View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by IntechOpen

We are IntechOpen,
the world's leading publisher of
Open Access books
Built by scientists, for scientists

5,000
Open access books available

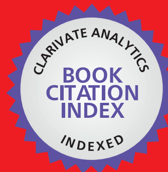
125,000
International authors and editors

140M
Downloads

154
Countries delivered to

Our authors are among the
TOP 1%
most cited scientists

12.2%
Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com

Chapter

Healthy Sexuality

J. Shivananda Manohar, Suman S. Rao, Abhinav Tandon and T.S. Sathyanarayana Rao

IntechOpen

Abstract

Sexuality is one of the basic instincts which determine the behavior of an individual. Though it is one of the basic drives, it is under researched. Sexuality has biological, psychological and social dimensions. Sexuality is a developmental phenomenon; from childhood to old age it has several implications. Exercise, sleep, nutrition, marriage, divorce and diseases have their own impact on sexuality. Sexuality is one of the key components in determining the quality of life. In this article, we have tried to explore various dimensions of sexuality.

Keywords: sexuality, healthy sexuality, psychological, social, fantasy

1. Introduction

The fundamental drive behind every thought, feeling and behavior is Sexuality. The way an individual projects himself psychologically and socially is defined by sexuality. Sexuality is the best example of mind body harmony. The world goes around sex. The basis of babies bonding, teens flirting, and adults having babies is sexuality. Our dressing sense, sense of humor and the way we talk is influenced by sexuality; sex defines who we are. Sexuality has been addressed in holy books of great religions.

Karl Pribram, a Neuropsychologist described four drives which motivates us to accomplish our goals. These drives included fighting, feeding, fleeing and sex. These drives are essential for physical and psychological health. The least understood as well as least studied drive is sex [1].

IntechOpen

2. History of scientific research in human sexuality

History of human sexuality is as ancient as human history. Some of the artifacts from ancient cultures are thought to be fertility totems. Kama Sutra (400 BC–200 BC), a Hindu epic describes about love, pleasure and desire; in fact about life in general. It is also a manual for sexual intercourse. Quran, Bible, Torah also have rules, advice and stories about sex.

Scientific research on sexuality started only around 150 years ago. Henry Havelock Ellis, an English physician used case study method to scientifically study sexuality. He published a seven volume book titled Psychology of Sex in which he tried to address different topics of sexuality which included arousal and masturbation. He emphasized that the sexuality of transgender is different from homosexuals. He advocated equal sexual rights for women and sex education at public schools [2].

Father of Psychiatry Sigmund Freud linked sex to health development. He recognized sexuality throughout the life span. Freud gave five stages of psychosexual development which includes oral, anal, phallic, latent and genital. According to Freud, each individual should pass all these stages. If the child's needs are unsatisfied or over-satisfied in these stages, either fixation or regression happens. This means child shows attachment to the previous stage, problems from that stage even persists into the adulthood. By keen observation of the individual behavior, one could recognize the psychosexual stage the adult had fixated or regressed [3, 4].

Alfred Kinsey, commonly referred to as Father of human sexuality research, believed most of the sexuality knowledge is guess work and there is lack of unbiased research. He had set a goal to interview around 100,000 people about sexual histories. Though he fell short of his goal, he could collect 18,000 interviews. Most of the contemporary scientists work on "behind closed door" behaviors were based on Kinsey's seminal work [5].

3. Sexual health

Sex describes means of biological reproduction. Sex also describes sexual organs both external as well as internal which defines individual to be male or female. According to the WHO, sexual health must be considered as "a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Human sexuality emerges in the body, but, like other human phenomena, it simultaneously unfolds in mental landscapes, social relations, and cultural spheres. Sexuality is closely linked to personal integrity, identity, body image, bonding, and social curiosity. Physiological and psychosocial determinants contribute significantly to sexual health."

Healthy sexuality is a dynamic equilibrium, whereby adversity is balanced by personal agency and available resources. Sexual health is not mere absence of sexual dysfunction, it is individual's ability to navigate through problems. Clinical and research experience indicate there is no correlation between subjective well-being and objective strains. Sexual health like any other health is contextual and multifactorial [6].

4. Gender and orientation

The term gender represents psychological and sociological representation of biological sex, which includes gender identity as well as gender role. Though Gender and sex are important aspects of person's identity, it does not tell anything about orientation. Gender orientation refers to persons' sexual attraction to others. Sexual attraction refers to persons' capacity to arouse interest in others. One must be comfortable with their chosen gender and sex role and accept themselves without shame, guilt or fear. Be able to maintain good relationships with both sexes, regardless of whether they are platonic or intimate [7].

5. Attitude towards sex

Associations between general health and sexuality are diverse and intricate, and the two can interact in both positive and negative ways. Culture significantly determines our attitude towards sex. Culture influences our beliefs about what is normal and what is deviant in sexuality. Based on cultural attitude towards sex;

DOI: http://dx.doi.org/10.5772/intechopen.92375

Cultures can be broadly classified into sex positive and sex negative cultures. Sex negative cultures which include India and Asian subcontinent believe that sex is for procreation while sex positive cultures which include western cultures consider sex beyond procreation. Sexual knowledge is usually acquired from someone in charge which may include parents, siblings, religious authorities, school, rumors from friends and mass media. One significant experience or stimulus that matches our fantasy would have long lasting impact on our attitude towards sexuality. Upbringing, witnessing parental interaction and intimacy shapes our life and beliefs [8].

6. Myths about sexuality

About female sexuality

- People think sex is dirty.
- Sex is sweet only during second decade of women's life.
- Sex during menstruation is harmful
- Bigger the breast-better sexuality
- Orgasm is a must in all sexual encounters
- Only vaginal and clitoral sex leads to orgasm
- A women's "no" convey "yes"
- Women never masturbate
- Sexual desire decrease dramatically after menopause

About Male Sexuality

- Erectile dysfunction is inevitable and incurable
- If a man does not get immediate erection he is not aroused
- If a man does not get aroused by mere site of partner he is not able to perform
- Masturbation leads to impotence
- Semen is a special cargo [9]

7. Sexual response cycle

Sexual response cycle which consists of desire, excitement and orgasm, have been classified by various authors in different ways. One of the simplest classifications is given by Kaplan, which is called DEOR model. D stands for desire, E stands for excitement, O stands for orgasm and R stands for resolution. Desire phase has biological, social and psychological component. Biological component

is the drive, sexual motivation is the psychological component and sexual wish is the social component. Excitement phase is characterized by penile tumescence in males and vaginal lubrication in female. Orgasm phase is characterized by heightening of sexual pleasure and resolution phase is characterized by disgorgement of blood from genital organs. Any impairment in any of these stages constitutes dysfunction [10].

8. Childhood sexuality

A strong emotional response is expected socially, whenever this topic is raised. Discussion on sexual behavior in children is obviously going to raise many eyebrows. Sexuality forms part of the personality and is a normal aspect of growing up. On one hand we resist talking to children regarding sexuality and on the other they get exposed to various sexual behaviors through the media. This makes it difficult for children to make right decisions during their adolescence. It is important to understand that the concept of normal sexual behavior in children is likely to vary with change in society's attitude. Research in the area of childhood sexual knowledge and behavior is scarce. Methodical issues are important during research as many of these rely on parental interviews leading to inconsistent results [11]. Sexual behavior is related to the age of the child, maternal education, family sexuality, family stress and violence, and hours spent in day care. For the clinician to understand the relationship between sexual abuse and sexual behaviors, it is important to understand normative childhood sexual behavior [12].

Much important psychosexual development occurs during childhood. Sexual development starts from birth and as the child develops the knowledge of gender identity during the first 2 years of life, genital exploration begins. Sexual knowledge is a child's basic under-standing of sexual acts. It varies with the child's age and the education level of the parents [13]. A child learns labeling of body parts including genitals and experiences genital pleasure during this time. They may use slang labels and touch other children's genitals or take off clothes in public. The physiology related to sexual arousal and orgasm is present in children at birth or even before that. Fetuses suck fingers/toes and penile erection or vaginal lubrication is seen in new born males and females. Sexual arousal is associated with REM (Rapid Eye Movement) sleep in infants and young children similar to adults. However infants and young children lack cognitive capacity to understand this autoerotic behavior which is more of "pleasure seeking" and is a reflex behavior. Sexual development occurs throughout early years but except for during puberty none of these sexual development milestones have been clearly defined [13].

During 3–5 years of sexual development, gender is permanently established and gender differences are clearly understood. The child has only little information regarding pregnancy and delivery. The child may use slangs for sexual parts of the body. During the preschool years (2–6 years) many overt sexual behaviors are seen. The child may masturbate for pleasure and experience orgasm either in public or private. Nudity is enjoyed and removing clothes in public may be noticed. Sex play with peers (mimicking dating behavior, using naughty words even if they do not understand the meaning) self-genital exploration and that of others, attempted intercourse may be noticed. Sitting close to others, touching breasts of mother or other females (in males), trying to view peer or adult nudity may be noticed. Masturbation is likely the most commonly observed sexual behavior in children. It has been noted in infants as young as 7 months, which is initially based on curiosity about one's body but gradually the pleasure obtained becomes a decisive act. Friedrich et al. [15] has reported that some of the behaviors like inserting objects

into vagina/ anus, putting mouth on sex parts and masturbating with objects may rarely be seen in children aged 2–12 years. Many parents may react negatively to this and punish their children for this behavior. Caregiving and nurturing provide the first sensual and erotic encounters to the new born and these experiences of physical affection are critical for healthy development of the child [14, 15].

During 6–12 years the child understands genital basis of gender. The child is able to label sex parts but uses slang. The child is able to understand sexual aspects of pregnancy; with increasing knowledge of sexual behavior, children may masturbate in private. Sex games with peers (like girlfriend/ boyfriend, truth or dare, playing family) role plays and sexual fantasy may be seen. Developmentally appropriate behavior includes touching their own genitals, trying to view another person's genitals or breasts and standing too close to other persons. Young children, who are yet to learn culturally appropriate distance, may rub against people, or casually touch their mother's breasts or father's genitals [16]. Sexual behaviors become more covert after 5 years of age [18]. Gundersen reported in 1981 that among preschool children aged 3–7 years sexual play was common including body exploration, genital manipulation and attempts at sexual intercourse. Kissing is part of normal sexual development. Exhibitionistic behavior in children, showing body parts to other children or adults, may be part of "playing doctor" [17]. About 85% of college women recalled engaging in sexual games during childhood in a study done by Lamb and Coakley in 1993. Over 40% reported fantasy sexual play including sexual stimulation, intercourse, rape, prostitution and strip shows. Over one third of the games involved genital fondling. These games are due to curiosity, however some children find them a source of sexual excitement. Coercive childhood sexual games are considered to be "normal" especially as boys and girls usually play together. Children may develop anxiety when parents or adults show affection towards each other. The frequency of childhood sexual behaviors when retrospectively recalled by adults may differ from the frequency reported by parents; recollection bias and personal acceptance of sexual behaviors as normal, differs. Educated mothers are likely to report more sexual behaviors in their children [18].

Sexual encounters between siblings are very similar to those seen with friends in terms of the activities occurring, motivations associated, age and perception of them being positive or negative. Finkelhor in 1981 reported that younger children are more likely to exhibit their genitals whereas older children are more likely to engage in attempted or actual intercourse. Younger children show a broad range of sexual behaviors which decrease with the growing age. Sex between siblings occurs much less frequently than between friends. Sexual encounters in siblings range from 9 to 13%. Lower reported rates of sexual encounters between siblings may be either due to age difference or biased retrospective reporting due to incest taboo. However frequency of coercive sexual encounters is almost similar to that with friends and girls are predominantly the victims. Young children are likely to explore their sexuality more at home than in structured and monitored settings among children. The results reported may not represent full range of sexual behaviors seen in children due to ethnic differences in subjects on which research is conducted. Women who have had sibling sexual experiences (positive or negative) are more likely to be sexually active as adults. Sexual sibling experiences before the age of 9 with large difference of age between siblings led to lower sexual self-esteem. Sexual experiences between friends or siblings suggest that normal sexual contact occurs on a continuum and differentiation between sexual play and abuse is not always clear [19].

The child gains knowledge of physical aspects of puberty by age 10. The child shows modesty and embarrassment and tries to hide sex games as well as masturbation from adults. Masturbation most likely increases before puberty especially

among boys. There are few physical changes associated with sexual development before the onset of puberty. Just before the teenage years body changes begin, menstruation starts in females and boys may experience wet dreams; fantasizing about sex, interest in media sex, using sexual language with peers is observed [19].

9. Adolescent sexuality

Adolescent sexuality has received much attention in comparison to childhood sexuality. Teens are sexually active but they are hardly prepared for developing responsible sexual behavior. Adolescents reach physical maturity but they are cognitively immature to handle it. A teenager's primary source of exposure to sexuality related information is his or her peer group. Family dynamics may not be strong enough to guide the teenagers in developing healthy and non-risky sexual behavior [20].

Puberty is the time when sexual development can be much clearly delineated especially the physical changes. There is variation in age at which puberty begins although the onset is typically 18–24 months earlier when compared to boys [21]. The average age of first ejaculation in boys is 14 years (range 14–16 years). However, girls' breast development begins between 8 and 13 years of age; menarche starts at an average age of 13 years (age range 10–16.5 years). Adolescents acquire knowledge about sexual intercourse, contraception and sexually transmitted diseases. Adolescents get fondness for dating, kissing and petting; sexual fantasies are common. The issue of greatest concern for parents has been the age at which teens engage in sexual intercourse. The average age of first sexual contact has decreased rapidly. They may make sexual contacts including mutual masturbation and first sexual intercourse may occur in 75% by the age of 18 years. However in India as per National Family Health Survey (NFHS), males are mostly likely to have their first sexual intercourse between 20 and 24 years, whereas in females, the peak age at first sex is lower between 15 and 19 years [5].

Early onset of sexual intercourse affects the psychosocial development. Early onset sexual activity has been linked to delinquent behavior. Chances of unintended pregnancy are higher in teens who engage in sexual activity earlier. Teenage parents are at an economic disadvantage and are more likely to drop out of school. Authoritarian parents, poor communication regarding sexuality and having older siblings who are sexually active can facilitate early sexual activity. Rutter and Rutter refer to early sexual activity as a "turning point" which can change the course of a teenager's life. Understanding early sexual activity can help in planning intervention programs. Other factors which are associated with adolescents who are sexually active include: (1) less educated mother, (2) lower educational expectation, (3) presence of a boyfriend or girlfriend, and (4) higher age. Adolescents are at cross roads as far as sexuality is concerned. A wrong decision can have strong and negative economic and social consequences for the society at large and for the individual in particular. Sex education is an important area which needs to be taken seriously particularly for the adolescent age group [22, 23].

10. Other factors influencing sexuality

10.1 Nutrition and sexuality

Mediterranean diet which includes fruits, nuts, legumes, monounsaturated fats from olive oils, vegetables and whole grains is gaining popularity in the last few

decades. Studies have shown that these groups of foods improve or at least diminish the progression of sexual dysfunctions. Paleolithic diet which is an ancestral diet, before agricultural revolution is gaining more attention in the recent past. Paleo diet which includes lean meat, fruits, legume, plant based foods, restricted consumption of dairy, salt and sugar similar to Mediterranean diet have shown to be beneficial, but well-designed studies are not available. Vegetarian or vegan diet which can be classified as pesco-diet (absence of all animal products except fish), lacto-ovo-vegetarian diet (absence of all animal products except egg and dairy products), ovo-vegetarian diet (absence of all animal products except egg) and vegan-diet (absence of all animal products). Vegetarian diet has shown to reduce morbidity due to vascular causes, which in turn may help in healthy sexual functioning. Vegetarian or vegan diet may cause protein and vitamin B12 deficiency which can be prevented through careful monitoring and supplementation [24].

10.2 Intelligence and sexuality

There is evidence for correlation between intelligence and the age at the first sexual contact. There is inverse correlation between intelligence quotient and the age at first sexual intercourse. Though there is evidence that more intelligent people have more sexual desire, but the frequency of intercourse is less. Emotional intelligence plays a key role in marital relationship. Knowledge, self-competence, secured attachment, emotional processing and self-compassion were few aspects which determined good marital satisfaction [25].

10.3 Job, vocation and sexuality

Job stressors have significant impact on sexuality. It majorly depends upon the role the individual is having in the job. It depends on working ability of individual for that job. Work ability includes physiological and psychological ability of the individual to cope with the specific type of the job. The managerial and organizational support also played important role in job stress. Job stress significantly affected desire, arousal and orgasm phases of sexual response cycle [26].

10.4 Exercise and sexuality

Exercise releases hormones called endorphins, which has a feel good component as well as analgesic effects. Exercise may be acute as well as chronic exercise. Acute exercise increases metabolic rate, causes muscle activation and increases blood flow. Chronic exercise causes long lasting adaptation and improves performance. Acute exercise improves physiological sexual arousal through increasing sympathetic nervous system activity and endocrine factors. Chronic exercise increases sexual satisfaction by maintaining autonomic flexibility. Autonomic flexibility helps in maintaining cardiovascular health as well mood. Chronic exercise also gives positive body image which in turn gives sexual well-being. A couple of small studies have shown the effectiveness of exercise as intervention for dysfunctions [27].

10.5 Sleep

Adequate sleep is essential for normal sexual activity. Quality of sleep has significant impact on various phases of sexual response cycle. Desire is a motivational state which drives the individual to search for sexual activity, while arousal prepares individual physically and psychologically for sexual activity. Rapid eye

movement sleep (REM) deprivation increases unstimulated sexual arousal but does not have any effect on desire. Sleep deprivation can also have impact on endocrine factors [28].

10.6 Fantasy

Fantasy both during masturbation as well as sexual intercourse enhances sexual responsiveness dramatically. Sometimes it may be perplexing for some individuals while having sex with someone. Sexual fantasies indicate person's sexual values that may not be overt in their behavior. Source of fantasies is not always obvious, it may be something one has read or seen or may be totally imaginary. Sexual fantasies can arouse sexual excitation and vice versa is also true, sexual excitation arouses sexual fantasy. Women and men who fantasize are more likely to experience orgasm during intercourse. Individuals who report frequent sexual fantasies are less likely to develop sexual dysfunctions. Themes of sexual fantasies are varied, imagining of having sexual intercourse with someone whom you love, having sexual encounters with strangers, having multiple sexual partners simultaneously, forcing someone to have sex or you being forced, being found sexually irresistible by someone, having sex with someone famous and many more. There are gender differences in sexual fantasies, men have more sexual fantasies than women. Even the content also varies, men fantasize an active role in sexual encounter while women more a passive role. Women fantasies' have more of emotional or romantic theme, revolves around current or previous partner, thoughts and feelings about love and devotion. Men usually fantasize impersonal sexual behavior, implicit visual sexual imagery, specific parts of partner's body, group sexual activity and focus on specific sexual activity [29].

10.7 Masturbation

Masturbation is genital self-stimulation with some anticipation of rewarding erotic feelings, though it is not a necessity that to achieve orgasm genital stimulation is required, some women achieve orgasm even with breast stimulation. Autoeroticism conveys a different meaning, it involves self-stimulation which may or may not involve external physical stimulation. It refers to personal sexual perception and feelings.

There are lots of myths and misconceptions about masturbation. Lot of cultural and religious myths surrounds masturbation. There is a misconception that masturbation is a dismal alternative to sexual intercourse. Professor NN Wig, an Indian psychiatrist described a syndrome called "Dhat Syndrome" which is characterized by "undue concern about debilitating effects of passage of semen". It has been included in International classification of disease (ICD 10) both under neurotic disorder and culture specific disorder. There is cultural myth that semen is made up of "Dhat" (Elixir), when individual loses semen either through masturbation or wet dreams, they start feeling apprehensive about loss of vitality. Though this syndrome is prevalent worldwide, it is more common in Indian subcontinent.

There are gender differences in masturbation. The frequency of masturbation is more in men when compared to women. Studies show that individuals who report masturbating more frequently, are more open minded about sexuality and have more satisfactory sexual relationship with the partners.

People who believe masturbation as second best mode of sexual expression, get perplexed finding a place for masturbation in relationship. Age, illness, boredom and interpersonal issues influence frequency and intensity of sexual relationship among couples. Masturbation is not always problematic in relationship. Men and

women view masturbation differently in a relationship. Men view it as a supplement to pent up sexual energy, while women view masturbation as a substitutive role.

Vibrators and Dildos are not synonyms. Dildos are erect "penis-like" objects which may or may not vibrate. Though vibrators are not substitutes for nurturance, love and sexual attachment, it helps to explore oneself about their sexual response cycle, remove inhibitions and enhance knowledge about themselves [30].

10.8 Marriage

Religious prohibitions prevalent in the society results in restrictive upbringing. Effect of mass media leads to unrealistic sexual expectations. This leads to a conflict, which in turn causes guilt. Lack of communication, exhaustion and unusual expectation can lead to sexual problems during honeymoon. Interaction patterns among couples play an important role in sexual relationship. Hostility, power struggle and conflicts are few of the destructive interaction patterns. Sex at times can be used as a weapon where one partner may forego sexual pleasure rather than give satisfaction to the other. Emotions like anger, anxiety can act as antierotic stimuli [31].

10.9 Pregnancy

Pregnancy and childbirth are both the part of woman's sexual life. Positive experiences of female sexual functioning (as measured by dimensions including sexual desire, arousal, and satisfaction) were negatively correlated with the experience of stress, anxiety, and depression, and positively correlated with general quality of life during pregnancy. Moreover, experiencing fulfilling sexual experiences during pregnancy has been shown to promote well-being and maintain partner-intimacy, while low sexual functioning during pregnancy has been linked to poor body image [32].

Changes occurring in every trimester of pregnancy have significant influence on the sexual behaviors. A number of physiological and psychological changes occur in pregnancy with surge of hormones like estrogen, progesterone and prolactin that ultimately affect not only the frequency but also the quality and the outcome of sexual intercourse. Duration of coitus decreases over the length of pregnancy due to unfounded fears that intercourse may hurt the health of mother or baby or cause premature labor [33].

Sexual satisfaction correlates with the feeling of happiness resulting from being pregnant. Pregnant women prefer the following types of sexual activity: non-genital fondling, stimulation of the clitoris, vagina and breasts, oral and anal stimulation and masturbation. However females and their partners are under informed on sexual life in pregnancy [34]. Many authors emphasize, that the pregnancy is a stimulus for partners to search for ways to maintain mutual emotional bond, close physical affinity and satisfy sexual needs not necessarily finished with an intercourse. As the pregnancy progresses patients report frequent dyspareunia, decline in orgasm and poor self-image. Anatomical changes during pregnancy compel couples to attempt abnormal uncomfortable positions. For a number of couples, pregnancy becomes a stimulus to search for new ways of pleasing each other in love play, which does not necessarily culminates with intercourse.

Mode of delivery also impacts sexual functioning. Patients who delivered vaginally even after 6 months postpartum may experience dysfunction in all phases of sexual cycle compared to women who deliver by caesarian section. Women who deliver vaginally have weakened pelvic floor muscles and may also have discomfort due to rectocele and cystocele. Kegel exercises are advised early in postpartum

period to strengthen pelvic floor muscles. The eventual benefits of cesarean delivery on sexual function do not last longer than a few months after childbirth.

The research makes it evident, that experiencing sexual satisfaction by pregnant women improves their self-esteem, facilitates mutual relationship between partners and tightens the marital bond. There are various factors that may be influencing the lack of dialog initiated by prenatal health-care providers with their pregnant patients and partners regarding sexual activity during pregnancy. For one, our society at large often deemphasizes the sexuality of pregnant women, finding the discussion of sex during pregnancy to be a taboo. Moreover, Hinchcliff et al. noted that prenatal care providers may avoid discussing sexuality proactively as it is a complex issue and requires sensitivity [35].

11. Marriage after living together

After marriage, couple's start taking one another for granted. At times when marriages happen due to social pressure, couple may start taking one another for granted after marriage. When marriage happens after a period of open relationship due to social pressure, they may feel trapped [36].

11.1 Divorce

The rates of divorce have increased in all age groups in the recent times. Life after divorce requires emotional, social and sexual adjustment. Individuals spending most of their lives in wedlock, finds it difficult to adjust to singlehood. Many people are so adjusted to think their adult life as couple, they take time to get used to singlehood. It is confusing and perplexing for people to learn divorced role. Divorce leads to decline in life style in some people while in others it may lead to sexual liberty. Spiritual values and Literacy levels determines the number and frequency of partners [36].

11.2 Remarriage

Multitude of factors influences the likelihood of remarriage. Younger the person, there is more probability of remarriage. About 89% who separate under the age of 25 remarry, it decreases to 31% after 40 years. Shorter the duration of first marriage, there are more chances of remarriage. Other factors are the age at first marriage, younger a person at first marriage, more probability of remarriage [36].

11.3 Families

The attitude of parents about sexuality has a significant impact on sexual well-being. Attitude of parents as well as siblings about nudity, masturbation, willingness to discuss about sex and homosexuality all contributes to the development of sexuality of an individual. Relationship of the parents with the individual as well as the partner also influences sexuality. Distorted intrafamilial relationship, lack of discipline, overcrowding, lack of warmth, unusual helplessness and withdrawal from society may lead to certain deviant sexual behavior [36].

12. Sexuality in geriatric population

Sexuality is an important aspect in Geriatric population. Elderly individuals look sexuality as a means of expression of passion, love, admiration and loyalty.

Furthermore sexuality acts as a means of affirming physical functioning, sense of identity and self-confidence. Though desire may remain the same, there may be alterations in other phases of sexual response cycle [9].

12.1 Sexuality and spirituality

The popular belief is that sexuality and spirituality exists in opposition, but in reality spirituality and sexuality go hand in hand. If we look at different geographical areas, there is lot of literature in Chinese Taoist tradition about practices bringing Yin (Feminine) and Yang (Masculine) in harmony. In Indian literature there is mention about energy generated in the pelvic region moving upwards through chakras to the crown, where one enters the cosmic orgasm generated eternally by union of Shakti and Shiva. In psychotherapeutic perspective, people believe that sexuality is something sin and it should be removed or cured. What spirituality should do is to help these people move from the belief that sexuality is sin to enjoying it as an integrated energy for passionate living [37].

12.2 Medical illness and sexuality

Looking at sexuality from the biological perspective, neurological, vascular and endocrine systems contribute significantly for normal sexual functioning. Neurological disorders like stroke, epilepsy, multiple sclerosis, traumatic brain injury and spinal cord disorders lead to sexual problems. Endocrine disorders like androgen deficiency, hyperprolactinemia, diabetes mellitus can produce sexual dysfunctions. Vascular disorders like hypertension and atherosclerosis, prostatic illness, carcinomas all can lead to sexual dysfunctions. Prevalence of sexual dysfunctions among these psychosomatic disorders is around 20–70%. Sex and intimacy are likely to be powerful providers of salutogenesis in both the chronically and critically ill patients. Sexual encounters can serve as a refuge in an otherwise chaotic and turbulent situation, and intimate relations might constitute engines of meaningfulness and coherence in a context of meaninglessness and incoherence that so often dominate the everyday life of patients with chronic illnesses [38].

12.3 Psychiatric illness and sexuality

Substance use disorders have varying effects on sexual functions. Alcohol at a smaller quantity may have some stimulatory effect, at higher quantity decreases both desire as well arousal through its effect on testosterone. Cannabis causes detrimental effect on initiation as well as maintenance of erection. Cannabis historically has aphrodisiac effect, but current evidence shows mixed results. Long term use of cannabis has detrimental effect on testosterone. Similarly opioids delay ejaculation in men and improve vaginismus in women, but long term use decreases testosterone as well as lutenising hormone.

The rates of sexual dysfunction in people suffering from schizophrenia, mood disorders, personality disorders, anxiety disorders and eating disorders is very high. In these disorders illness itself can have effect various stages of sexual response cycle, and also medication used can have adverse effects on sexuality. One of the major psychiatric disorder schizophrenia has negative symptoms like blunted affect, anhedonia and avolition itself causes impedance in enjoying sexual life. Loss of libido is one of the symptoms in major depressive disorder. Anxiety disorders are usually associated with premature ejaculation. Mania is associated with increased libido during the episode, at times disinhibited sexual behavior leads to high risk sexual behavior [39].

13. Conclusion

Sexuality is one of the key factors for wellbeing. There are more myths than adequate knowledge about sexuality. It plays an important role in molding the personality during childhood and adolescence, while it contributes to self-esteem throughout life. Various bio psychosocial factors may influence sexuality. It is one area where research is lacking. In this chapter we have tried to explore some of the key areas influencing sexuality. More research and evidence based data is needed in this area.

Author details

J. Shivananda Manohar, Suman S. Rao, Abhinav Tandon
and T.S. Sathyanarayana Rao*
Department of Psychiatry, JSS Medical College and Hospital, JSS Academy of Higher Education and Research, Mysore, India

*Address all correspondence to: tssrao19@gmail.com

© 2020 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/3.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

References

[1] Malacane M, Beckmeyer J. A review of parent-based barriers to parent–adolescent communication about sex and sexuality: Implications for sex and family educators. American Journal of Sexuality Education. 2016;**11**:27-40

[2] Antón SC, Swisher CC III. Early dispersals of homo from Africa. Annual Review of Anthropology. 2004;**33**:271-296

[3] Freud S. The Ego and the Id. New York: WW Norton & Co.; 1923

[4] Freud S. Three Essays on the Theory of Sexuality. New York: Basic Books; 1905

[5] Kinsey AC, Pomeroy WB, Martin CE. Sexual Behavior in the Human Male. Philadelphia: Saunders; 1948

[6] Marshall DS, Suggs RC. Human Sexual Behavior: Variations in the Ethnographic Spectrum. New York: Basic Books; 1971

[7] Avasthi A, Rao TSS, Grover S, Biswas P, Kumar S. Clinical practice guidelines for management of sexual dysfuntions. In: Gautham S, Avasthi A, editors. Clinical Practice Guidelines for Management of Substance Abuse Disorders, Sexual Dysfunctions and Sleep Disorders. New Delhi: Indian Psychiatric Society; 2006. p. 144

[8] Bhugra D, DeSilva P. Sexual dysfunction across cultures. International Review of Psychiatry. 1993;**5**(2-3):243-252

[9] Sathyanarayana Rao TS, Tandon A, Manohar S, Mathur S. Clinical practice guidelines for management of sexual disorders in elderly. Indian Journal of Psychiatry. 2018;**60**(Suppl 3):S397-S409

[10] Shivanand MJ, Hrishikesh Solunke K, Reddy S, Rajesh R. Sexual disorders in Asians. Journal of Psychosexual Health. 2019;**1**(3):222-226

[11] Gordon BN, Schroeder CS. Normal sexual development. In: Sexuality: A Developmental Approach to Problems. USA: Springer; 1995. pp. 162-384

[12] Friedrich WN, Fisher J, Broughton D, Houston M, Shafran CR. Normative sexual behavior in children: A contemporary sample. Pediatrics. 1998;**101**(4):E9

[13] Gordon BN, Schroeder CS, Abrams JM. Age differences in children's knowledge of sexuality. Journal of Clinical Child Psychology. 1991;**19**:33-43

[14] Finkelhor D. Sex between siblings: Sex play, incest, and aggression. In: Constantine LL, Martinson FM, editors. Children and Sex: New Findings, New Perspectives. Boston: Little, Brown; 1981. pp. 129-149

[15] Friedrich WN, Grambsch P, Broughton D, Kuiper J, Beilke RL. Normative sexual behavior in children. Pediatrics. 1991;**88**(3):456-464

[16] Kellogg ND. Sexual behaviors in children: Evaluation and management. American Family Physician. 2010;**82**(10):1233-1238

[17] Gundersen BH, Melas PS, Skar JE. Sexual behavior of preschool children. In: Constantine LL, Martinson FM, editors. Children and Sex: New Findings, New Perspectives. Boston: Little, Brown; 1981. pp. 45-72

[18] Lamb S, Coakley M. "Normal" childhood sexual play and games: Differentiating play from abuse. Child Abuse & Neglect. 1993;**17**:515-526

[19] Miragoli S, Camisasca E, Di Blasio P. Child sexual behaviors in school context: Age and gender

differences. Journal of Child Sexual Abuse. 2017;**26**(2):213-231. DOI: 10.1080/10538712.2017.1280866

[20] Grant LM, Demetriou E. Adolescent sexuality. Pediatric Clinics of North America. 1988;**35**(6):1271-1289

[21] Rutter M. Normal psychosexual development. Journal of Child Psychology and Psychiatry. 1970;**11**:259-283

[22] Donovan C. Adolescent sexuality. BMJ. 1990;**300**(6731):1026-1027

[23] Rutter M, Rutter M. Developing Minds: Challenge and Continuity across the Life Span. New York: Basic Books; 1993

[24] La J, Roberts NH, Yafi FA. Diet and men's sexual health. Sexual Medicine Reviews. 2018;**6**:54-68

[25] Garrison M, Rodgers JL. Casting doubt on the causal link between intelligence and age at first intercourse: A cross-generational sibling comparison design using the NLSY. Intelligence. 2016;**59**:139-156

[26] Mokarami H, Toderi S, Pordanjani TR, Taban E. Role of psychosocial job stressors on sexual function of male nurses: The mediator role of work ability. American Journal of Men's Health. 2018;**12**(6):1908-1915

[27] Stanton AM, Handy AB, Meston CM. The effects of exercise on sexual function in women. Sexual Medicine Reviews. 2018;**6**(4):548-557

[28] Costa R, Costa D, Pestana J. Subjective sleep quality, unstimulated sexual arousal, and sexual frequency. Sleep Science. 2017;**10**(4):147-153

[29] Comfort A. The Joy of Sex. New York: Crown; 1971

[30] Westheimer R k, Lopater S. Human Sexuality: A Psychosocial Perspective. 2nd ed. New York: Lippincot, Williams and Wilkins; 2004. pp. 254-281

[31] Kinsey AC, Pomeroy WB, Martin CE. Sexual Behavior in Human Female. Philladelphia: Saunders; 1953

[32] Antonini G, Busetto GM, De Berardinis E, Giovannone R, Vicini P, Del Giudice F, et al. Minimally invasive infrapubic inflatable penile prosthesis implant for erectile dysfunction: Evaluation of efficacy, satisfaction profile and complications. International Journal of Impotence Research. 2016;**28**(1):4-8

[33] Carteiro DM, Sousa LM, Caldeira SM. Clinical indicators of sexual dysfunction in pregnant women: Integrative literature review. Revista Brasileira de Enfermagem. 2016;**69**(1):165-173

[34] Abouzari-Gazafroodi K, Najafi F, Kazemnejad E, Rahnama P, Montazeri A. Demographic and obstetric factors affecting women's sexual functioning during pregnancy. Reproductive Health. 2015;**12**:72

[35] Faisal-Cury A, Huang H, Chan Y-F, Menezes PR. The relationship between depressive/anxiety symptoms during pregnancy/postpartum and sexual life decline after delivery. The Journal of Sexual Medicine. 2013;**10**(5):1343-1349

[36] Bumpass L, Sweet J, Martin TC. Changing patterns of remarriage. Journal of Marriage and the Family. 1990;**52**:747-756

[37] Paloutzian RF, Park CL. Handbook of the Psychology of Religion and Spirituality. New York/London: The Guilford Press; 2005

[38] Shivananda MJ, Rao TS. Sexual dysfunction in medical practice.

Current Opinion in Psychiatry. 2016;**29**(6):331-335

[39] Sathyanarayana Rao TS, Manohar S, Spurthi TN. Psychiatric disorders and treatment emergent sexual dysfunctions. Indian Journal of Psychiatry. 2018;**60**(Suppl S1):46

IntechOpen

IntechOpen