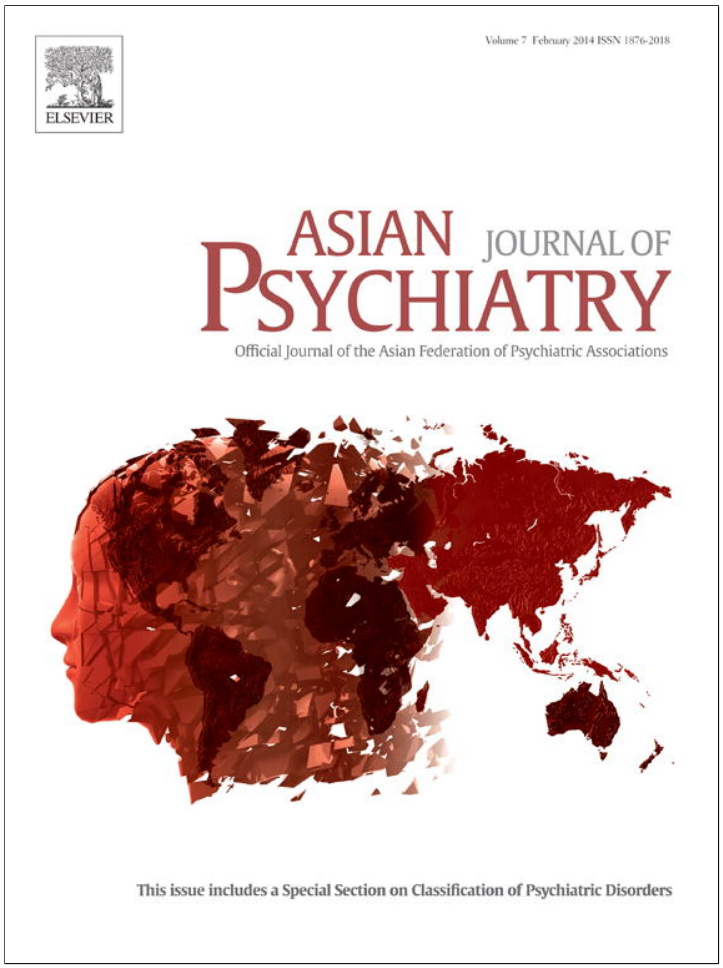

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Sexual disorders in Asians: A review

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ABSTRACT

Sex is an integral part of the basic needs of an individual. However, Asian populations have had a conservative attitude towards discussing and expressing their sexual concerns to the clinician. Consequently, very limited research on sexuality-related issues has been done on these populations. Many of the biological and socio-cultural factors are different for Asians and Asian migrants to the West, when compared to the native Western population, and this requires dedicated research. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders 5th Edition) has made the classification of sexual dysfunctions gender-specific and has introduced the concepts of 'gender dysphoria' and 'paraphilic disorders' (distinct from paraphilias); it has removed subtypes based on sexual orientation. These changes will have a definite impact on our understanding of sexual dysfunctions and related disorders in the Asian populations.

1. Introduction

Sex has played an important role in human lives across different cultures. However the importance given to this issue often varies in cultures with some such as Asian cultures seeing it as a taboo (Ho et al., 2011) and taking its sole purpose as procreation, while the Western cultures viewing it as recreational. These contrasting views toward sex have affected sexuality related research. Though there is at least some research on sexual dysfunction within East Asian countries, similar research within South Asia is seriously lacking (Andrade, 2005). Asian populations are physically, culturally and socially different from Western populations and hence it is not always possible to extrapolate findings of Western studies to Asian populations (Van Houten and Gooren, 2000), which hence underscores the importance of more regional research in this area.

Sexual dysfunction leads to distress and discord within a relationship and exists across different populations though with different rates. Asian men for instance, have shorter times to ejaculation than Caucasians and Afro-Caribbeans (Kinsey et al., 1948) with Indian men being more susceptible to premature ejaculation (Verma et al., 1998). This has been replicated in many studies that have reported premature ejaculation to be the commonest sexual dysfunction in clinical samples of Indian men (Jain et al., 2000; Kendurkar et al., 2008). Rates of sexual dysfunction are much lower in Asian women (Kameya, 2001) although it could be argued that Asian women rarely consult for sexual problems given the sexually conservative nature of the Asian society. In this context, rates of mental sexual arousal and pleasure from genital stimulation were found to be significantly lower in Asian women (Brotto et al., 2005). Anxiety over nocturnal emissions and passing semen in urine, the so called *dhat* syndrome needs special mention within the Asian context. This semen-loss related psychological distress has been extensively studied and comprises of vague somatic symptoms attributed to semen loss in various ways.

2. Etiology of sexual disorders in Asians

2.1. Risk factors

Indian men are supposedly more prone to cardiovascular diseases (CVDs) and are affected 5–10 years earlier than other populations around the world (Sharma and Ganguly, 2005). CVDs share a common etiology of atherosclerosis with erectile dysfunction (ED). ED is an independent marker for CVD risk and often precedes a CVD event by 2–5 years (Jackson et al., 2013). Andrade (2005) has suggested that ED due to vascular causes may be more common in India than other parts of the world. Although there is no data to corroborate this, it would be interesting to explore similar risk factors for ED in other Asian countries.

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2.2. Culture

Although cultural factors have a deep impact on one's sexuality (Brotto et al., 2005), they are highly under-researched. Such factors are more important in case of migrants and refugees. Cultural factors are more likely to affect expression of distress due to sexual dysfunction although this would need further exploration. For instance, Chinese men feel embarrassed to discuss erectile dysfunction and choose to suffer in silence (Ho et al., 2011). In this context, Brotto et al. (2005) hypothesized that an individual's perception of sexual difficulty is influenced by his/her notion of normal and abnormal sexual function, which is related to one's sense of self which in turn is related to culture. Complaints of ejaculatory delay are common in Asian populations when compared to men living in Europe, Australia or the United States (DSM-5). The concept of being masculine, in Asian men, goes against health care seeking for general medical and sexual problems. However this behavior has not been noted in immigrant Asians to Western Countries (Ng et al., 2008; Bhui et al., 2002; Galdas et al., 2007).

2.3. Changing gender roles

Asian society has largely been patriarchal with recent shifts in gender roles, as women are coming out of their houses and working alongside men. As per a hypothesis put forth by Andrade (2005), many men from such societies may not be used to these gender-role changes resulting in relationship difficulties and hence an increase in sexual dysfunction such as ED in men. Although Andrade talks within the context of India, much of this may be applicable to the rest of Asia and would need to be further explored.

2.4. Urbanization

Andrade (2005) further hypothesizes the negative effect that urbanization has on an individual's sexual functioning due to increasing stress levels with changing lifestyles. Many Asian countries are currently witnessing widespread urbanization which may be possibly causing sexual dysfunction.

3. Diagnosis of sexual disorders in Asians

A reliable diagnosis is the key to understanding the natural course of a disorder, its treatment and the impact it can have on an individual (Freedman et al., 2013). Asian men and women may present in clinical set-ups with related somatic symptoms and not exactly sexual symptoms. Wig in 1960 coined the term *dhat* syndrome characterized by vague somatic symptoms and guilt attributed to semen loss through nocturnal emissions, urine and masturbation though there is no evidence of loss of semen (Wig, 1960). Patients with symptoms of *dhat* syndrome are mostly young, poor, from rural background, from families with conservative attitude toward sex and recently married (Behere and Natraj, 1984; Bhatia and Malik, 1991).

4. Treatment of sexual disorders in Asians/Asian Americans

Asian men and women rarely present for treatment in sex therapy clinics and have higher dropout rates than their western counterparts (Petrak and Keane, 1998; Ho et al., 2011). This could be related to the sexually conservative social milieu in Asian societies and a reluctance of Asians to admit to sexual concerns supposedly due to embarrassment or anxiety (Ip et al., 2001). This is truer with Asian women as Liu and Ng (1995) reported a mere 4% proportion of women attending a sexual dysfunction clinic in China compared to 43% in the United States.

Treatment of sexual dysfunctions is affected by factors such as issues in healthcare access in Asian countries with most formal healthcare services limited to urban areas (Ho et al., 2011). Many healthcare professionals may not be comfortable dealing with sexual dysfunction cases (Yates et al., 2008). In addition, alternative medicine systems find a large user base in Asia with more men feeling that it is better than conventional medication (Low and Tan, 2007) especially since modern medicine has more side effects (Sun and Liu, 2007) while traditional medicine is more affordable and congruent with Asian values and beliefs (Wong et al., 2008). As far as modern medications are concerned, almost all forms of treatment modalities are available in Asian countries, including pharmacological agents such as sildenafil, tadalafil, dapoxetine, intracavernosal prostaglandin E_1, vacuum devices etc. Sildenafil in doses of 25, 50, or 100 mg is effective, safe, and well-tolerated treatment for ED in Asians with increased cardiovascular risk (Buranakitjaroen et al., 2007). Female sexual dysfunction is primarily managed by sex-therapy, hormonal treatments (Avasthi and Parthasarathy, 2004), or antidepressants including bupropion.

5. Implications of DSM-5 for understanding sexual disorders in Asians/Asian Americans

DSM 5 still allows the use of social norms to define 'healthy sexual practice', rather than scientific evidence (Keenan, 2013), which makes it interesting to understand the context of DSM 5 within Asian cultures. It is already known how clinical assessments for diagnosis can be challenging in cross-cultural consultations especially if clinicians assessing patients are from different cultures. This becomes more important if the consultations are regarding sexual dysfunctions. Only a good rapport and firm leading questions may help clinicians in obtaining adequate information regarding sexual dysfunctions especially in females who are reluctant to report such problems.

For a better understanding and conceptualization, gender-specific sexual dysfunctions have been added in DSM-5. For females, sexual desire and arousal disorders have been combined into one disorder, considering the fact that both often coexist and are elicited in response to sexual cues (DSM 5, 2013). For a better diagnostic validity, duration and severity criteria have been revised in DSM-5, except for substance-/medication-induced sexual dysfunction. All the DSM-5 sexual dysfunctions require a minimum duration of 6 months and certain more stringent severity criteria (American Psychiatric Association, 2013). Dyspareunia and vaginismus have been combined into genito-pelvic pain/penetration disorder, as both are mostly co-morbid and diagnosis of sexual aversion disorder has been dropped due to lack of research supporting the diagnosis. DSM-5 includes lifelong versus acquired subtypes, generalized versus situational subtypes, and severity specifiers (mild, moderate, severe), whereas psychological versus combined subtypes have been dropped; medical and other nonmedical correlates have been added, among which cultural and religious factors have been reasonably highlighted (DSM 5, 2013). Culture-related diagnostic issues (including factors related to Asian populations) for each disorder are mentioned separately.

A new diagnostic class of 'gender dysphoria' (with separate criteria for children and adolescents/adults) has been added in DSM-5 emphasizing gender incongruence instead of cross gender identification as in DSM IV (Diagnostic and statistical manual of mental disorders IVth edition). The subtyping based on sexual orientation has been removed citing it to be not useful clinically. This is a positive step for the Lesbian and Gay population toward reducing stigma which is much more in the Asian populations. Keenan (2013) has pointed that despite a change in name, the

continued presence of paraphilias in DSM-5 is unscientific and unnecessary. Points have been raised for and against 'Paraphilic Disorders' and 'Transvestic Disorder' in DSM 5. In DSM-5, paraphilias are not necessarily mental disorders (Gray, 2013). A paraphilia causing distress to the individual or harm/risk of harm to self or others is labeled as 'paraphilic disorder'. Specifiers, "in a controlled environment" and "in remission" have been added to further enhance the diagnostic criteria. The underlying paradox that has been highlighted and argued by authors is that, though the book establishes criteria and categories, aspects of sexuality go beyond such categorization (Friedman, 2013).

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