

Description of Sexual Dysfunction in Females in Ancient Medicine

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ABSTRACT

Sexual dysfunctions tend to affect the well being of individuals. Female sexual dysfunction refers to problems of sexual desire, orgasm, arousal and sexual pain. Most of the studies on sexual dysfunctions primarily focus on men than on women. The present article was written to understand the conceptual changes about female sexual dysfunctions in various time periods. It was seen that not much focus was given to problems of females in ancient times. They were considered to be responsible for unholy desires of men and marriage was considered to be the solution of problems present in females. With the advancements in the field of psychiatry, female sexual dysfunctions came to be understood in a better way and were also included as a separate disorder in the Diagnostic and Statistical Manual.

KEYWORDS: Sexual Dysfunction, Female Sexual Dysfunction, Diagnostic and Statistical Manual

INTRODUCTION

Sexual functions in human are an important element of life, be it for species propagation or quality of life. Sexual dysfunction can often lead to reduced quality of life. Sexual dysfunction refers to problems that occur during the sexual response cycle that prevents a person from experiencing satisfaction from sexual intercourse [1]. Masters and Johnson in 1966 described a six- phase sexual response in women based on i) desire, ii) arousal iii) lubrication iv) plateau v) orgasm and vi) resolution [2]. First, 3 components being interdependent and are responsible to achieve plateau, orgasm and resolution. For the successful achievement of sexual response, desire is the basis [3]. Female Sexual Dysfunction (FSD) is defined as “a disorder of sexual desire, orgasm, arousal and sexual pain that results in significant personal distress” [4].

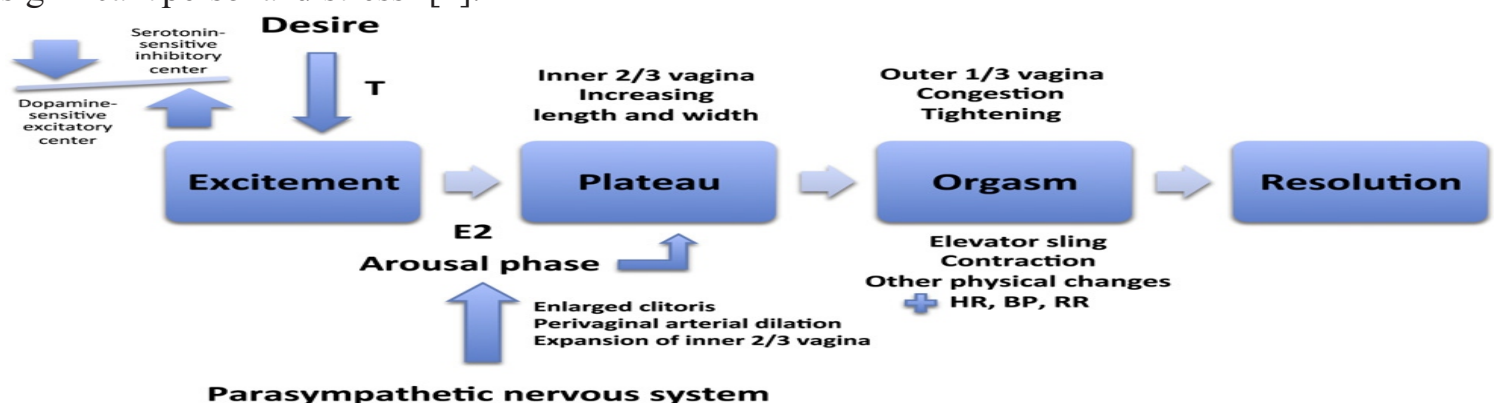


Fig. 1. Physiological changes in the current model of the female sexual response cycle [5].

BP : blood pressure; HR : heart rate; RR : respiratory rate.

However, it is really difficult to estimate prevalence of Female Sexual Dysfunction (FSD) compared to Male Sexual Dysfunction (MSD). American Psychiatric Associations' Diagnostic and Statistical Manual of Mental Disorder classifies sexual response based on Kaplan in 1979 into four phases: Phase I desire or libido; Phase II arousal or excitement; Phase III orgasm or climax; Phase IV refractory or resolution. Today, FSD is regarded as a multifactorial and progressive problem affecting approximately 19% to 50% of the female population [6,7].

HISTORY

Female sexual problems date back to the time of Hippocrates. The problem of melancholic madness was considered to affect the young girls and marriage was considered as the only possible cure for the same [8].

During the seventeenth century and even before, uncontrolled sexuality was considered as sexual problem associated with females. It was then known as 'furoruterinus' and later on came to be known as 'nymphomania'. Many cases were reported of the same in various countries like Italy, France, Spain, Portugal etc. It has been defined as "immoderate burning in the genital area of the female, caused by the surging of hot vapour, bringing about an erection of the clitoris" by Italian physician, Girolamo Mercuriale in the sixteenth century [9].

In the eighteenth century, sexuality was understood as per the teachings of the church. What was normal and what was not normal was defined by these teachings. The females were considered responsible for the unholy desires of men and resulted in castigation of females.

With the beginning of the 'Victorian Era', the status of women was reduced to that of a wife, a mother and a lady [10]. They did not have high position in the society. They were given only one goal and that was marriage. They could not even support their family economically. A lot of value was given to moral purity and virginity. As per those times, pathologies started when women crossed these boundaries. Some of the problems mentioned are: masturbation, hysteria and nymphomania. These were considered to be problems of oversexuality.

The current understanding of female sexual dysfunctions is influenced by the works of twentieth century [11]. By this time psychiatry had become professionalized and medicalized. Psychoanalytic theory as given by Sigmund Freud was popular during this time. Psychopathology during this period was considered as a result of too much or too little desire. As per Freud, lack of or non-possession of penis was considered by the females as a loss. This experience resulted in unresolved conflicts and neurosis in females [11]. Desire for clitoral stimulation by women rather than vaginal intercourse was considered to

result in neurosis, isolation, and social disintegration. Feminism and lesbianism was also considered as problems and were linked to clitoral stimulation [12,13].

The Ayurveda considers genital secretion to result in progressive weakness or even death. The females of South Asian countries have reported complaints of dizziness, backache and weakness caused by vaginal discharge [14]. These women usually presented with the complaints of safed pani (white water), dhatu or swet pradhar. This was considered as a vital fluid of the body by women and was based on the belief which said that 100 drops of blood is required to make a drop of safed pani [15,16]. Similar beliefs about vaginal discharge are present among Muslim women as well [17,18].

DSM & IT'S CLASSIFICATION

The connotations regarding female sexual problems as mental disorders remained an important topic of discussion by the American Psychiatric Association's Diagnostic and Statistical Manual in the post war period.

First edition of DSM (1952) included Sexual Deviation (including homosexuality, tranvestism, pedophilia, fetishism and sexual sadism) under the domain of Personality Disorders. Problems of impotency and frigidity were included in the category of 'Psychophysiological autonomic and visceral disorders' [19]. The second edition DSM (1968) was similar to that of first, it has just added dyspareunia and

impotence to the list of examples [20].

In DSM III of 1980, importance was given to biological psychiatry and had a separate chapter on 'Psychosexual Disorders'. This included a category of gender identity disorders (transsexualism and gender identity disorders), and paraphilias (fetishism, transvestism, pedophilia, voyeurism etc.) and psychosexual dysfunctions for women which included the following: inhibited sexual desire, inhibited sexual excitement, inhibited (female) orgasm, functional dyspareunia, functional vaginismus, Atypical psychosexual dysfunction [21]. The DSM-III-R of 1987 changed 'Psychosexual Dysfunctions' to 'Sexual Dysfunctions' [22].

DSM-IV of 1994 remained all the more the same except that Inhibited Orgasm becomes Orgasmic Disorder. It also added Sexual Dysfunction due to a general medical condition- Induced Sexual Dysfunction [23]. According to DSM-IV TR, sexual dysfunction is characterized by a disturbance in the processes of sexual response cycle or by pain associated with sexual intercourse [24].

DSM 5, published in 2013, added gender specific sexual dysfunction and female disorders of desire and arousal were clubbed into single category of Female Sexual Interest/Arousal Disorder. It also states that a sexual dysfunction must have persisted for a minimum of 6 months, causing distress excluding a non-sexual mental disorder or severe stressors [25].

CONCLUSION

Female Sexual Dysfunctions have been highly prevalent from the ancient times but have not been the topic of concern for many years. Understanding of female sexual dysfunctions clearly states that males and females have different dysfunction. However, now it is being researched a lot but more and more also need to be explored. Emphasis should be given not only to physical but also to psychological reasons associated with these.

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