry. Some ignore it. Few worry for it. Very few understand the intense pain underneath the cry. The pain of victims of sexual assault is often poorly understood and empathized. The victims are mostly females, but males are also affected. No age is spared from this heinous crime.

Crimes related to sexuality has been increased many folds worldwide in past several years, India being no exception to it. Due to huge number of cases and ever increasing incidences, India is called as the rape capital of world. Many point fingers towards degraded social norms and values; failure of government to provide security and to punish the culprit. Often the culprit has history of crimes, sexual and others. Reasons are so many and solutions are not simple, which put us in the cross roads. We are not able to prevent it successfully.

The impact of sexual assault lasts for varied extent of time on the victims. However, the impact is not only limited to the victims. Family members and close associates are also affected. Sometimes the impact is enormous, as seen after that dark day of December 2012 when a girl was gang raped in a public transport in New Delhi, the capital city of India. The whole country was shocked. This incident made the policy makers think about the legislative loopholes, lapses in administrative and judicial system. People from all spheres of life united and advocated for the need to control the sexual crime in the country. But it was neither the first nor the last sexual brutality happened in India.

Victims of sexual assault go through a lot of trauma throughout their life. The physical trauma and psychological trauma, though more intense immediately following the assault, but their long term impact cannot be underestimated. The severity of immediate and long term impact depends on the type of medical, legal and psycho-social support a victim receives following the traumatic experience. What is required is to hear & understand the cry, few words of empathy and a helping hand.

A good medical, legal as well as psycho-social support helps in ameliorating the intensity of sufferings and facilitates the victim to get into the main stream of life. Sexual assaults are preventable. It does not exclusively mean that Government will take initiatives to stop sexual crime by enacting strong laws and facilitating quick and strong action against the perpetrators. This is only a small part of preventive measure. The focus should also extend to creating awareness regarding the risk factors, protective factors, help-lines, legal assistance provisions, importance of medical, legal as well as psychological intervention and rehabilitation.

It's injustice to say, that attempts are not being taken to prevent sexual assault. The Government, many NGOs and individuals are working for the victims of sexual assault to provide medico-legal assistance, psycho-social support and rehabilitation. But, probably it is falling short, considering the large population of the country and very high prevalence of sexual crimes. This is high time to create awareness, empower the victims and strengthen the legislative framework.

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Introduction

Sexual assault is a heinous crime. It ranges from molestation to rape and even may follow murder. The trauma resulting from sexual assault has enormous impact on the physical as well as psychological well-being of the individuals and also on the family concerned. Whatever the number of cases of sexual assault reported, are just tip of the ice berg and most cases go unreported or unnoticed [1]. Social stigma, unawareness, fear and many more contextual factors attribute to the under-reporting of rape in India [1]. As per the United Nations statistics (2013), the highest rate of rape was reported in an African country Lesotho (91.6 per 100,000 population) followed by Trinidad and Tobago (58.4 per 100,000 population) and the lowest rate was reported in Egypt (0.1 per 100,000 population [1, 2]. Though, India reports a relatively lower rape rate (<2 per 100,000 population), being a heavily populated country, the total number of rape cases per year in India is quite high [1]. Gradually, the reporting of cases of rape is increasing in India

[1]. This review tries to highlight the sexual crime scene in India.

Sexual assault

Sexual assault is the resultant to deviant sexual behavior. The victim can be any one irrespective of gender, age, race and religion. Many factors increase the vulnerability to sexual assault, which may be broadly categorized as –

I. Victim specific vulnerability factors

II. Perpetrator specific vulnerability factors

III. Context specific vulnerability factors

Victim specific vulnerability factors are – female gender, extreme age groups, psychiatric illness, drug intoxicated state, physical disability etc. The major reason is the male dominant society, where females, population of extremes of ages and people with disability, can be easily overpowered. An individual in intoxicated state can be easily overpowered and can be indulged in sexual activity due to altered mental state. Perpetrator specific factors like – antisocial personality, substance use, psychiatric illness also increases the vulnerability for sexual assault.

Revenge, socio-cultural factors, poverty, loneliness are some of the contextual factors which may increase the vulnerability for sexual assault.

Current scenario in India

The National Crime Records Bureau (NCRB), under the Ministry of Home Affairs of Government of India,records the crime statistics and updates the crime statistics in India every year. As per NCRB records, in the year 2013, a total of 33,707 cases of rape has been reported, with a conviction rate of 27.1% [3] . So far the crimes against women are concerned, in the year 2013, more than 70,000 cases of assault on women with an intention to outrage her modesty has been reported with an conviction rate of 25.7% [3]. The low conviction rates are quite shocking and raises question against the social security as well as legal protection system of our country. As per the latest statistical data from NCRB, in the year 2013, a total of 4335 cases of rape have been reported in Madhya Pradesh, which is found to be the national highest figure among the states and Union Territories of India [4]. Madhya Pradesh, have also reported highest number of reported cases of assault on women with an intention to outrage her modesty in the year 2013 [4].

In 2013, a total of 12,363 cases of rape in children have been reported in India, with maximum reported cases in Madhya Pradesh followed by Maharashtra and Uttar Pradesh [4].

The NRCB-2013 data says that, in more than 94% of cases of rape, the perpetrators were known to the victims [4]. The NRCB-2013 statistics also reports about the highest percentage of filing of charge-sheet for rape (more than 98%) among all registered crimes against children [4]. In India, in every 15 minutes a case of rape is being reported [4]. Between 1971 to 2013, there is 1255.3% increase in incidences of rape in India [4]. Among the victims of rape in the year 2013, 13.1% were below 14 years of age and 26.3% were between 14 to 18 years of age [4]. Among the rape offenders, 33.9% were neighbors of the victims, where as 1.7% were either parents or close family members and 7.3% were relatives of the victims [4]. A study conducted in the Indian national capital, it was found that most victims of rape had peno-vaginal penetration (more than 80%) [1]. In the same study, it was found that 6% survivors of rape were found to be positive in urine pregnancy test [1]. After the brutal gang rape case of Delhi – 2012, there is increased reporting of crime against women. Approximately 25% increase was seen in the statistics of crime against women in 2012 in comparison to the year 2008 [5]. An investigating officer fails to record any information given to him in relation to sexual

assault is punishable with rigorous imprisonment which shall not be less than six months but may extend to two years, and shall also be liable to fine. This may be the possible reason for increased conviction rate [6].

In India, another embarrassing situation is the scarcity of female police personnel (constitutes approximately 6.5% of total police personnel), due to which the victims of sexual assault are forced to give their statements to male police officers breaking the comfort zone of their privacy [5]. Sex –trafficking is common in South Asia, and India is one of the most vulnerable country [7]. Victims of sex-trafficking are victims of sexual abuse as well as physical abuse [7]. In a study, it was found that 45.6% of victims of sex-trafficking had high seroprevalence for HIV [7].

A victim of sexual assault always needs urgent medical attention for treatment of injuries, prevention of sexually transmitted disease and psychological support. Hence a physician, no matter where (private / government) she/ he works should treat the victim immediately in a holistic manner and inform the same to the police. Non-treatment of victims of sexual assault is a punishable offence with imprisonment for a term which may extend to one year or with fine or with both [6].

In India, media stands as one of the four pillars of democracy. However, the information disseminated to public through the media sounds very awkward, if we go through the conflicting way of presenting the news of gang-rape case, New Delhi, 2012 [8]. Media's role is to disseminate accurate information, creating awareness, questioning the fallacies of the system as well as to empower the victims. But the dramatizing presentation to get easy popularity points finger towards cheap journalism.

Conclusion

Sexual crimes against women in India are in an increasing trend which indicates the gross social disharmony in the country. It can be prevented through strict enforcement of law and addressing different vulnerability factors adequately. At the same time, increasing awareness, de-stigmatization, empowerment of women and prompt response to the physical as well as mental health needs of the survivors of sexual assault is highly essential.

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CHILD SEXUAL ABUSE AND TRAUMATIC SEXUALIZATION

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Introduction

Child sexual abuse (CSA) is a major problem across the globe [1]. The World Health Organisation (WHO) defines CSA as "the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society" [2]. The term CSA includes a range of activities like "intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography"[3]. The issue of CSA is intricate and challenging to study. The estimates vary widely depending on the country under study, the definitions used, the type of CSA studied, the extent of coverage, and the quality of data [1, 4, 5, 6]. However, sexual violence is seen to occur in all ages, in all socioeconomic classes, and nearly in all countries with differences in the magnitude [4].

The prevalence of child sexual abuse was found to be high throughout the world including India. The WHO in 2002 estimated that 73 million boys and 150 million girls under the age of 18 years had experienced various forms of sexual violence [1]. A review of studies from 21 high- and middle-income nations showed that seven to 36% of females and three to 29% of males reported being victims of sexual abuse during their childhood [7]. A meta-analysis conducted in the year 2009 analyzed 65 studies in 22 countries and estimated an "overall international figure". The main findings of the study were: [8, 9, 10]

- An estimated 7.9% of males and 19.7% of females universally faced sexual abuse before the age of 18 years
- The highest prevalence rate of CSA was seen in Africa (34.4%)
- Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively.
- With regards to females, seven countries reported prevalence rates as being more than one fifth i.e., 37.8% in Australia, 32.2% in Costa Rica, 31% in Tanzania, 30.7% in Israel, 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland.
- The lowest rate observed for males may be imprecise to some extent because of under reporting.

India has the world's largest number of CSA cases. For every 155th minute a child less than 16 years is raped, for every 13th hour a child under 10, and one in every 10 children are sexually abused at any point of time[11]. A survey by United Nations International Children Education Fund (UNICEF) on demographic and health was conducted in India from 2005 to 2013, which reported that 10% of Indian girls might have experienced sexual violence when they were 10–14 years of age and 30% during 15–19 years of age [12]. A study was conducted in 2007 by Ministry of women and child development in India covering 13 states. The study reported that about 21% of the participants were exposed to extreme forms of sexual abuse. Among the participants who reported being abused, 57.3% were boys and 42.7% were girls, about 40% were 5–12 years of age. About half of the participants were exposed to other forms of sexual abuse [7].

CSA can cause a lot of psychological problems like low self esteem, guilt, anger, hopelessness and suicide attempts. High prevalence of post traumatic stress disorder, depression, anxiety disorders, body image concerns, eating disorders and substance use disorders have been reported in this population. Later on these children also show behavioral problems like violation of law, social misconduct, violent behavior, lower academic performance, absenteeism and abnormal sexual behaviors. Act of sexual abuse can adversely affect cognitive and emotional development of the child [13].

Traumagenic dynamics

Finkelhor and Browne reviewed the literature on the effects of sexual abuse and postulated traumagenic dynamics (TD) framework which ultimately alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities. The traumagenic dynamics (TD) framework (Finkelhor & Browne, 1985) suggests one set of psychological variables that may mediate the CSA-adult sexual risk behavior relation. According to the TD framework, CSA may lead to four consequences: (1) traumatic sexualization, in which maladaptive scripts for sexual behavior are developed and reinforced

because the child is rewarded for sexual activity; (2) betrayal and lack of trust, in which the child feels betrayed by the abuser, by others' reactions to abuse disclosure, or by others' failure to recognize and stop the abuse; (3) stigmatization, in which the child feels stigmatized because of the abuse as sexually different and thus feels shame and guilt; and (4) powerlessness, in which the child feels unable to control the sexual aspects of relationships [14,15].

The notion of traumagenic dynamics offers a way both to organize and theorize about many of the observed outcomes. As listed in the table below most of the outcomes can be conveniently categorized according to one or two of these dynamics. However it must be noted that there is no one-to-one correspondence between dynamics and effects. Some effects seem plausibly connected to two or even three traumagenic dynamics; for example, depression can be seen as growing out of stigmatization, betrayal, or powerlessness [14].

AREA OF IMPACT	CHILD'S VULNERABILITY	CHARACTERISTICS
Traumatic sexualization	Sexual development	• Overly curious sexual behaviors • Re-enacts abusive acts • Aggressive sexual behaviors • Sexual dysfunction • Sexual identity confusion • Sexual fears/addictions
Betrayal	Trust	• Clinging behavior • Damaged trust • Vulnerability to future • abuse • Social withdrawal • Depression • Anxiety • Physical ailments
Stigmatization	Disclosure of sexual abuse Parents' reaction	• Feels disgusting • Low self-esteem • Self-deprecation/self-injury • Suicide • Guilt • Shame • Feels odd • Delinquency • Substance abuse

Powerlessness	Tricked/not believed	• Anxiety • Sleeping disorders • Fears • Hyper-vigilance • Learned helplessness • Becoming an abuser • Re-enacts “victim” role in other areas of life • Tolerates continued abuse

Traumatic sexualization

According to the theory of David Finkelhor, traumatic sexulization is the shaping of a child's sexual feelings and attitudes in a manner inappropriate for the child's level of development as a result of sexual abuse.

This process can happen in a variety of ways during the course of the abuse. If molestor gives undue affection, attention or special privileges and gifts to a child in exchange of certain sexual behavior, then there is high possibility that this child learns to use sexual behavior as a strategy for manipulating others to satisfy a variety of his or her needs. Similarly process of traumatic sexualisation takes place when certain anatomical sexual organs of child are fetishized and given distorted importance and meaning. It occurs when offender creates misconceptions and confusions about sexual behavior and sexual morality in the child. It also occurs when very frightening memories and events become associated in the child's mind with sexual activity [14].

Characteristics of sexual abuse experiences are very important in determining the amount and kind of traumatic sexualization like whether the molester made the child active or passive during sexual experience or brute force was used by the molester or not. Experiences in which the offender makes an effort to evoke the child's sexual response, for example, are probably more sexualizing than those in which an offender simply uses a passive child to masturbate with. Experiences in which the child is enticed to participate are also likely to be more sexualizing than those in which brute force is used. However, even with the use of force, a form of traumatic sexualization may occur as a result of the fear that becomes associated with sex in the wake of such an experience [14].

The degree of a child's understanding about sex and related behavior may also affect the degree of sexualization. In a child who has less awareness of sexual and related issues, because of early age or developmental level, the sexual experience may be less sexualizing than that involving a child with greater awareness. Ultimately the process of traumatic sexualisation and its outcomes will be different in both the child [14].

Children who have been traumatically sexualized emerge from their experiences with inappropriate repertoires of sexual behavior, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities [14].

Effect of traumatic sexualisation

There are many observed effects of sexual abuse

that seem readily connected to the dynamic of traumatic sexualization.

At it's most basic level, sexual abuse heightens awareness of sexual issues, especially among young children who might not otherwise be concerned with sexual matters at their stage of development and these children display knowledge and interests that are inappropriate to their age, such as wanting to engage school-age playmates in sexual intercourse or oral-genital contact. Sexual preoccupations and repetitive sexual behavior have been reported among young child victims, such as masturbation or compulsive sex play. This preoccupation is related to sexual stimulation of the abuse and the associated conditioning of behavior, but it also consists of the conflicts provoked by the abuse about the self and interpersonal relations [16, 17, 18, 19, 20, 21]. Such children often traumatically stuck in the addiction created by the arousal that overwhelms them and does not allow them to move on [22]. Research into sexual compulsiveness or addiction described by Hunter (1990) shows that 37.1 per cent of men and 65.2 per cent of women members of Sex Addicts Anonymous reported that they were sexually abused as children [23].

One of the major concerns is the tendency for such adolescents who have experienced sexual coercion to develop a pattern of continued victimization. Sometimes even younger children, become sexually aggressive and victimize their peers or younger children and some victims apparently find themselves inappropriately sexualizing their children in ways that lead to sexual or physical abuse [24, 25, 26, 27]. Young and Furman (2008) reported that, after an initial incident of sexual coercion, adolescents' risk for subsequent incidents increased more than sevenfold [28] . Adolescents may engage in risky sexual behavior as a means to cope with negative emotions [29, 30].

Multiple or ongoing experiences of sexual coercion may have cumulative effects upon psychological adjustment and likely impact the health of future romantic relationships [31, 32]. Victims of peer sexual coercion often experience heightened psychological symptoms of depression, anxiety, and post-traumatic stress [33, 34].

Child sexual abuse also creates confusion in the victim about sexual identity. Victimized boys, for example, may wonder whether they are homosexuals. When boys are sexually abused by other males, fears about homosexuality are common. The experience of a homosexual act contradicts the child's understanding of sexual relationships. A victim may worry that he is homosexual; that there must have been something about him that was recognizably homosexual for him to have been singled out by another male. A male may attribute his selection to a particular aspect of his appearance, his speech, his clothing or any other personal characteristic that might be perceived as effeminate and to have contributed to the assault. If he does not actively resist the molestation this may be taken as further proof of his lack of masculinity. He may be sexually aroused which creates further conflict in his sense of sexual identity and he may define himself as homosexual. The more closely the victim is psychologically identified with the perpetrator, the more intense and exacerbated are his sexual identity issues. Significant males, such as fathers and father figures, play a large part in the formation of the psychosocial identity of young males. When sexual abuse occurs between a boy and a psychologically close male, the victim is likely to be left with confusion about his sense

of self-identity as related to his identity struggles with the offender [14, 22].

Concept of sexual norms and standards is also altered and become highly confused by traumatic sexualization. As a result sexually victimized children often have misconceptions about sex and sexual relations. One of the common confusion is about the role of sex in affectionate relationships. If molester has exchanged affection for sex over a period of time, this may become the view of the normal way to give and obtain affection for that child. Some of the apparent sexualization in the behavior of victimized children may stem from this confusion [35, 36].

Another impact that traumatic sexualization may have is in the negative connotations that come to be associated with sex. Sexual contact associated in a child's memory with revulsion, fear, anger, sense of powerlessness, or other negative emotions can contaminate later sexual experiences. These feelings may become generalized as an aversion to all sex and intimacy, and very probably also account for the sexual dysfunctions reported by victims. It has been reported that victims often have an aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, vaginismus, as well as negative attitudes toward their sexuality and their bodies [19, 26, 37, 38, 39].

Conclusion

Child sexual abuse is an universal problem including our country. Child sexual abuse (CSA) is associated with sexual risk behavior in adulthood, but few research has investigated processes that might mediate this relation. The model of traumagenic dynamics postulates that the experience of sexual abuse can be analyzed in terms of four trauma-causing factors namely - traumatic sexualization, betrayal, powerlessness, and stigmatization. These dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities. Developing a conceptualization of these dynamics may serve as a step in the direction of advancing our understanding of sexual abuse and mitigating the effects of these experiences on its victims.

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APPROACH TO CHILD SEXUAL ABUSE & MANAGEMENT OUTLINES

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Introduction

Child sexual abuse (usually by a family member) or assault (usually by a stranger) and sexual interference are common problems [1]. The prevalence of child abuse is 12-13% (8% for boys and 18% for girls) worldwide [2]. This article deals with the relevant points which will help in the physical examination of sexually abused child. The focus of the article is on the physical findings of abuse, its not at all dealing with the psychiatric consequences.

Definition of chid sexual abuse

It is the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, and to which they are unable to give informed consent, or that violate the social taboos of family roles [3].

Medical history taking

A proper history taking plays very vital role in the diagnosis of an abuse. History should be taken

under the following headings-

1) General
2) Pediatrics
3) Gynecological

Overall history should cover all the relevant physical, social and emotional parameters as required for the diagnosis of abuse. A proper history helps in eliciting that what would have been gone wrong and the examiner comes to know that what physical examination should be performed.

Attitude of the examiner should be open, calm and friendly so that child can trust the examiner and history should be elicited properly. Child's reaction to the examination depends on associated anxiety for the procedure, previous exposure to doctors, developmental stage of the child and severity of abuse suffered. Usually a child cooperates during examination as long as it is gently conducted.

More time is required for the extraction of history and then for the proper physical examination. The whole procedure takes less than 1 hour. Ideally abused child should be examined by a doctor at once for recording the biological evidences of the abuse.

Consent

As always, physical examination should only be done after taking consent from the child and her parents after proper explanation of the procedure.

Examination must be focussed on assessment of perineum including external genitalia, vaginal introitus, hymen, anus, and surrounding areas. If more time is lapsed since abuse, injuries in the area become less visible as the tissue undergoes rapid healing.

Acute abuse cases

If child is having bleeding then it should be managed by emergency interventions. Vaginal examination and palpation of anal or vaginal region are not indicated.

Chronic / Old abuse cases

Child should be seen by the physician as early as possible, but not always as an emergency. Examination may require sedation or general anaesthesia.

Physical examination

Physical examination of whole body should be done, to avoid focus on the anogenital region so that other body parts should not be overlooked [4, 5, 6].

The physical examination gives following important findings –

On inspection

Local examination consists of three different methods and techniques while the child is suitably positioned [7,8,9,10] .

1) in lateral decubitus position
2) in knee chest position
3) in supine position

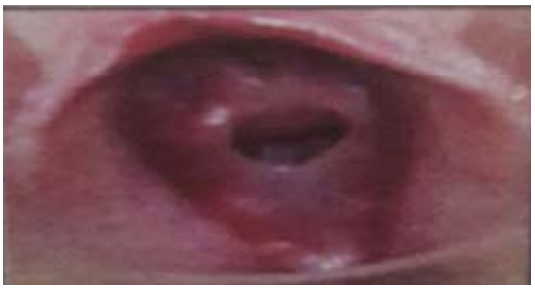
Techniques mentioned above increases the chances of extraction of positive findings. Above mentioned techniques are also important if the examiner wants to classify according to Adam's classification for proof of abuse [11,12].

All injuries visible on body must be suspected and should be documented [13]. One more important standard technique to follow is the use of colposcope as it gives the benefit of proper lighting and magnification. It also provides the idea of injuries to the second examiner and limits the requirement for repeating follow up examination [4, 5, 6, 8, 11, 12, 14, 15].

Examination of external genitalia

The appearance depends upon the constitutional, hormonal factors and mostly on the age of the victim. In early life (neonatal period) due to effect of estogen hormone the hymen appears pinkish in colur and bulging. With further development, resting phase for hormones come and it changes to semilunar form.

Figure 1
A semilunar hymen with intravaginally visible longitudinal ridges and mild periurethral dilatation



Source-Herrmann B, etal. 2nd edition, Heidelberg, Berlin, Newyork , Springer Vales; 2010.

Adam's classification

This classification is the main guideline for suspected cases of child abuse [2].

Adam's class 1-Normal findings or findings with a medical explanation other than abuse

Adam's class 2- Findings of unclear significance that arouse the suspicion of sexual abuse

Adam's class 3-Findings of injury that establish the diagnosis of sexual abuse [16].

This classification has been consensually and continually updated and further developed, most recently in 2011 [11, 16].

Initially most of the findings which were misinterpreted as proof of abuse are taken as normal findings now a days such as injury to hymen which may occur due to exercises; i.e. stretching, jumping, splits [9, 17, 18, 19].

The medically documented fact that penetrating abuse may not be associated with any subsequently abnormal findings must be known and understood by the treating personnel and the government authorities like police, prosecutors [2].

Normally the examination findings in child abuse cases are normal. Abuse may be chronic or acute. The use of the term "virgointact" is obsolete nowadays [20, 21, 22].

Examination findings

Local examination

The findings in such cases are very much influenced depending upon the age of child, self defence offered by child, degree of force applied and the object used and frequency of the abuse [23].

There are some findings that are significantly correlated with the diagnosis

1) Bleeding per vaginum
2) Pain in anogenital region

In presence of above findings it should be matched with the time lapsed since the event of abuse[2].

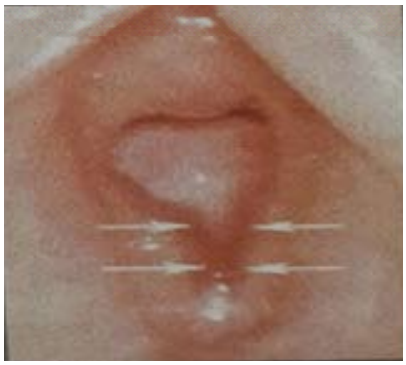
Local examination in female child

In most of the cases, interference at vaginal introitus produces the tear in the posterior area of hymen. The injuries varies from simple erythema and abrasions, deep contusions to severe injuries i.e. peneterating. Usually the breech in the continuity of peripheral edge of hymen occurs between 3 and 9 O'clock positions while examining in supine position. Best seen in knee-chest position, these injuries are mostly due to penetration (penis

or similar objects). Such trauma results in a 'V' shaped injury which gradually assume the shape of 'U'.

Even deep injuries of hymen in prepubertal phase heals fully[23].

Figure 2
Complete notching at 6 O'clock [arrow]- an Adams class3 finding



Source-Herrmann B, etal. 2nd edition, Heidelberg, Berlin, Newyork , Springer Vales;2010.

Definitive diagnosis

Often child abuse is diagnosed with the help of-

1) Multi professional child protection team assessment
2) Specified above mentioned criteria
3) Information obtained from the child

Definitive evidences that sexual intercourse has taken place are Adam's class 3 findings and demonstration of the abuser's DNA and pregnancy [11].

Management

All cases of child and adolescent abuse should be managed delicately after the history in elicited and physical examination is done with collection of all samples required for further examination.

Investigation

Routine blood investigations (Hb%, DC, TLC, ABORh typing), routine and microscopic urine examinaiton, vaginal swab culture and sensitivity if needed should be performed.

Treatment

Treatment can be outlined in following steps .

a) Treat local injuries

In acute assault cases sometimes vulval or vaginal hematomas, vaginal tear occurs, anal sphincter tone even gives way or 3rd degree perineal tear occurs. If so, hematoma should be drained and tear should be repaired under anaesthesia with catgut (0,1) or Vicryl (2,0) suture.

b) Treat superficial injuries of local area

Abrasions and small hematomas heal completely in 3-4 days, while larger hematomas takes 10-14 days and skin takes around 28-30 days to heal completely.

c) Emergency contraception

Emergency contraception should be offered to all perimenarchal child as ovulation starts even before menarche.

d) Prevent sexually transmitted diseases

Sexually transmitted diseases are rare(1-4%), but sometimes this is the only indication of sexual abuse. If specific lesions, vaginal discharge are present then screening is to be done. Demonstration of gonorrhoea, syphilis, HIV is considered as definite evidence of sexual contact if perinatal infection or history of blood transfusion can be ruled out.

e) Treat injuries to surrounding structures

Urinary bladder and anogenital injuries should

be tackled with multidisciplinary approach involving expert opinion from a urologist and general surgeon respectively.

Conclusion

Primary care practitioners are pivotal to evaluation of child sexual assault and abuse. Family physician can briefly explore the history of alleged interference, examine for physical findings of abuse or assault and can refer the child or adolescent to most appropriate higher centre for timely intervention.

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Our Vision

Harmonious existence between male and female leading the mankind towards ultimate bliss

Our Goals

INDIAN INSTITUTE OF SEXOLOGY BHUBANESWAR (IISB)

- *Aims to facilitate the integration of knowledge and expertise across various disciplines like medicine, psychology, sociology, law and ethics for greater understanding of complexities of human sexuality*
- *Aims to adequately address the individual sexual problems and social issues*

Objectives

- *To bring experts of different disciplines to a common platform for sharing of knowledge and views on human sexuality*
- *To promote research on human sexuality*
- *To impart training on 'Sexology' and strengthen the discipline of 'Sexual Medicine'*
- *To encourage medical professionals to choose 'Sexual Medicine' as a career*
- *To create public awareness on human sexuality and gender issues*
- *To advocate any social change for betterment of mankind*

THE PSYCHOLOGICAL CONSEQUENCES OF SEXUAL VIOLENCE

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Introduction

Sexual violence is common throughout the world. Over the past few years, the issue of women's safety has become a prime focus of public attention and concern in India. Sexual violence has a profound impact on physical and mental health. It can also profoundly affect the social wellbeing of victims; individuals may be stigmatized and ostracized by their families and others as a consequence.

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Coercion can cover the whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not

obtaining a job that is sought. It may also occur when the person egressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation. Sexual violence includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. Most cases are not reported by victims because of various reasons such as family pressure, in sensitive police, unreasonably long and unjust judicial process and the resulting consequences thereof [1].

Sexual assault in India

National Crime Records Bureau of India reports 35% increase in rapes in the year 2013 over the previous year, 11.7 % of total IPC crimes are against women in the year 2013. 3.2% cases of molestation and 4.5% cases of assault on women are by their husband or his relatives. Domestic violence accounts for 50% of crimes against women. According to latest figures presented by NCRB, 93 cases of rapes are reported in a single day in India. Madhya Pradesh followed by Rajasthan has reported the highest number of rape cases in the year 2013. Of 33,707 cases of rapes reported in 2013, 94% of victims knew the offender. India also reports only 27% conviction rate involving cases of rapes in 2013 [2].

World scenario

A recent analysis by WHO with the London School of Hygiene and Tropical Medicine and the Medical Research Council, based on existing data from over 80 countries, found that globally 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In some regions this is much higher. Globally as many as 38% of all murders of women are committed by intimate partners [3]. Intimate partner violence and sexual violence are mostly perpetrated by men against women. Child sexual abuse affects both boys and girls. International studies reveal that approximately 20% of women and 5–10% of men report being victims of sexual violence as children. Violence among young people, including dating violence, is also a major problem.

Psychological impact

Some of the psychological and health effects that can occur in someone who has been sexually harassed are: depression, anxiety and/or panic attacks, nightmares, shame and guilt, difficulty concentrating, headaches, fatigue or loss of motivation, stomach problems, eating disorders, alcoholism, feeling betrayed and/or violated, feeling angry or violent towards the perpetrator, feeling powerless or out of control, increased blood pressure, loss of confidence and self esteem, withdrawal and isolation, overall loss of trust in people, traumatic stress, post-traumatic stress disorder (PTSD), suicidal thoughts or attempts, suicide.

Sexual violence against children is fairly common and is frequently associated with psychological distress that continues into adulthood. There is also evidence that the mental

health effects of childhood sexual victimization might be different from those due to adulthood victimization [4]. Survivors of childhood sexual trauma are at high risk of post traumatic stress disorder (PTSD). Women who reported childhood sexual abuse were five times more likely to be diagnosed with PTSD compared to non victims [4]. Another study showed that the lifetime rate of a PTSD diagnosis was over three times greater among women who were raped during their childhood compared to non victimized women [5]. Survivors are also more likely to suffer from depression, suicide, and other mental health problems. Childhood sexual abuse was associated with an increased risk of suicide even after accounting for the effects of previous psychological problems and twin's history of suicidal behaviors [6]. Survivors of childhood sexual abuse have also been shown to be at greater risk of alcohol abuse [7] and eating disorders [8] later in life. Childhood sexual trauma may also affect certain developmental processes, such as the ability to develop and maintain relationships. Clinical observations have revealed that some adult survivors of childhood sexual abuse report problems of low sexual interest and few close relationships. Some survivors display high-risk sexual behaviors (e.g., promiscuity) that may be attributed, in part, to modeling some of the behaviors shaped earlier in life by the perpetrator. Extreme experiences of victimization are also associated with symptoms of a personality disorder known as Borderline Personality Disorder. Childhood sexual trauma is also associated with other personality disorders, including those that are distinguished by enduring patterns of distrust and suspiciousness (i.e. Paranoid Personality Disorder), grandiosity and need for admiration (i.e. Narcissistic Personality Disorder), social inhibition and feelings of inadequacy (i.e. Avoidant Personality Disorder), or submissive and clinging behavior (i.e. Dependent Personality Disorder). There is substantial evidence that, for many women, childhood sexual trauma increases vulnerabilities to mental health problems later in life.

Women who are victimized in adulthood are vulnerable to short and long-term psychological consequences. Immediate distress may include shock, fear, anxiety, confusion, and social withdrawal [9]. Survivors may also experience some PTSD symptoms shortly after a violent act has occurred, such as emotional detachment, flashbacks, and sleeping problems [10]. The literature on long-term outcomes of adulthood sexual trauma has predominately focused on PTSD. The reported rates of PTSD among rape survivors vary from approximately 30% to 65%. Sexual violence by an intimate partner aggravates the effects of physical violence on mental health. Abused women reporting experiences of forced sex are at significantly greater risk of depression and post-traumatic stress disorder than non-abused women. Psychological symptoms also include symptoms of depression, physical symptoms without the presence of medical conditions (i.e. Somatoform Disorders), severe preoccupations with physical appearances (i.e. Body Dysmorphic Disorders), disordered eating behaviors, sexual dysfunction, and extreme body piercing and tattooing (i.e. Compulsory Body Mutilation). According to World Health Oraganisation a woman who had been sexually harassed is 3 times more likely to suffer from depression, 6 times more likely to suffer from PTSD, 13 times more likely to abuse alcohol, 26 times more likely to abuse drugs, 4 times more likely to contemplate suicide.

Few studies in India have been conducted and they have largely focussed on the experiences of women at work place. These studies have been extremely important in estimating the prevalence and identify the

factors associated with harassment. According to a cross sectional study on harassment done in Mangalore [11], out of 160 working women interviewed, about 28.8% were found to be harassed whereas in Kerala, 1000 women were interviewed about street harassment out of which 98% said they had experienced and 90% said that it was either physical or verbal. 62% reported that the harassment was notable on public transportation [12]. An exploratory study was undertaken in 2005-2006 among 135 women health workers, including doctors, nurses, health care attendants, administrative and other non medical staff working in two govt. and two private hospitals in Kolkata. Four types of experiences were reported by 77 women who had experienced 128 incidents of sexual harassment: verbal (41), psychological (45), sexual gestures and exposure (15) and unwanted touch (27) [13].

In many cultural settings, it is held that men are unable to control their sexual urges and women are responsible for provoking sexual desire in men [14]. How families and communities react to acts of rape in such settings is governed by prevailing ideas about sexuality and the status of women. In some societies, the cultural 'solution' to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union [15]. Such a 'solution' is reflected in the laws of some countries, which allow a man who commits rape to be excused his crime if he marries the victim [16].

Conclusion

Sexual harassment is a serious problem for women worldwide. It is a human rights violation. Psychological consequences of sexual trauma in childhood and adulthood are diverse and highly individualized. There is no single response that is experienced by all survivors. Whereas a large portion of the literature has focused on PTSD symptoms, survivors are also at risk of experiencing a range of other mental health problems, such as depression, suicidal thoughts and attempts, alcohol abuse, disordered eating behaviors, and sexual dysfunction. Maximizing efforts to reduce sexual violence requires combining resources and coordinating activities across different settings (e.g. research, health care, criminal justice). Successful collaborations rely on individuals having a basic foundation of knowledge and communicating with a common language and conceptual models of mental health. Resources have to be mobilized and coordinated around the issues related to preventing victimization of sexual abuse (i.e. primary prevention), minimizing psychological consequences (i.e. secondary prevention), or treating full-blown psychological symptoms and disorders (i.e. tertiary prevention).

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If you have scintillating ideas in line with the goals and objectives of IISB, Please do share with us at **sexualityinfo@gmail.com** *or write to us at* **Indian Institute of Sexology Bhubaneswar,** *Sanjita Maternity Care & Hospital, Plot No-1, Ekamra Marg, Unit-6, Bhubaneswar-751001, Odisha, India.*

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PSYCHOSOCIAL MANAGEMENT OF VICTIMS OF SEXUAL ASSAULT

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Introduction

Sexual assault is defined as forcing an unwilling person to engage in any kind of sexually intimate behavior and can range from touching, grabbing etc. to penetration. According to National Crime Records Bureau (NCRB) data, there is a gradual increase in the number of rapes reported in India - from 24,923 in 2012 to 33,707 in 2013 [1]. The data shows that rape occurs in all age groups and among both sexes, but predominant in the age group of 18-30 yrs. In the same year, there were also 40,613 cases of molestation reported, which includes other forms of sexual assault that do not involve peno-vaginal penetration. While there is evidence of a steady rise in the reporting of rape, other forms of sexual assault such as sexual harassment at work place, eve teasing and marital rape go largely unrecorded. Moreover, in spite of the rising numbers, these form only the tip of the iceberg and the crime remains largely hidden, given the stigma attached to sexual assault.

Sexual violence is a pervasive yet, until

recently, largely ignored violation of women's human rights in most countries [2,3]. It occurs across socio-economic and demographic spectrums, and is frequently unreported by victims [4,5]. Sexual violence is associated with negative physical, sexual and reproductive health effects and, as importantly, it is linked to profound long term mental health consequences [6]. Rates of mental health services utilization vary across studies, but it appears that approximately 25%-40% of victims seek treatment [7, 8].

The needs of victims of sexual assault are often overlooked by public sector health services in resource poor settings. Where services for victims of sexual assault do exist, generally they are limited to the provision of medico-legal services, with little attention given to addressing the psychological impacts of sexual assault.

Mental health consequences of sexual violence

Women are more commonly victims of sexual assault, although men are also sexually abused and appear to suffer the same mental health impacts as women [9]. Most victims exhibit high levels of psychological distress in the first week after the sexual assault. Immediately post-assault, most victims will experience shock, intense fear, numbness, confusion, feelings of helplessness, disbelief, in addition to self-blame, hyperarousal and high levels of anxiety [10]. This distress peaks in severity three weeks post-assault, continues at high levels for one to two more months before finally abating in two to three months post-assault [11]. Throughout this process of recovery, victims experience guilt, shame, fear, anxiety, tension, crying spells, an exaggerated startle response, depression, anger (both generalized and specifically toward men), discomfort in social situations, impaired memory and concentration, and/or rapid mood swings [12]. One third of rape survivors will go on to develop post- traumatic stress disorder (PTSD) [13]. Even when evaluated several years after the assault, survivors are more likely to have a serious psychiatric diagnosis, including major depression, alcohol abuse and dependence, drug abuse and dependence, generalized anxiety, obsessive-compulsive disorder, and post-traumatic stress disorder.

Assessment

One of the first areas to address is some exploration of what the survivor has experienced. There is evidence that certain characteristics of the violent act may increase the likelihood that a survivor will experience negative mental health outcomes. Some survivors react negatively to extensive questioning about the event because of perceptions that they are being blamed for the victimization. The likelihood of a negative response might be particularly high during early stages of the recovery period and in a new relationship with the service provider.

There has been particular interest in the effects of structured disclosure activities, such as written and oral elaboration of the traumatic experiences on survivors' mental health. Extensive information gathering about the violent act should be avoided except when in the context of a long-term therapeutic relationship to contain the high levels of emotional distress that may be triggered by recalling sexual trauma. Identification of psychological distress and symptoms is the next most critical component of an assessment, contributing to referrals for specialized therapeutic services and the development of treatment plans. Current recommendations in the area of violence against women include conducting brief, but comprehensive, assessments of psychological functioning with the use of clinical interviews and/or psychological tests [14].

Treatment approaches

Many of the harmful and lasting psychological impacts of sexual violence may be prevented or minimized with structured interventions and the provision of psychological support post sexual assault. Whilst many people will recover spontaneously from the psychological aftermath of assault, the identification and treatment of psychopathology can be of great benefit to survivors.

Survivors attach great importance to having their story believed, as well as being treated with respect, kindness, empathy. This, as well as a non-judgemental attitude, should be the basis of any treatment and the ethos of any service.

Psychological impacts of sexual trauma are diverse and unique to each woman. Ideally, the selection of treatment strategies should depend on the primary areas of difficulty, the survivor's willingness to engage in a particular type of treatment, and strength of the clinician-client relationship.

Early intervention

Early interventions helping individuals through their initial reactions to assault can reduce or even prevent more severe psychological distress [15]. Even though some studies have failed to show significant differences in measured symptoms, early interventions may still provide benefits for survivors. Early interventions might also help mobilize a positive support network for the survivor and reduce exposure to negative interactions earlier in the recovery process.

Early mental health interventions for survivors of sexual violence [16] include:

- Assess the safety of the survivors
- Ask about immediate concerns and work out plans to address these
- Provide Psychoeducation /psychological first aid
- Help the survivors understand that their reactions are normal and explain the likely psychological responses and what to expect
- Aid the survivors in taking control by giving information which assist in making informed decisions and offering options
- Coordinate access to referral resources and safety
- Assess for and respond to suicidality
- Provide simple messages to tackle issues of self-blame and guilt
- Discuss disclosure to family and friends
- Screen those with delayed presentation for psychological indicators of PTSD
- Recommend counselling and follow-up

In the developed world, use has been made of psychological debriefing and / or other adaptations of cognitive behavioural therapies in the immediate aftermath of any serious trauma, however considerable controversy surrounds the practice [17]. Current evidence indicates that debriefing should not be encouraged in the first month after assault. Rather than assuming that the form of emotional processing employed by psychological debriefing – immediate expression of emotions – is suitable for all, staff should be supportive and allow the survivor to determine what they wish to share and whether they would like further psychological help [18]. Instead, the literature supports the use of psychological first aid as a first response to a survivor post rape.

A survivor's response in the first 4 weeks post-assault is considered a good indicator of their likely long-term mental health prognosis. Some, but not all survivors, may find it difficult to cope on their own and may develop chronic symptoms [19]. Scarce resources should be targeted to these individuals so that they receive psychological interventions in the medium to long term. Though a screening tool was developed by Brewin et al (2002) to identify those likely to develop PTSD

after a traumatic event, has not been tested on victims of sexual assault [20].

Intermediate and long term intervention

In the first months post-assault, the focus of therapy shifts to the management and prevention of more chronic symptoms. Though each individual will respond uniquely to assault, most studies have focused on the treatments for the three main areas of common psychopathology associated with sexual assault: PTSD, depression and anxiety [21].

Evidence consistently points to cognitive behavioural therapies being more effective in reducing symptoms of PTSD than counselling[22]. Combination therapies involving psychotherapy and medications are often used. Therapies must be tailored to the individual circumstances and needs of each victim. Traditional modes of healing, be those religious or simply spiritual, have been reported though there has been no evaluation of their effects. In spite of the above interventions, between 15-50% of survivors will still have diagnosable PTSD or clinical depression at the end of treatment [23].

Targeted approaches

It is the implementation of therapies that focus on specific categories of psychological symptoms and particular theoretical frameworks. Many of these targeted approaches, including exposure techniques and cognitive processing activities, are adaptable for a group format [24]. They are typically combined with other group interventions, such as assertion training, coping skills, relationship building, and supportive and self-esteem enhancing techniques. Studies on the effectiveness of group psychotherapy for sexual assault survivors have shown improvements in posttraumatic stress symptoms, depression, fears and intrusions.

Multimodal approaches

Given that some sexual trauma survivors experience a variety of psychological difficulties, strictly-focused therapies may not always be adequate[25]. Targeted techniques may lead clinicians to minimize or overlook co-occurring problem areas, such as depression or alcohol abuse, that impact the overall effectiveness of the treatment and increase the likelihood of future negative consequences if other problem areas are ignored.

Implementation of this approach in mental health settings is not always feasible due to the requirements of longer treatment duration and professional training in multiple intervention and theoretical frameworks.

Conclusion

Sexual violence is an under-researched area across the globe. Particularly there is lack of research on the mental health aftermath of sexual violence in resource poor countries. Future improvement of the quality and accessibility of mental health services for survivors rests largely on combining resources and developing strong collaborations among researchers, clinicians, advocates, and policy makers. Another collaboration to be enhanced is between sexual assault coalitions and organizations and behavioral and public health systems. Efforts to promote mental health screenings and utilization of psychological services among the general public often occur independently from activities promoting the needs of sexual trauma survivors. Health promotion fields would help reduce the stigma associated with victimization and related mental health consequences.

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CRIMINAL LAW AMENDMENT ACT-2013 : CAN IT STOP SEXUAL ASSAULT ?

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Introduction

Sexual assault is defined as any form of sexual act committed against another person without his or her consent or against individuals who cannot give valid consent [1]. It includes a group of heinous crimes like indecent assault, rape, sodomy, bestiality, etc. Crime related to sex is one among the most rapidly increasing violent crimes [2]. It is prevalent worldwide and leads to serious health problems among the victims including Post Traumatic Stress Disorder (PTSD) and increased suicidal risk [1]. In India, sexual violence, particularly rape, received extensive media coverage following a fatal gang rape of a physiotherapy student in New Delhi on 16 December 2012. She died after 13 days of intensive hospital care. The incident led outrage and anguish throughout the country. There was lots of debate regarding the weaknesses of existing legislation to prevent the sexual offences. It was emphasized to make the punishment for sexual offences more rigorous and some activists even suggested considering death penalty as a punishment of rape. However, many opposed the idea

of considering death penalty for rape anticipating the risk of abuse of law in India. However, the demands to change or reinforce law related to sexual offences, led to passing of the Criminal Law (amendment) Act, 2013 a year later.

Amendments in existing laws

Criminal Law (amendment) Act, 2013 popularly known as anti-rape act amended certain sections as well as inserted new laws in Indian Penal Code (IPC), Criminal Procedure Code (CrPC), Indian Evidence Act (IEA), and Protection of Children from Sexual Offences (POCSO) Act-2012. Followings are comparison between existing laws and changes made in Criminal Law (amendment) Act, 2013 [3].

Offence/Issue	Definitions	Existing Laws	Criminal Law (Amendment) Act, 2013
Definition of Rape		Against the consent and will Peno-vaginal intercourse only	Against the consent and will Penetration of the mouth, anus, urethra or vagina with the penis or other object
Disobedience of law by a public servant	Failure to record information given to him in sexual offences cases; knowingly disobeying any direction of laws on investigation	No specific provision	Punishable with rigorous imprisonment for six months to 2 years and fine
Punishment for non-treatment of victim	Whoever, being in charge of hospital (Govt./private/local bodies) should treat the victim first	No specific provision	Punishable with imprisonment for a term which may extend to one year with or without fine
Rape resulting in death or vegetative state	Rape causing death or persistent vegetative state of the victim	Rape and murder dealt with two separate offences (376 & 302 IPC) Rape: 7 years to life imprisonment Murder: Imprisonment for life or capital punishment	Punishable with rigorous imprisonment for 20 years to life or death
Rape by armed personnel	"Armed Forces" means the naval, military and air forces and includes any member of the Armed Forces constituted under any law for the time being in force, including the paramilitary forces and any auxiliary forces that are under the control of the Central Government or the State Government	No specific provision Public servant includes armed personnel	Punished with rigorous imprisonment of either description for a term which shall not be less than ten years, but which may extend to imprisonment for life and shall also be liable to fine

Punishment for repeat offenders	Punishments for persons previously convicted of an offence punishable under sec 376 IPC	No specific provision	Life imprisonment or with death
Age of Consent	Legal age at which a person is considered competent to give consent for sexual intercourse	16 years	18 years
Sexual harassment and punishment	Physical contact involving unwelcome and explicit sexual overtures, request for sexual favours, showing pornography against the will of a woman, making sexually coloured remarks	Outraging a woman's modesty Punishment: Imprisonment for maximum 2 years and fine	Rigorous imprisonment for a term of 3 years and/or fine
Stalking	Follows a woman/attempt to contact to foster personal interaction repeatedly despite a clear indication of disinterest. Monitoring electronic communications	No specific provision	Specific offence. 1st offence: Punishable up to 3 years imprisonment and fine (Bailable) 2nd offence : Punishable with up to 5 years imprisonment and fine (Non-bailable)
Disrobing	Use of criminal force to a woman to undress and lie in naked condition	No specific offence Punished as an offence of outraging modesty of a woman	Specific offence. Punishable with 3 to 7 years imprisonment and fine
Voyeurism	Watching or capturing the images of a woman when she is engaging in a private act including sexual acts, use of lavatory, or when private parts are exposed	No specific offence as per IPC	Specific offence. Only protects women. 1st offence: Punishable with 1 to 3 years imprisonment and fine 2nd offence: Punishable with 3 to 7 years imprisonment and fine
Recording of information by woman officer		No special requirement for woman officers to record information about sexual offence cases	All information related to sexual offences would be recorded by woman officer

Protection against confrontation of victim by accused		No special protections to victims of sexual offences	Proper care has to be taken so that victim is not confronted by the accused
Examination of victim at trial stage		No special protections to victims of sexual offences	The statement recorded by the Judicial Magistrate will be treated as the evidence of the victim presented by the prosecutor Protects the right to be cross- examined
Requirement to fast track		No requirement to fast track sexual offence cases	Trial to be held on day- to-day basis In case of rape cases, trial to be completed in 2 months of filing of charge sheet
Previous sexual history		No specific provision barring the use of previous sexual history in rape cases	Bars the use of past sexual history in determining consent of the victim Bars evidence or questions in connection to the general immoral character of the victim or past sexual history with any person
Presumption of consent Punishment for rape		Lies with the victim to prove that she did not consent 7 years to life imprisonment and fine	Shifts the burden on to the accused to prove that consent was given 10 years to life imprisonment and fine
Punishment for gang rape		10 years to life imprisonment and fine	20 years to life imprisonment and fine
Special provisions for evidence by differently abled persons		No special provision	Court take the assistance of an interpreters to take evidence of differently abled persons Statement to be video recorded

Conclusion

The legislations are framed in any country or state in order to protect the rights of individuals. With time there occurs change in social as well as cultural perception. Hence there is need of revision of the legislation to protect the rights of individuals. In countries like India, the need to protect the rights of individuals, particularly when it is intended to prevent the sexual offences, is much more than just the amendment of law. The emphasis should be to evaluate that the law is working in the way it is designed and intended and implemented at the grass root level. Otherwise, the tug of war between claim and blame will continue forever.

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INTERNET SEX ADDICTION

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Introduction

Since the inception of internet, everything has become a click away. Internet has become enormous source of information for all. Gradually it is reaching more and more people and the world is becoming a cyber-village. But its excessive and compulsive use has made some people addicted to it. Most people don't assume excessive sex as an addiction and there are different sociological, conventional, scientific and moral standpoints for excessive sex [1]. Concept of excessive sex being pathological is not new, rather it has been described in different ways since centuries by different names like Casanova Type, Compulsive Promiscuity, Compulsive Sexuality, Don Juanism, Don Juan Syndrome, Don Juan Complex, Erotomania, Hypererotocism, Hyperlibido, Idiopathic Sexual Precocity, Libertinism. The Messalina Complex, Nymphomania, Over Sexuality, Pansexual Promiscuity, Pathologic Promiscuity, Satyriasis and Sexual Hyperversion [2]. Initially human being used to fulfil sexual needs

only through natural sex but as the human have advanced, they have adapted different modalities to fulfill their sexual needs and internet is latest and most widely used medium which has led to a kind of addiction known as internet sex addiction. Internet pornography is any pornography that is accessible over the internet, primarily via websites, peer-to-peer file sharing, or using net news groups. The availability of widespread public access to the World Wide Web in 1991 led to the growth of internet pornography.

Although it is difficult to establish the extent of sex addiction but estimates range from 3-6% of the total population. Prevalence of internet addiction in Indian college population using Young's original criteria: 74.5% as moderate users, 24.8% as possible addicts, and 0.7% as addicts [3]. One study of a sample of 9,265 people found that 1% of Internet users were clearly addicted to cybersex and 17% of users met criteria for problematic sexual compulsivity on Kalichman Sexual Compulsivity Scale [4]. Research on internet addiction disorder indicates that rates may range from 1.5 to 8.2% in Europeans and Americans [5].

Further, researches in this field also indicate a high correlation between childhood abuse and sexual addiction in adulthood, and it is common for sex addicts to have faced high levels of emotional, physical and sexual abuse [6]. Newer technologies have great impact on society either in positive or negative way.

Adolescent are more commonly affected as they are more technology savvy than adults and they frequently use technologies like television, the internet, CDs, videos, audio system, books and magazines etc. for communication, recreation and entertainment. Surprisingly in several countries, many adolescents spend six to seven hours per day using internet or other media. One of the most common uses of internet in adolescents is about exploring regarding sex and sexuality [7]. From a study in Malaysia it was estimated that about 12% all websites were related to sexual materials or pornography, many of which are very popular among adolescents [8]. It is a matter of concern as this number is very alarming because internet influence a lot about how the people think, feel and react in the real world.

Internet sex addiction has been defined as a sexual addiction characterized by internet sexual activity that causes serious negative consequences to one's physical, mental, social, well-being. It is also known as cybersex addiction and it's a type of internet addiction [9, 20]. Internet sex addiction manifests through various behaviors like reading erotic stories, viewing & downloading online pornography, online activity in adult fantasy, chat rooms, cybersex relationships, masturbation while engaged in online activity, the search for offline sexual partners and information about sexual activity. Cybersex addiction is a form of internet addiction disorder which can be considered a subtype of technological addiction which is defined as non-chemical or behavioral dependency that comprehends excessive human-machine interaction [10].

According to Young (1999) there are five subtypes of internet addiction proposed: (a) cyber-sexual addiction (compulsive use of adult websites for cybersex and cyber-porn); (b) cyber-relationship addiction (over-involvement in online relationships); (c) Net compulsions (obsessive/compulsive activities such as online gambling, shopping); (d) information overload (compulsive web surfing or database searching); and (e) computer addiction (obsessive computer game playing). Only first two are specifically related to potential sexually-based addictions [11].

Diagnostic criteria for internet addiction

Beard recommends that the following five diagnostic criteria are required for a diagnosis of Internet addiction: (1) Is preoccupied with the

Internet (thinks about previous online activity or anticipate next online session); (2) Needs to use the Internet with increased amounts of time in order to achieve satisfaction; (3) Has made unsuccessful efforts to control, cut back, or stop Internet use; (4) Is restless, moody, depressed, or irritable when attempting to cut down or stop Internet use; (5) Has stayed online longer than originally intended. Additionally, at least one of the following must be present: (6) Has jeopardized or risked the loss of a significant relationship, job, educational or career opportunity because of the Internet; (7) Has lied to family members, therapist, or others to conceal the extent of involvement with the Internet; (8) Uses the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression) [12].

There are diverse reasons for individuals experimenting with different forms of sexual behaviours which can be associated with an individual's psychological disorders. Most common reasons associated with internet sex addictions are low self-esteem, severely distorted body image, untreated sexual dysfunction, social isolation, depression and recovery from a prior sexual addiction [13]. Other minor reasons for this addiction include struggles for intimacy, self-worth, self-identity, self-understanding [14].

Problems with internet sex addiction

Similar to craving for alcohol, emotions such as stress, depression, loneliness or anxiety can lead to an addict's need to go online, which acts as source of temporary distraction to fill an emotional gap [15]. Internet sex addicts also explain that they feel a difference between online and offline emotions. They feel frustrated, worried, angry, anxious and depressed when offline but feel excited, thrilled, disinhibited and more desirable when they are online. These strong positive emotions associated with internet sex reinforce the compulsive behavior [16].

Models of internet sex addiction

Internet is relatively more preferred and highly compelling than other media due to its interactivity, seductivity and disinhibiting effects [17]. In order to understand the attraction of the internet, several model have been developed. One of them is Triple A Engine suggested by Cooper (1998) which is comprised of accessibility, affordability and anonymity, three primary factors that promotes usage of the internet for sexual purposes [18].

A variant of the Triple A Engine was developed by Young which is called as ACE model that comprised of anonymity, convenience and escape. These factors are the risk factors for Internet users with psychological vulnerabilities, which can render them for developing such compulsive behavior to use internet for sexual fantasy [18, 6].

Another framework developed by Carnes et al known as Cyberhex is a six-sided figure representing various aspects of the internet including interactive, intoxicating, isolating, integral, inexpensive, and imposing. These component when combined together can create an almost 'hex' or trancelike state [19].

Since internet has the potential to provide short-term relief, excitement and distraction, is also a cause for excessive use. Sexually related activities on the internet are perceived to be legal, available in the privacy of one's own home, do not put users at risk for sexually transmitted disease, and are easily hidden without obvious evidence of any sexual encounter which gives the sense of safety and ready access to partners[20]. Internet also provides anonymity of the user, due to which user have a greater sense of perceived control over the content and nature of the online sexual experience. Because of all these factors addictive use of internet has increased manifold [11].

Process of internet sex addiction

Internet sex addiction is very difficult process and its severity increases with time. There are five consecutive and independent processes: discovery, experience, escalation, compulsion and despair. These stages highlight how internet users can use it as a means of progressive cycle of addiction. 'Discovery' is the first step of the addiction process. New users discover the internet as an exciting feeling and he finds great and interesting things on the internet and start to search various information. After that comes 'Experience', when people who start using internet using various methods like sex chat, webcams develop sexual behaviors on internet without problems initially and gradually become used to masturbation and exploring new sexual behavior without assessing that this behavior can be so addictive later on. In 'Escalation', users develop tolerance and in order to achieve the same initial pleasure they start using internet for more and more for their sexual gratification. These behaviors become very chronic and inappropriate and it becomes more worrisome when a person enters the room of incest and child sexual because the mind appearing in this section is ready to find their sexual prey in real space. In 'Compulsion', users develops violence and uses coercion. This stage of life becomes dangerous for marital life and relationship and patients develops distressing emotions and nervousness. At this stage strong sense of compulsion for internet develops which gradually becomes out of control. Ultimately 'Disappointment' results in the final stage of the process of addiction, when addict realizes that he has been hit hard due to addiction and considers himself an addict. He will be more disappointed by the day he thought that his life is out of control due to the internet. The person feels guilt and shame. After that the emotional behavior of the addict sees itself as a personal failure and promises not to do it again and tries to reorganize his life like before [21].

Warning signs

Young has also produced a checklist of warning signs for cyber sexual addiction [21]. These are:

1. Routinely spending significant amounts of time in chat rooms and private messaging with the sole purpose of finding cybersex.
2. Feeling preoccupied with using the Internet to find online sexual partners.
3. Frequently using anonymous communication to engage in sexual fantasies not typically carried out in real-life.
4. Anticipating the next on-line session with the expectation of finding sexual arousal or gratification.
5. Frequently moving from cybersex to phone sex (or even real-life meetings).
6. Hiding on-line interactions from a significant other.
7. Feeling guilt or shame about online use.
8. Accidently being aroused by cybersex at first and then actively seeking it out when logging online.
9. Masturbating while online while engaged in erotic chat.
10. Less investment with a real-life sexual partner and a preference for cybersex as a primary form of sexual gratification.

Evaluation

There has been also a variety of assessment tools used in evaluation. Young's Internet Addiction Test, the Problematic Internet Use Questionnaire (PIUQ) developed by Demetrovics, Szeredi, and Pozsa and the Compulsive Internet Use Scale (CIUS) are all examples of instruments to assess this disorder [22].One can evaluate oneself by using free instruments accessible on the web like

1. Cyber sexual Addiction Test (www.netaddiction.com)
2. Male Sexual Addiction Screening Test (www.sexhelp.com)
3. Women's Sexual Screening Addiction Test (www.sexhelp.com)
4. Sexual Compulsive Anonymous (http://www.sexaa.org)

Management

Today, most people need to use the computer every day for work. As most of the jobs involve computers complete abstinence from the Internet may be impossible. Forcing the internet sex addict to use self-control and abstinence from cyberporn or cybersex while they are using the computer is important to achieve corrective action. According to Patriccarnes, an expert in sex addiction, while treating online sex addiction, several immediate types of crisis intervention should be employed that reduces access to internet sex. Concrete steps should be taken like moving the computer to a public area in the house, installing filtering software like Cyber Patrol, Surf Watch, Net Nany and self-limiting the time of being online and time of the day being online and disclosing to one trustworthy person the nature of the problem. These actions as 'first-order changes' provide crisis management to the symptoms surrounding internet sex addiction. More self-reflection and raised awareness is required on the underlying issues which drives for online sex addiction such as depression, anxiety, substance use disorders, or obsessive compulsive disorders [23].

Schneider and Weiss in their book 'Cybersex Exposed' discuss the importance to put together a Sexual Recovery Plan which is an adaptation from Sex Addicts Anonymous, done in the form of three columns that represent the areas needing attention and focus. Column 1 asks the addict to list actions that he or she knows are shameful, problematic, Column 2 asks the addict to list the actions of thoughts that lead to problem situations and Column 3 asks to list the positive rewards of maintaining sobriety and refraining from internet sex [7]. According to Young, recovery from internet sex addiction is similar to recovery from food addiction and she has also given an integrated recovery approach that combines cognitive-behavioral and insight-oriented therapies. Like food addicts cannot simply stay away from food, sex addicts must discover healthier ways to live with the internet. Addicts must readily identify and understand the underlying emotional, cognitive, or contextual factors that trigger the addictive behavior, such as depression, anxiety, loneliness, stress, marital troubles, divorce, or career problems, and learn to cope with those underlying issues in a more adaptive manner.

Cognitive-behavioral therapy has been suggested as a possible effective treatment for pornography addiction, though no clinical trials have been performed to assess effectiveness among pornography addicts. Acceptance and commitment therapy has also been shown to be a potentially effective treatment for problematic internet pornography viewing [12].

The role of Selective Serotonin Reuptake Inhibitors (SSRI) , mood stabilizers and antipsychotics has been inconclusive although psychotherapy and behavioral techniques have shown successful results even without pharmacotherapy. One of the researchers has found out relationship of mesolimbic system related to reward given by sex and used Naltrexone to suppress excessive sexual activity [11].

Conclusion

In the emerging era lot of young people are exposed to the internet and it has become important medium of social interaction. However, it may still remain a matter of debate whether to

call internet addiction a distinct disorder by itself or a behavioral problem secondary to another disorder. At present, DSM IV has not accepted criteria to diagnose or label internet addiction. In future, if it is added, it is more likely to be classified as an impulse control disorders not elsewhere classified rather than in the diagnostic criteria for substance dependence [24, 25].

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TURNER SYNDROME: FOCUS ON THE DIFFICULT SEXUAL LIFE

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Introduction

Turner Syndrome is one of the most common types of aneuploidy in humans and is present in 1 in 2000 newborns with female phenotype [1, 2]. This syndrome occurs in 1 in 2500 to1 in 3000 live born girls and is associated with absence of all or part of a normal second sex chromosome. There is a broad array of clinical findings in Turner Syndrome which includes congenital lymphoedema, short stature and gonadal dysgenesis [3, 4, 5]. A large number of these findings occur due to haplo-insufficiency of genes that are normally expressed by both X chromosomes [6]. The short stature is mainly due to SHOX haploinsufficiency and accounts for an average reduction of about 20 cm from the adult height [7].

Clinical features of Turner Syndrome

Turner syndrome can be suspected by looking at following clinical findings

- Short stature

- Gonadal failure
- Micrognathia
- Cubitus valgus
- Low posterior hairline
- Short neck
- High arched Palate
- Short fourth metacarpal
- Multiple naevi
- Webbed neck
- Lymphoedema of hands and feet
- Nail dysplasia
- Broad shield like chest with inverted nipples
- Madelung deformity

History

Turner Syndrome was first described by the anatomist Giovanni Morgagni in 1768, who reported renal malformations and gonadal dysgenesis in post-mortem findings of a short woman [8]. The definitive description of the clinical features of Turner Syndrome was given by Ullrich in 1930 and was confirmed by karyotyping, 57 years later [9]. Finally the syndrome was named as "Turner Syndrome" by an American Endocrinologist Henry Turner in 1938 [10]. He emphasized the presence of gonadal dysgenesis in this syndrome and was the first person to start estrogen replacement therapy for this syndrome.

Genetics

The most frequent chromosome composition in Turner syndrome is 45X [11]. About half the patients have a mosaic chromosome complement, out of which the most common is 45X / 46XX in 15% of patients, and 46 XXq or 46XXp deletion in 6% of patients. In rare cases a ring X chromosome complement can also be identified [12]. The cause of the chromosomal abnormality in patients with a 45X karyotype whether monosomic or mosaic is usually non-disjunction during meiosis [13]. Turner mosaics usually have a less severe phenotype and about 40% show spontaneous puberty before developing gonadal failure [14]. The chromosome constitution is important because patients with short stature and congenital malformations have deletion on Xp whereas chromosome having deletion on Xq have only gonadal dysfunction [11].

Reproductive biology of Turner Syndrome

The gonads in Turner Syndrome differentiate normally until the 3rd month of gestation. After this period, there is increased degeneration of oocytes and increase in ovarian stromal fibrosis due to the absence of part or whole of X chromosome in the germ cell [15].The ovaries have decreased number of primordial follicles in utero which undergo premature apoptosis and are usually absent by adult life [16]. Ovarian failure also occurs within the first few months and years. Majority of Turner Syndrome patients have streak ovaries and identification of these ovaries becomes difficult due to their small size as seen in the ultrasound studies of pelvis [17]. The uterus is also hypo-plastic and remains pre-pubertal in size.

Deficiency of 'Oestrogen' and 'Androgen' leads to failure of development of gonads in early years of life. There is increased concentration of plasma gonadotropins especially Follicle-Stimulating Hormone (FSH) by 14 years of age [18]. There is poor development of breasts along with primary amenorrhea and failure of development of spontaneous puberty. In less than 5% of women spontaneous pregnancy occurs especially in those with mosaicism [14,19]. The outcomes of these pregnancies are usually

poor with approximately 40 % of conceptions terminating as spontaneous abortion or perinatal death.

Sexual dysfunction in Turner Syndrome

Females with Turner Syndrome find difficult to enter into sexual relationship. This can be due to difficulty in understanding nonverbal communication and poor self image as a result of short stature and delayed sexual maturation [5].

Individuals with Turner syndrome usually have biological changes, which ultimately affects the morphology of secondary sexual characters like – morphology of external genitalia, breast, pubic and axially hair as well as internal genital organs (poor development of ovary and uterus). The poorly developed genitalia may lead to dyspareunia. The neuro-hormonal imbalance due to streak gonads leads to infertility and spontaneous abortions.

The distorted self image frequently leads to decreased self confidence and increased subjective distress which may affect the libido. Some females become sexually active at a later age than their peers [19, 20].

Treatment

Majority of women with Turner Syndrome require long term oestrogen replacement therapy. Oestrogen therapy should start at about 14-15 years of age for proper development of secondary sexual characteristics. It should be started with low daily dose of estradiol followed by incremental dose to achieve gradual process of feminization [21, 22].After initiation of breast development and uterine growth oestrogens are given with progestogens in form of cyclic therapy to induce cyclical vaginal breakthrough bleeding [21, 23]. Spontaneous pregnancy occurs in Turner syndrome only in very few cases and even if they do occur, the outcome of these pregnancies is very poor with an increased incidence of miscarriage and stillbirths due to uterine abnormalities [24]. Assisted reproductive technologies are promising approaches in inducing conception in women with Turner Syndrome. This can be achieved with In-vitro fertilization for the treatment of women with ovarian failure [25]. It is observed that women who conceive after oocyte donation are at increased risk of possible sudden death of fetus or miscarriage due to abnormalities in uterus. There is amplified risk of cardiovascular complications involving aortic root dissection, severe hypertension, ventricular insufficiency and risk of pre-eclampsia due to additional cardiac work necessary for pregnancy [26]. It is thus necessary to consider single embryo transfer for pregnancy to avoid complications that can arise due to multiple pregnancies. A complete cardiac assessment including echocardiography and thoracic MRI should be done before conception.

Conclusion

There remains a therapeutic challenge till date in the treatment of Turner Syndrome. Being a chromosomal anomaly, there is no definitive cure for Turner Syndrome. Symptoms can be managed by low dose estrogen followed by progestogen as well as hormone replacement therapy. Fertility counselling, Preconception screening and Assisted Reproductive Technologies have future hopes for individuals with Turner syndrome. Ovarian tissue from young girls with Turner Syndrome can be cryopreserved for fertility treatment in upcoming days, but optimal age of ovarian biopsy has to be studied.

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PSYCHOLOGICAL MANAGEMENT OF ERECTILE DYSFUNCTION

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Introduction

Erectile Dysfunction (ED) is one of the most common medical conditions that affect the sexual life of millions of men worldwide [1]. The reported worldwide prevalence is about 10%. With progress of age, prevalence of erectile dysfunction usually increases. It is a stressful condition that may lead to low self-esteem, performance anxiety and depression. It is associated with significant morbidity and can impair the patient's quality of life. It may be defined as the consistent inability to attain or maintain penile erection for satisfactory sexual intercourse [2,3]. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), classifies erectile disorder as belonging to a group of sexual dysfunction disorders typically characterized by a clinically significant inability to respond sexually or to experience sexual pleasure.

Etiology

Erectile Dysfunction has many etiologies, which could be divided into three major groups; (a) organic (b) psychological and (c) mixed. Common organic etiology include Diabetes Mellitus [4], vascular diseases e.g. atherosclerotic disease, obesity, medication use e.g. antihypertensive drugs, estrogens, and anti-androgens [5], alcohol and other dependence-inducing substances e.g. cocaine , cannabis, heroin etc., neurological condition e.g. traumatic and neoplastic spinal cord disease, various neuropathy, nutritional deficiency e.g. vitamin B12 deficiency, zinc deficiency and endocrine or hormonal problems. Common psychological etiology includes depression, anxiety and stress. The cause may be due to combination of these organic and psychological factors.

Diagnosis

Detailed medical, psychosocial, sexual history and complete physical and local genital examination is necessary to make an accurate diagnosis of ED. There are no preferred routine tests, and routine screening is not recommended in all cases. Only few cases require investigations.

Management

Management can be broadly classified into pharmacological and non-pharmacological. Non-pharmacological management further can be categorized into psychological or surgical. This review primarily will focus on only psychological aspect of management of erectile dysfunction. Psychological factors frequently cause and are responsible for maintenance of sexual dysfunction [6].Psychological intervention differs from pharmacological in the absence of side effects associated with the drugs.

Sex education

Bagadia et al on the basis of earliest studies on male sexual problems observed that ignorance, myths, fears and guilt feelings about sex are an important factor and also designed a group therapy protocol, involving psycho-education and psyche-body continuum involving sexual dysfunction[6]. The first step is to educate the client about sex and giving him other related information including human sexual anatomy, normal sexual response cycle, masturbation, semen, clarification of sexual myths and addressing any unrealistic expectations, with the basic aim of reducing stress and anxiety regarding sex [7].

Components of psychoeducation for sexual dysfunction

1. Explain about human sexual anatomy and physiology.
2. Encourage patients to explain about sexual problems in detailed and comprehensive manner as some patients are reluctant to discuss their sexual problems and must be specifically asked.
3. Explain about normal sexual response cycle, masturbation, formation of semen, night fall, types of sex, stages of sexual intercourse.
4. Dispelling sexual myths like masturbation is harmful, sexual enjoyment depends on the size of the sex organs, semen loss damages men's health, most men lose their sexual drive around age of fifty, there is something wrong with a person who hasn't had sex by the time he is an adult.
5. Educate patient about variations of sexual desire from person to person and from time to time in the same individual.

6. Discuss the couple about importance of timing and frequency of sex. Time of the day and frequency suitable for one partner may not be suitable for the other partner. Assist couple in planning time and frequency acceptable to both partners.
7. Educate the couple about significance of non-sexual means of intimacy and communication.
8. Explain the couple about the non-offending ways to refuse sex (in case he/she is not interested) when other partner sexually advances.
9. Help shy or reluctant partner with learning to initiate sex more frequently.

Couple therapy/ marital therapy

Approximately four decades ago, Masters and Johnson noticed, in relationship with sexual inadequacy, both the partners suffer [8]. In any relationship, liveliness of sex is beyond just physiological competency. There are certain requirements, of which important are positive reinforcing feedback from one partner to the other and novelty of sexual behavior within relationship. When these essentials are not fulfilled, one or both partners may lose charm and interest in the sexual aspect of the relationship and, as a result, induce physiological sexual impairment in the partner, including erectile dysfunction. Partners may be the factor in causation and maintenance of sexual problems. Renshaw found high prevalence (62%) of sexual difficulties in female partners of men who present with ED [8]. So involvement of partner is paramount important in management of sexual dysfunctions.

Marital therapy primarily target issues of relationship problems. Various types of methods include social skills training, communication training, or cognitive interventions such as perspective taking, in order to improve mutual understanding.

Objectives of marital/couple therapy [7]

a) Helping the couple in identifying sources of conflict; as well as each partner contribution in conflict and assistance in constructive conflict resolution.

b) Assist in realization of the expectations from one partner to other and vice versa.

c) Guiding in defining the rules of smooth functioning of marriage, fulfilling roles, defining the limits of internal boundaries (individual) and external boundaries (separating the relationship from the rest of the world)

d) Making mutual verbal communication between partners to a new level of betterment (to avoid further misunderstandings). Similarly, nonverbal communication amongst couple should be improved to make it clearer and easier to express emotions.

e) Assist in deciding whether to continue the relationship or not (note: the responsibility for this decision lies exclusively to the spouses/ partners.

Couple therapy: Method [9]

In the first meeting with partners in chaos, when there are lots of worries, proceeding to work on these situations need careful and active listening with a aim of satisfactory solution to couple problems. Various types of techniques that target different issues in couple are used.

1. Techniques that help to engage the couple

a) Establish collaborative alliance with each partner and to enroll his or her support for relationship-focused therapy. This can be achieved by responding emphatically in order to validate the experience of each partner, especially his or her emotional experience accepting.
b) Help the couple to form good partner alliance. Letting each partner to address each other problems directly rather than involving therapist as mediator can sometimes do this.
c) Deal couple as a single unit by reframing their individual problem in term of relationship issue.
d) Encouraging partners to maintain activities, daily chores, surroundings and relationships that provide them positive feedback to strengthen the relationship.
e) Teach techniques that help to deal with stress and tension.

2. Techniques that help to improve positive communication between the couple

a) Teach active listening skills to both partners.
b) Ask partners to clarify rather debate what one partner to other is saying in non-judgmental and empathic manner.
c) Encourage partners to sum up and respond back what they have heard, particularly in relation to key issues voiced.
d) Teach partners about disclosing skills by promoting direct communication, rather putting statement in confusing manner.

3. Techniques that help to address sexual problems.

a) Generate and test hypothetical situations that could factor in sexual dysfunction through the relational contexts in which they occur.
b) Educating the couple about erectile dysfunction and explain the associated felling, thought and behavior in erectile dysfunction
c) Explain erectile dysfunction to be viewed as an illness, and thereby encouraging the female partner to be supportive.
d) Make aware the roles played by each partner in creating and maintaining sexual dysfunction, and exploring possible reasons for these.
e) Educating couples about potential links between sexual dysfunction and stressful couple relationship.
f) Focus on and reduce negative cycles of influence between sexual dysfunction and couple interactions.
g) Explore the present status of their sexual relationship and its meaning to both partners.
h) Identifying changes in sexual relationship that has taken place over a period from premorbid to current situation of dysfunction.

Sex therapy [7, 9]

Sex therapy of couple primarily focuses on 'Sensate Focus Technique' which was originally suggested by Master and Johnson (1970) to treat couple with sexual problems [8]. This technique is also helpful in various issues related to physical intimacy and to promote sexual awareness in couple.

Sensate focus technique is compilations of unique and specifically ordered stages of specific home exercises for couples, which encourage each partner to take turns paying increased awareness to their personal senses. This method is especially helpful for a couple to re-establish physical intimacy, sense of trust and closeness in a more easy and relaxed way and allows free

communication about emotions, needs, feelings and desires. Sensate focus is done in several stages over the course of treatment. Before proceeding to stages, the therapist should explain the aims and objectives i.e. to assist partners develop a sense of faith, trust and proximity, to become more aware of what each one likes and to encourage good communication. The instruction must be given to couple in a detailed and precise manner to carry out at home. Before starting the exercise at home, therapist must always ensure that the couple has fully understood the instructions before the treatment session begins.

In the first stage, the couple is instructed to touch each other's bodies except genitalia and women breast and asked to focus and stay on rebuilding physical relationship by first learning to enjoy and get pleasure by general physical contact. The couple is instructed not to involve in sexual intercourse in this stage. They are explained that during the session at home, partner whenever he or she likes, should invite the other partner for home session and the other partner should honor the invitation if he or she is feeling same towards it. If the other partner is not feeling the same, it should be informed to the partner in a diplomatic and empathetic way. These instructions help partners to open up the communication with each other without being pressurised to perform. After the first session of touching and caressing, the pattern of inviting then alternates, to have equal involvement of both partners. Clinician should not force a too rigid schedule, rather home session frequency should be as per interest and comfort of couple. The goal of the touching is to make aware of sensations by feeling textures, temperature, and contours. The partner who is actively doing the touching is told to concentrate on what interests him/her and not on any guesses of what his/her partner likes or does not like. Initial sessions should be as silent as possible because talking could lead to distraction from the awareness of touching sensations. If partner who is being touched is feeling uncomfortable at any point of time, he/she should convey the same to other partner. The partner at the receiving end of touching is encouraged to focus on the sensation. The couple is clearly mentioned not to have sexual intercourse if arousal occurred.

Reaction of couple should be enquired after completion of session and various question related to home session experience must be asked. Initial feedbacks to these sessions vary from couple to couple. Some couple may find this enjoyable and others may not. In some cases, couple just requires active listening of their problems and empathetic assurance from treating therapist. Assurance should include explaining couple that sexual problem need to be tackle in systemic and orderly manner. Some couples may react more repulsively to homework sessions by not following the instructions as advised. These cases may need excessive therapeutic session. In such cases, sometimes therapist need to temporarily shift the focus of therapy towards problem which is causing hindrance to session progression and might need primary consideration. Even in few cases, sometimes therapist could not be able to figure out the cause of couple difficulties. In such cases, it is worth seeing the partners separately to find out whether important information is being withheld by one of them.

In the second stage of senate focus, touching and caressing is expanded to include both partner genitalia and female breasts. Primary objective of this stage is to make this

exercise more sexually arousing without allowing intercourse. To begin with this stage couple is asked to continue the exercise of first stage and along with it extend their exercise to the next level to genitalia and breast. The therapist should assert the couple that this stage is an addition to the previous one, and not a replacement. The "active partner" is instructed to begin with caressing and touching which initially be gentle, exploratory and enjoyable rather rushing to the genitals or breasts. Once again the emphasis is on the awareness of physical sensations and not the expectation of the sexual response.

Third stage of sensate focus allows vaginal containment and sexual intercourse. But again couple should be instructed that this stage is not the substitution but rather addition to previous stages. It is extremely important stage especially for men with erectile dysfunction whom primary anxiety and fear is related to intercourse. While practicing exercise if they are sexually aroused, the woman may proceed with lying on top position without any attempt of introduction of her partner's penis into her vagina. From this position, the woman can rub her clitoris, vulva, and vaginal opening against the penis, irrespective of penile state (erect or flaccid). Later female can proceed with insertion of her partner's penis into her vagina and the partner should then lie still, while focusing on the physical sensations. The couple should be asked to maintain vaginal containment as long as they found it pleasurable. If either partner becomes anxious during this session then they should return to previous level. The couple should repeat containment till they get mastery over successive sessions.

Once this stage is well learned and mastered, the couple should introduce movement during vagina containment, with preferably woman starting the movements first. After completing a good number of sessions at this level, couples are often comfortable enough to proceed to intercourse without difficulty.

Relaxation therapies [10, 11]

Various relaxation therapies are used in erectile dysfunction. Objective of these relaxation techniques is to target anxiety, fear and stress related to dysfunction. Some of the techniques like rhythmic breathing, visualized breathing and progressive muscle relaxations are used.

Rhythmic breathing: Rhythmic breathing characterized by long and slow inhale and exhale of air. Count to five while inhalation and again to five during exhalation at slow rate. During the phase of slow exhalation, pay attention to how body naturally relaxes, this will help further to relax.

Visualized breathing: This is done in a comfortable and soothing place where person close his/her eyes and combine rhythmic breathing with imagination. Breathe slowly and deeply, but in a rhythmic manner. Imagine breath coming into nostrils, then going into the lungs and expanding the chest and abdomen. Then, imagine your breath going out in similar fashion.

Progressive muscle relaxation: This is a technique for learning of how to control the state of muscular tension. American physician Edmund Jacobson developed this technique in early 1920s. In this technique person tense up particular muscles and then relax them, and then practice this technique consistently involving other group of muscles of body [9].

Lifestyle modification [12, 13]

Life style modification has a positive role in the management of erectile dysfunction. Depending on the causal factors these can be

1) Smoking cessation: Nicotine could decrease penile blood flow and thus may be contributory factor to impotency.
2) Altening medications: Sexual problems including erectile dysfunction are side effects of many drugs. Treating psychiatrist/therapist may consult with other treating physician of patients regarding substituting medication without these side effects.
3) Limit alcohol intake: Alcohol can have detrimental effects on sexual functioning.
4) Weight reduction and exercise: Sexual dysfunction is often associated with decreased blood flow to the penis. Weight reduction by means of aerobics exercise, high fiber and low fat diet can have positive effect.
5) Stress-reduction technique like meditation or yoga may be helpful.

Conclusion

Erectile dysfunction is one of the most common sexual problems a man faces. This has ramifications on the physical, psychological and social functioning of not just one, but both the partners. A myriad of reasons exists for the condition. A thorough history and proper examination in most cases is adequate to diagnose it. The management approaches are multipronged, involving both the partners, and psychological issues have a major role to play in them.

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ASANAS FOR HEALTHY SEXUAL LIFE

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Introduction

Yoga is an invaluable gift of India's ancient tradition. It embodies unity of mind and body; thought and action; restraint and fulfilment. It is not about only exercises but to discover the sense of oneness with the self, the world and the nature. By changing our lifestyle and creating consciousness, it can help us deal with environmental change [1].

The concise definition of Yogasana is 'Sthiram Sukham Asanam'. It means asana is that position which is comfortable and steady. Yogasanas are the tools to higher awareness, providing the stable foundation necessary for the exploration of the body, breath, mind and higher states. Practicing asan as stimulates the chakras, distributing the generated energy of Kundalini all over the body[2].

Benefits of Asanas

Described below are few asanas which are beneficial for healthy and fulfilling sexual life

Cobra pose (Bhujangasana)
It tones the reproductive organs, stimulates digestion and relieves constipation[2].

Striking cobra pose (Shasank Bhujangasana)
It gently tones the female reproductive organs, alleviates menstrual disorders and is an excellent post-natal asana, strengthening and tightening the abdominal and pelvic organ[2].

Wheel pose (Chakrasana)
It influences all the hormonal secretions and relieves various gynecological disorders[2].

Shoulder pose (Kandarasana)
It tones the female reproductive organs and is especially recommended for women who have a tendency to miscarry[2].

Two-legged shoulder pose (Dwipadakandarasana)
It tones all the abdominal and pelvic organs, improving the efficiency of the digestive, reproductive and eliminatory systems.The solar plexus and the adrenal glandsare powerfully massaged, increasing vitality[2].

Hanuman's pose (Hanumansana)
It massages the abdominal organs, tones the reproductive system and prepares the female body for children.It improves flexibility and blood circulation in the legs and hips[2].

Cat stretch pose (Marjariasana)
It gently tones the female reproductive system. Women suffering from menstrual disorders and leucorrhoea will obtain relief by doing this asana. It may be practiced during menstruation for relief of cramps[2].

Back stretching pose (Paschimottanasana)
It helps to alleviate disorders of the urogenital system. It stretches the hamstring muscles and increases flexibility in the hip joints[2].

Pose of the moon or hare pose (Shashanka sana)
It tones the pelvic muscles and the sciatic nerves and is beneficial for women who have an underdeveloped pelvis. It helps to alleviate disorders of both the male and female reproductive organs[2].

Sleeping thunderbolt pose (Sputa vajrasana)
It enhances creativity and intelligence and redirects sexual energy. It massages the abdominal organs alleviating digestive ailments and constipation. The chest is stretched and expanded to its full capacity[2].

Triangle pose (Trikonasana)
It strengthens the pelvic area and tones the reproductive organs.It affects the muscles on the sides of the trunk, the waist and the back of the legs. It stimulates the nervous system and alleviates nervous depression. Regular practice will help reduce waist line fat[2].

Camel pose (Ushtrasana)
It is beneficial for digestive and reproductive systems. It stretches the stomach and intestines, alleviating constipation. It loosens up the vertebrae and stimulates the spinal nerves. It tones the organs in the neck region and regulates the thyroid gland[2].

Tiger pose (Vyaghrasana)
It tones the female reproductive organs. It exercises and loosens the back and tones the spinal nerves. It reduces weight from the hips and thighs[2].

Fish pose (Matsyasana)
The pelvic region is given a good stretch and the

pressure of the feet on the thighs greatly reduces blood circulation in the legs, diverting it to the pelvic organs. This helps prevent and remove disorders of the reproductive system. It increases youthfulness and vitality[2].

Wide-Legged Straddle Pose (UpavisthaKonasana)

It increases blood flow (and thus sensation) in the pelvis[3].

Bound Angle Pose or Cobbler's Pose (Baddha Konasana)

It alleviates urinary and uterine disorders and strengthens the uterus. Eases irritability, anxiety and fatigue, three reasons we might choose not to have sex[3].

Shoulder Stand Pose (SalambaSarvangasana)

This pose works on many woes that can plague a healthy sex life. It relieves fatigue, calms the mind, lessens symptoms of depression and anxiety, and eases digestive problems[4].

Goddess Pose (SuptaBaddhaKonasana)

This pose can help alleviate PMS and menopausal symptoms It promotes healthy function of the reproductive organs[4].

Downward Dog Pose (AdhoMukhaSvanasana)

It calms the mind and invigorates the body, both important ingredients in good sex[4].

Bridge Pose (SetuBandhaSarvangasana)

It strengthens the pelvic floor muscles, tones the vagina and improve orgasms[4].

Celibate's pose (Brahmacharyasana)

A special asana for males, it strengthens the abdominal organs and muscles, as well as the arms. It is an important asana for the conservation of sexual energy[2].

Other poses

Halasana, Matsyasana, VipritaKarani, Sarvangasana, Sirhasana are some of the postures that help in better sexual performance[5]. Child's Pose (Balasana), Lizard Pose (UtthanPristhasana), Pigeon Pose (EkaPadaRajakapotasana) and Eagle Pose (Garudasana) also improve our sex life[6].

How it works?

Manyasanas refer to the root lock 'Mula Bandha' which is the root of the spine, the pelvic floor, the perineum. Bringing awareness to these areas during practicing the asanas helps us to be more in touch with them and can help us enjoy having sex more. In the challenging physical postures such as downward dog, chatarunga, suptakonasana and plow pose, engaging Mula Bandha actually helps lift the pelvic-floor muscles, which increase core strength[4]. Using and engaging Mula Bandha helps us to have better orgasms. By slightly contracting the pubococcygeal muscles, we create an energetic seal. This contraction brings circulation and awareness to the pelvic region and can be used during sex to increase arousal[4].

How to practice ?

The best time of practice of asanas is the two hours before and including sunrise (Bramhamuhurta). In the evening the two hours around sunset is also a favorable time. But asanas may be practiced at any time of day except after meals. The place of practice of asana should be a well ventilated room where it is calm and quiet. Asanas may also be practiced outdoors but the surroundings should be pleasant. A folded blanket of natural material should be used during the practice of asana. The blanket acts as an insulator between the

body and the earth. During the practice it is better to wear loose, light and comfortable clothing. The stomach should be empty while doing asanas and to ensure this, they should not be practiced until at least three or four hours after food. Asanas may be practiced by people of all age groups, male and female. Anyone interested to practice asana must seek the guidance of a competent and knowledgeable yoga therapist[2].

Conclusion

Regular practices of asanas help to strengthen and tone our body which will make us feel better about our self. Improved self-thoughts about our appearance will boost our self-esteem. All of these will help us feel more sexy and comfortable with another body beside us[4].If we are not worried about other things and feel mentally balanced, we are more likely to want and be able to give to our significant other[4]. Increased flexibility that comes with a regular asana practice can come in handy when we are getting creative in the bedroom and are coming up with different sexual positions[4].Asana helps develop an awareness of our sensations of our total body and how our body feels. This ability will help us with sensuality during sex[4].

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