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Sexual Impotence: Its History, Causes, and Treatment

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***Abstract*—** Sexual dysfunction, sexual malfunction, sexual disorder, or impotence is the difficulty of one or both parties to a sexual relationship during any phase of normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), for a person to be diagnosed with impotence, the person must have had the disorder for at least 6 months (except for cases that have sexual dysfunction or are taking medications that cause impotence).). Sexual dysfunctions can have a profound impact on the quality of an individual's sexual life. The term sexual disorder may refer only to physical impotence, but at the same time it refers to homosexuality; which is sometimes called the term sexual preference disorder.

***Keywords*—** Sexual dysfunction – sexual disorder – Sexual Impotence – Mental Disorders

I. INTRODUCTION

Of great importance is a comprehensive sexual history and assessment of the patient's general health and other sexual problems (if any). Assessment of anxiety, guilt, and stress when performing sexual intercourse is an integral part of optimal management of impotence. Many cases of impotence are defined according to the human sexual response cycle, proposed by William Hutt. Masters and Virginia E. Johnson, then modified by Helen Singer Kaplan.

II. TYPES OF SEXUAL IMPOTENCE

Sexual desire disorders

Low libido appears as a loss or no desire to engage in sexual activity or sexual fantasies for some time. The condition ranges from a general lack of sexual desire or no sexual desire in the current partner. The condition may begin after a period of normal sexual performance or the person may have permanent low sexual desire or desire.

The causes of sexual desire disorders vary widely, but they include a possible decrease in the production of estrogen in women or testosterone in both men and women. Other causes may include old age, fatigue, pregnancy, taking

medications (such as SSRIs) or psychological causes, such as stress or anxiety. While several underlying causes can be cited for low libido, only some of these have been the subject of empirical research.

Sexual arousal disorders

Sexual arousal disorder, formerly known as frigidity in women and impotence in men, has now been replaced by less strict terms. Impotence is known today as erectile dysfunction, and the term cold is now replaced by a number of terms that describe specific problems that can be divided into four categories as described in the Diagnostic and Statistical Manual of Mental Disorders issued by the American Psychiatric Association: loss of desire, loss of arousal, pain during intercourse, And no orgasm.

For both men and women, these conditions can manifest as aversion to or avoidance of sexual contact with a partner. In men, there may be failure to achieve or maintain an erection, or loss of arousal and pleasure during sexual activity.

There may be physiological origins to these disorders, such as reduced blood flow or vaginal dryness. Chronic diseases may also contribute to this condition, as well as the nature of the relationship between the two partners.

In addition, POIS may cause symptoms when it increases, which include increased adrenaline, rapid breathing, paraesthesia, palpitations, headache, slurred speech, nausea, itchy eyes, fever, muscle aches, weakness and fatigue.

From the onset of the arousal phase, symptoms can persist in patients for up to a week.

The causes of this condition are unknown, although it is believed to be a disease of the immune system or the autonomic nervous system. The US National Institute of Health defines it as a rare disease, but its prevalence is unknown. This condition is not believed to be of a psychological nature, but it may appear in the form of anxiety related to vital activities and thus may be misdiagnosed as such. There is no cure or cure for this condition.

Erectile dysfunction

Erectile dysfunction is sexual dysfunction characterized by the inability to develop or maintain an erection of the penis. There are several causes of erectile dysfunction, such as damage to the stimulating nerves that prevent or delay an erection, diabetes or cardiovascular disease, which simply means reduced blood flow to the tissues of the penis, and many of these causes can be treated.

Erectile dysfunction may be due to psychological or physical causes. Usually, patients with psychological erectile dysfunction can be treated in cases that believe in its existence; As there is a large placebo effect in this regard. The physical erectile dysfunction will be more serious. The main physical cause of ED is persistent or severe damage to the excitatory nerves. The sympathetic nerves are located next to the prostate and originate from the sacral plexus and can be damaged during prostate or rectal surgery.

Diseases are also a common cause of erectile dysfunction; Especially in men. Diseases such as cardiovascular disease, multiple sclerosis, kidney failure, vascular disease and

spinal cord injury are considered a cause of erectile dysfunction.

Because of the embarrassing nature and shame of erectile dysfunction, delving into the topic has long been a taboo, and has been a central theme of many urban legends. It was usually treated with folk recipes, which began to be widely promoted since the 1930s. It could be argued that an effective drug treatment for impotence, sildenafil (sold under the trade name Viagra), which was introduced in the 1990s, caused a flurry of public interest, which was fueled in part by news of stories on the subject and intense advertising.

It is estimated that about 30 million men in the United States and 152 million men in the world suffer from erectile dysfunction. However, social stigma, low health knowledge and social taboos contribute to underreporting of this disease, making it difficult to determine its exact prevalence.

Premature ejaculation

Premature ejaculation occurs when ejaculation occurs before the other person reaches an orgasm, or before a sufficient period for both parties to feel satisfied during intercourse has passed. He does not want the correct length of time for intercourse, but in general, premature ejaculation is believed to occur when ejaculation occurs within less than two minutes of penetration. For example, the case should have a chronic history of premature ejaculation, poor ejaculation control, and the problem should cause a sense of dissatisfaction as well as frustration for the patient, partner, or both. Historically, premature ejaculation has been attributed to psychological causes, but new theories suggest that premature ejaculation may be due to a neurobiological cause that leads to rapid ejaculation.

Orgasm disturbances

Orgasmic disorders, especially lack of orgasm, appear as delayed or absent orgasm following the stage of normal sexual arousal in 75% of sexual encounters. This disorder may be due to physical, psychological or pharmacological causes (for some types of medication). Selective serotonin reuptake inhibitor (SSRI) antidepressants are a common cause of this disorder, as they can delay or prevent orgasm. A common physiological reason for not having an orgasm is menopause, with one in three women having trouble reaching an orgasm during sexual stimulation following menopause.

In addition, there are so-called post-orgasmic disorders, which are best categorized as 'post-orgasmic dysphoria syndrome' (see post-orgasmic disorders section).

Sexual pain disorders

Sexual pain disorders affect women exclusively and are also known as dyspareunia (painful intercourse) or involuntary vasospasm (involuntary spasm of the muscles of the vaginal wall that hinders intercourse).

Dyspareunia may be due to insufficient secretions for penetration inside the vagina (vaginal dryness. Lack of secretions may result from insufficient stimulation and foreplay, or from hormonal changes caused by menopause, pregnancy, or breastfeeding. Irritation can also be caused by the use of Contraceptive creams or foams for vaginal dryness, as well as fear or anxiety about sexual intercourse.

The exact causes of vasospasm are not known, but it is thought that past sexual trauma (such as rape or abuse) may play a role. There is another female sexual pain disorder called vulvodynia. In this case, the woman experiences a burning pain during intercourse that appears to be related to the skin of the vulva or vaginal area. Its cause is unknown.

Post-orgasm diseases

Post-orgasmic symptoms occur shortly after an orgasm or ejaculation. Post-coital dysphoria is the feeling of depression and anxiety after sexual intercourse that lasts for more than two hours. A sexual headache affects the skull and neck during sexual activity, which includes masturbation, arousal or orgasm.

In men, post-orgasmic syndrome causes muscle aches and other symptoms that occur right after ejaculation. Symptoms last up to a week. Doctors speculate that the frequency of PMS among people may be greater than what has been reported in the academic literature, and that many people with this condition go undiagnosed.

Symptoms of post-orgasmic syndrome include high adrenaline, rapid breathing, paresthesia, palpitations, headache, slurred speech, nausea, itchy eyes, fever, muscle aches, weakness and fatigue.

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III. UNCOMMON SEXUAL DISORDERS IN MEN

Erectile dysfunction due to vascular disease is usually seen among older people with atherosclerosis. Vascular diseases are common in people with diabetes, peripheral artery disease, hypertension, and smokers. When blood flow to the penis is poor, the result is erectile dysfunction. Hormonal deficiency is a relatively rare cause of erectile dysfunction. In people with hypogonadism such as in cases of Klinefelter syndrome, or patients undergoing radiotherapy, chemotherapy or children exposed to the mumps virus, this may lead to hypogonadism and a lack of testosterone production. Other hormonal causes of erectile dysfunction include brain tumors, hypothyroidism, hyperthyroidism or adrenal gland disorders. Structural abnormalities of the penis such as Peyronie's disease can cause difficulty in sexual intercourse. This disease appears in the form of thick fibrous bands on the penis, which leads to the appearance of the appearance of the penis. Medicines are also a cause of erectile dysfunction. People who take antihypertensive

medications or antipsychotics, antidepressants, sedatives, narcotics, antacids or alcoholic beverages may have problems with sexual performance or a loss of libido. Priapism may cause a painful erection that lasts for hours and occurs in the absence of sexual stimulation. This condition develops when blood becomes trapped in the penis and becomes unable to penetrate. If left untreated, this disease can lead to severe scarring and permanent loss of an erection. This disease occurs in young people and children. People with sickle cell disease who abuse certain types of medications may develop the disease.

IV. CAUSES OF IMPOTENCE

There are a lot of factors that may lead to an individual suffering from impotence. Impotence may result from emotional or physical factors. Psychological factors include personal or psychological problems, which may lead to depression, sexual fear or guilt after sex, previous sexual trauma, sexual disorders, and other causes.

Impotence is particularly common among people with anxiety disorders. Normal anxiety may cause erectile dysfunction in men without psychological problems, but a clinically diagnosed disorder such as panic disorder may be a common cause of avoidance of intercourse and premature ejaculation. In women, the occurrence of pain during intercourse is usually associated with anxiety disorders.

The physical factors that can lead to impotence include the use of medications, such as alcoholic beverages, nicotine, narcotics, stimulants, antihypertensives, antihistamines, and some psychiatric medications. For women, any physiological changes that affect the reproductive system - premenstrual syndrome, pregnancy and the postpartum period, menopause - can affect sexual desire. Back injuries may also affect sexual activity, as can problems with an enlarged prostate, problems with blood flow, or nerve damage (as occurs in impotence after spinal cord injuries). Diseases such as diabetic neuropathy, multiple sclerosis, tumors, and rarely, stage III syphilis may affect sexual activity, as it can lead to failure of several organ systems (such as the heart and lungs), endocrine disorders (thyroid gland, pituitary gland, or adrenal glands), hormonal deficiency (low testosterone, androgen or estrogen) and some birth defects.

In the context of heterosexual relationships, one of the main reasons for the decline in sexual activity between these couples is the male partner's erectile dysfunction. This can be very painful for the male partner, causing poor physical image, and can also be a major source of decreased sexual desire for these men. Among older women, it is normal for the vagina to become narrow and atrophied. If a woman does not engage in regular sexual activity (particularly, activities related to vaginal penetration) with her partner, if she does not decide to engage in penetrative intercourse, she will be at risk of injury or pain when entering the penis that may turn into a vicious cycle, leading to impotence feminine.

Female sexual dysfunction

Many theories have been researched into female sexual dysfunction, from the medical or psychological standpoint. The three social psychological theories: the self-perception

theory, the over-justification hypothesis, and the insufficient justification hypothesis:

Self-perception theory: People who describe their attitudes, feelings, and behaviors by relying on their observations of external behaviors and the conditions in which those behaviors occur.

Excessive justification hypothesis: When a person is given an extrinsic reward for performing an intrinsically rewarding activity, the person's intrinsic benefit will decrease.

Insufficient justification hypothesis: It is based on the cognitive dissonance theory (inconsistency between perception or behavior that creates discomfort), which states that people will change one of their perceptions or behaviors to restore consistency and reduce distress.

The importance of how women perceive their behavior should not be underestimated. Many women view sex as a chore rather than a pleasurable experience, and they tend to consider themselves sexually inappropriate, which in turn does not motivate them to engage in sexual activity. There are many factors that influence a woman's view of her sexuality. They may include: race, gender, ethnicity, educational background, socioeconomic status, sexual orientation, financial resources, culture, and religion. Cultural differences may be how women view menopause and its effect on their health, self-perception, and sexuality. One study found that African American women are more optimistic about life after menopause; Whereas Caucasian women are the most anxious, Asian women are more attuned to symptoms, and Hispanic women are more sober about menopause.

About two-thirds of women suffer from impotence, which can lead a woman to distrust her sexuality. Because these women have sexual problems, their sexual lives with their partners become a burden without pleasure, and eventually, they may lose interest in sexual activity entirely. Some of these women are hard to arouse mentally; however, some of them suffer from psychological problems. There are a lot of factors that can affect a woman's impotence, such as situations in which a woman is not confident in her sexual partner. The environment in which sexual activity occurs is critical, since being in a place that is too public or too private can make some women feel uncomfortable. Inability to focus on sexual activity due to poor moods or workloads may also cause a woman's sexual dysfunction. Other factors include physical discomfort or difficulty achieving arousal, resulting from aging or changes in the state of the body.

Menopause

The female sexual response system is complex and even today it has not been fully understood. The most common types of female sexual dysfunction associated with menopause include lack of sexual desire and frigidity; This is closely related to the hormonal physiology. It is a decrease in the level of estrogen that causes these changes in sexual performance. Androgen depletion may also play a role, but it is currently less clear. The hormonal changes that occur during the menopausal transition suggest that the female sexual response is influenced by different mechanisms, some more certain than others.

Aging

A controversial topic is whether or not aging is a direct factor in affecting female sexual activity during menopause. However, many studies, including Hayes and Dennerstein's original review, have claimed that aging has a significant impact on sexual function and impotence in women, particularly with regard to desire, sexual interest, and orgasm frequency. In addition, Dennerstein and colleagues found that the initial precursor to sexual response in menopause precedes the performance of sexual activity. This means that it is necessary to understand how physiological changes in women and men affect their sexual desire. Despite the obvious negative impact of menopause on sexuality and sexual activity, confidence and sexual desire may increase with age and menopause. Moreover, the impact that relationship status can have on quality of life is often underestimated. Testosterone, and the dihydrotestosterone metabolite, is critical to normal sexual activity in both men and women. Dihydrotestosterone is the most prevalent androgen in both men and women. Testosterone levels in 60-year-old women are, on average, half the levels in women at age 40. Although this decline is gradual in most women, women who have had hysterectomy experience a sudden drop in testosterone levels; This is because the ovaries produce 40% of the body's testosterone. Sexual desire is linked to three separate components: leadership, beliefs and values, and motivation. For menopausal women in particular, waning driving is the first step in the female sexual response.

V. TREATMENT OF SEXUAL IMPOTENCE

Treatment of impotence in men

Several decades ago the medical community believed that the majority of impotence cases were related to psychological issues. Although this may be true in a segment of men, it has now been determined that the vast majority of cases are psychological or related to a psychological problem. If impotence is considered to have a psychological component or cause, psychotherapy may work. Situational anxiety arises from a previous bad incident or lack of experience. This anxiety usually develops into a fear of sexual activity and leads to avoidance of it. Avoidance, in turn, leads to a cycle of heightened anxiety and insensitivity to the penis. In some cases, erectile dysfunction may be due to marital disharmony. In this case, marital counseling sessions are recommended.

Lifestyle changes such as quitting smoking, medications or alcoholism may also help with some types of erectile dysfunction. Various oral medications such as Viagra, Chialis and Levitra have become available to help people with erectile dysfunction and have become a first-line treatment. These medications provide an easy, safe, and effective treatment for approximately 60% of men. In the remaining cases, medical treatment is ineffective due to a misdiagnosis or chronic medical history. Another type of treatment that affects 85% of men is called cavernous pharmacotherapy, which involves direct injection of a vasodiliter into the penis to stimulate the penis. This methodology increases the risk of priapism if used in combination with other medications, and causes localized

pain. When moderate treatments fail, an uncomfortable or restricted treatment option is penile prosthesis or penile implantation, which may be chosen by the patient. Technological advances have made penile implants a safe option for erectile dysfunction treatment, which provides higher levels of patient and partner satisfaction compared to other erectile dysfunction over-the-counter options.

Pelvic floor physical therapy has been shown to be a valid treatment for men with sexual problems and pelvic pain.

Treatment of impotence in women

There are no approved medications for female sexual disorders, although many are in the process of researching their effectiveness. The vacuum device is the only medical device approved for the treatment of arousal and orgasm disorders. This device is designed to increase blood flow to the clitoris and external genitalia. Women who suffer from group pains are usually prescribed analgesic, muscle relaxant, and anti-allergic medications. Lubricants are also prescribed to increase vaginal moisture and/or hormone therapy. Most women with female impotence are usually advised to see a doctor or psychologist for psychological counseling.

VI. CONCLUSION

Prior to Masters and Johnson, the clinical approach to the study of sexual problems was derived from Freud's thought. The studies were conducted within psychopathology and dealt with some pessimism regarding the opportunity to help or improve the condition of patients. Sexual problems were a symptom of a deeper illness and was based on the diagnostic methodology of psychopathology. There was a slight difference between difficulties in performance and changes on the one hand, and deviation and problems on the other. Despite the work of psychopathologists such as Balint, sexual difficulties were categorically divided into frigidity and erectile dysfunction, two terms that quickly acquired negative connotations in popular culture.

The achievement of the study of human sexual insufficiency was aimed at moving from psychopathological methodology to learning, and the problem could only be considered within psychopathology when it did not respond to educational therapy. The treatment was also directed at the couple, whereas in the past the two partners were treated individually. Masters and Johnson considered sex to be a joint business. They believed that sexual intercourse was a key to sexual problems rather than a personal problem. They also suggested a combined therapy, two identical therapists, to treat patients, claiming that a male therapist could not fully understand the difficulties faced by females.

Masters and Johnson's main treatment program was an intensive two-week treatment program to develop effective sexual communication. The program, which included the treatment of spouses by specialists (male and female), began with a discussion and then focused on the relationship between the spouses to develop common experiences between them. From experience, the difficulties involved can be identified and dealt with with specific treatment. In a limited number of males (41) only, Masters and Johnson

developed the use of a woman's surrogate, an approach that soon abandoned the ethical, legal, and other issues raised.

In scoping out sexual problems, Masters and Johnson defined the boundaries between impotence and deviance. Impotence was transient and affected the majority of people, and impotence was limited to erectile dysfunction, premature ejaculation, delayed primary and secondary ejaculation in males; not having an orgasm, whether permanent or temporary; Pain during intercourse (dyspareunia) and primary involuntary vasospasm in females. According to Masters and Johnson, sexual arousal and orgasm is a functionally normal psychological process for every adult, but although it is a mechanical process, it can be prevented or inhibited. The Masters and Johnson Therapy program had an 81.1% success rate.

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