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Editorial

Male sexual dysfunction: A vast area that needs more exploration and action

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Since the advent of nature, males have been regarded as the primary source of increasing the progeny of their generation. In this process, males suffer from a substantial internal pressure of performance and societal pressure to perform well regarding sexual activity. Females have always been considered passive recipients of sexual activity. However, with changing times, these viewpoints have been grossly changed. Both males and females should be active participants in enduring sexual activity, as it gives sexual pleasure and satisfaction to both partners (Addis and Mahalik, 2003).

In this regard, males and females can suffer from sexual dysfunctions. The prevalence of male sexual dysfunction (MSD) is more reported when compared to female sexual dysfunction, mostly because of the stigma attached to discussing openly sexual issues in females with any specialist unless asked. Society, media, and peer groups play a significant role in fixing the mind set of the males that they have to be sexually active with more stamina to last long with any female (Sullivan et al., 2015). Usually, it is said that masculinity is more if the stamina and performance of a male are more. There are several myths about masculinity (as mentioned in Box 1).

Box 1: Myths regarding masculinity

1. A man's toughness is linked with his physical strength.
2. A man should be able to defend himself by fighting using physical force.
3. Males should take risks and should not engage in weak activities.
4. A male should be the sole or primary contributor to the family's finances.
5. Male should experience feelings of superiority over females.
6. Men who do not engage in certain behaviours (like excessive drinking, smoking, flirting, having multiple sexual affairs, etc.) are deemed feminine or non-masculine.
7. A male should always be ready for sex any time of the day and eager to acquire another sexual conquest.
8. The male should control the sexual activity and overpower the female partner.
9. Male should last long in bed, or else he is impotent.
10. Once failure in achieving erection means the male is impotent.

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Some myths become the basis of sexual dysfunctions in males, primarily psychogenic erectile dysfunction, performance anxiety, masturbation-related myths,dhat syndrome, and premature ejaculation (Fleming et al., 2014; Rösing et al., 2009). MSDs are had been included in the International Classification of Diseases (ICD system) and Diagnostic and Statistical Manual of Mental Disorders (DSM system). Over the years, there has been more acceptance

and recognition of MSDs worldwide. There are specialties dealing with MSDs specifically (such as sexual medicine, urologists, psychiatrists, and psychologists), and there are certificate courses and fellowships for sexual medicine.

In the current issue of this journal, the unique theme of MSDs was chosen, and ten articles highlighting many aspects of MSDs have been discussed in great detail. Box 2 highlights the main key findings of the articles in this issue on MSDs, irrespective of the sequence of articles in the journal.

Overall, this issue can be considered a resource

Box 2: Highlights of this issue on MSDs

1. A detailed assessment should be done using a comprehensive Dhat syndrome checklist questionnaire that must include clinical features and beliefs held by the patient and his peers/ relatives/society. The assessment helps carrying out focussed tailor-made psycho-education and cognitive behaviour therapy for patients with Dhat syndrome.
2. MSDs have co-morbid psychiatric disorders (anxiety, depression, substance use, etc.) and physical disorders (Hypertension, diabetes, cardiovascular disorders, etc.). Treatment of underlying co-morbid conditions is often the mainstay of treating MSDs, along with mediations and surgical implants as per the case.
3. Classification of Premature ejaculation (PE) and differences between lifelong, acquired variable and subjective PE.
4. Penile Dysmorphic Disorder (PDD) is having persistent preoccupation about having a small penis, leading to repeated checking behaviour and significant distress/impairment. Psychosexual psychotherapy with adequate psycho-education can be beneficial for patients with PDD.
5. Delusional disorders such as pathological/morbid jealousy have been linked with MSDs, which need careful history taking, assessment for alcohol dependence, drug abuse, intake of any medications, etc. Patients with MSDs and pathological jealousy can be at risk of self-harm or harm to their female partner and hence, needs appropriate pharmacological measures and treatment.
6. Non-pharmacological interventions for treating MSDs should be the cornerstone of the treatment of MSDs of psychological nature. Therapies such as couple sex therapy, mindfulness-based therapies, directed masturbation, kegel exercises, and lifestyle changes are some important non-pharmacological interventions with proven efficacy.
7. Regular yoga practice helps to maintain health and wellbeing. About nine main types of Yoga therapies have been discussed for managing MSDs.
8. Available policies across the globe on MSDs are from the American Urological Association and the American Academy of the Family Physicians; no such policies on sexual dysfunction in India yet exist.
9. Nurses' perspectives should be taken care of while teaching the nursing students how to take a sexual history as part of their clinical duties. It should be included in their standard nursing curriculum with practical clinic-based teaching by the supervisors/faculties. In addition, nurses need to be imparted education in sexuality and communication skills so that the knowledge learned can be put into practice.
10. Patients with erectile dysfunction need judicious investigations to rule out possible physical disorders that may attribute to erectile dysfunction. It helps the clinician in planning the management.

material on MSDs with various clinical aspects for practicing clinicians and young scholars. These articles also highlight the fact that although the area of MSDs has been well-explored, there are limited pharmacological measures and fewer numbers of specialists dealing with non-pharmacological interventions. There is limited literature on clinical practice guidelines across the world. Indian Psychiatric Society has recently published clinical practice guidelines for treating MSDs, and it can also be regarded as a document for training and learning (Avasthi et al., 2017).

However, considering the prevalence of MSDs in the general population, there is a needfora wake-up call for clinicians and researchers to take up active and collaborative efforts to improve the outcomes of patients with MSDs.

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