ROLE OF SATVAVAJAYA CHIKITSA IN THE MANAGEMENT OF PSYCHO-SEXUAL DISORDERS

Ashish Patel¹, Radhey Shyam Tiwari², K.H.H.V.S.S. Narasimha Murthy³ and J. S. Tripathi⁴

¹Junior Resident, ²Senior Resident, ³Assistant Professor and ⁴Professor & In-charge, Division of Manas Chikitsa (Psychosomatic Medicine & Neuropsychiatry) Department of Kayachikitsa, Faculty of Ayurveda, Institute of Medical Sciences, Banaras Hindu University, Varanasi-221 005, Corresponding Author: Ashish Patel

Abstract: Sexual dysfunction is defined as the chronic inability to respond sexually in a satisfying way the one finds, the word chronic being a consistent long term inability to respond. It does not denote mere transient lack of interest or inability to respond sexually due to exhaustion, excess alcohol intake, anger etc (Nadelson 1978, La Piccolo 1980) Several reports reveals that psychological disturbance such as stress, anxiety, guilt, depression, low self-esteem, conflict between partners, performance anxiety etc. cause 10% to 20% of ED cases. Other possible causes include organic pathological condition damage to nerves, arteries, smooth muscle and fibrous tissue, disease-diabetes mellitus, hypertension, chronic alcoholism, multiple sclerosis, smoking etc. In Ayurveda vajikaran chikitsa is described for treatment of sexual dysfunctions. Vajikaran is an important treatment modality as per Ayurveda and proposed benefits are manifold including increased sexual capacity, improving health of future progeny as well as in treatment of many common sexual disorders like infertility, erectile dysfunction and premature ejaculation. Vajikarana therapy is not merely the usage of medicinal plants but is also includes non medicinal measures which comes under Satavavajaya chikitsa. Satavavajaya Chikitsa in Ayurveda refers to one of the three broad based approaches to therapy. It is specifically indicated for the treatment of mental illnesses such as attavanivesh, cittavsada, chitodvega and manus Klaibya.

Key word: Klaibya, Sexual Dysfunction, Satavavajaya, Vajikarana.

Introduction: Sexuality has fascinated the people in all walks of life from ancient times to present. Healthy sexual functioning plays pivotal role in maintaining the happiness and harmony in marital life. It is most essential thing to fulfil the procreation, recreational and relational aspects of life. It provides a media to express love, which is the base for all sort of creative activities. The absence of which hampers the marital relationship leaving to frustration sometime ends into divorce and causes inefficiency in performing the routine duties. The male sexual dysfunction includes all sorts of disturbances of coital performance and sexual congress in male. Among the various phases of sexual response, the most essential is the achieving of normal erection with sufficient rigidity for penetrative intercourse, the absence of which ends into failure and dissatisfaction. This condition has been elaborately described as ‘Klaibya’ in Ayurvedic classics and 'Erectile dysfunction' in modern texts.

Klaibya or erectile dysfunction (ED) is a very common male sex dysfunction which affects majority of men sometimes in their lives. It has been reported to affect as many as 152 million men worldwide. Over half of men referred to sexual dysfunction clinics complain erectile dysfunctions. Several reports reveals that psychological disturbance such as stress, anxiety, guilt, depression, low self-esteem, conflict between partners, performance anxiety etc. cause 10% to 20% of ED cases. Other possible causes include organic pathological condition damage to nerves, arteries, smooth muscle and fibrous tissue, disease-diabetes mellitus, hypertension, chronic alcoholism, multiple sclerosis, smoking etc.

The comparative study of Ayurvedic and modern literature revealed that term Klaibya represents all the feature of diagnostic entity sexual dysfunction ED. If use sees the sexual dysfunction in male in our ancient literature there is much comprehensive description available in...
this respect. The male sexual dysfunction is mainly enlightened in the form of Klaibya and the person is called ‘Kleeba’ Shanda & Napunsaka are the synonyms to Kleeba.

The disease Klaibya is a multifactorial condition, mainly involving bahudosavasthas a whole and sukra-asaya in specific, manodosa, and sukravaha-strudusti. It is commonly observed in the society, owing to the feeling of inadequacy less commonly reported, even though Masters and Johnson reported a fear of impotence in all men above 40years. Considering the grave nature of the disease though it does not reduces the life expectancy.

Vajikarana has been described specially to improve the sexual health to enhance the status of sukr and to please the mind. Considering the various factors involved in the pathogenesis of Klaibya, particularly to overcome the bahudosavastha, specially the aggravated monasodasa and sukradusti.

**Sexual Dysfunction (SD):** It is defined as the chronic inability to respond sexually in a satisfying way the one finds, the word chronic being a consistent long term inability to respond. It does not denote mere transient lack of interest or inability to respond sexually due to exhaustion, excess alcohol intake, anger etc (Nadelson 1978, La Piccolo 1980). The essential feature of sexual dysfunction (SD) is inhibition in one or more of the phases of sexual response cycle (includes four phase Viz Desire, excitement, orgasm and resolution) including disturbances in the subjective sense of pleasure or desire or disturbance in the objective performance (DSM-IV) [1]. A special group of disorders of coital performance and sexual congress in male in total either primary or secondary is called as Male Sexual Dysfunction (Greenberg and Sands et.al). Seven major categories of sexual dysfunction are listed in DSM-IV in both male and female: 1. Sexual desire disorders. 2. Sexual arousal disorders. 3. Orgasm disorders. 4. Sexual pain disorders. 5. Sexual dysfunction due to a general medical condition. 6. Substance-induced sexual dysfunction. 7. Sexual dysfunction not otherwise specified. Here only male sexual dysfunctions are considered.

1. **Male Sexual Desire Disorders:** It is divided into two classes: (a) Hypoactive sexual desire disorders: It is characterised by a deficiency or the absence of sexual fantasies and desire for sexual activity. (b) Sexual aversion disorder: It is characterised by an aversion to and avoidance of genital sexual contact with a female partner. The former condition is more common than the latter.

2. **Male Sexual Arousal Disorder:** It is commonly called as ‘Male erectile disorder’ or ‘erectile dysfunction’ - characterised by the recurrent and persistent partial or complete failure to attain or maintain an erection until the completion of the sexual act. As erectile dysfunction refers to the ‘Klaibya’ the topic of present work, it will be explained elaborately in the subsequent chapters.

3. **Male Orgasm Disorders:** In this condition the man achieves climax during coitus with great difficulty, if at all. A man suffers from lifelong orgasmic disorder if he has never been able to ejaculate during coitus. The disorder is diagnosed as acquired if it develops after previous normal functioning. Some workers suggest that a differentiation should be made between orgasm and ejaculation. Certainly, inhibited orgasm must be differentiated from retrograde ejaculation in which ejaculation occurs but the seminal fluid passes backward into the bladder, where as in ‘premature ejaculation’ the man recurrently achieves orgasm and ejaculation before he wishes to do so. There is no definite time frame within which to define the dysfunction. The diagnosis is made when the man regularly ejaculates before or immediately after entering the vagina or following minimal sexual stimulation.

4. **Male Sexual Pain Disorders:** It is characterised by recurrent and persistent genital pain in man during intercourse and it is also known as Dyspareunia.

5. **Sexual Dysfunction due to a General Medical Condition:** The category covers sexual dysfunction that results in marked distress and interpersonal difficulty when there is evidence from the history, the physical examination, or the laboratory findings of a general medical condition judged to be casually related to the sexual dysfunction.

6. **Substance-induced Sexual Dysfunction:** Almost every pharmacological agent, particularly those used in psychiatry has been associated with an effect on sexuality. In men those effects include decreased sex drive, erectile failure, decreased volume of ejaculate and delayed or retrograde ejaculation.

7. **Sexual Dysfunction not Otherwise Specified:** This category includes sexual dysfunctions that do not meet criteria for any specific sexual dysfunction. Examples include person who experience the physiological
components of sexual excitement and orgasm but report no erotic sensation or even anaesthesia, and the male experience of orgasm with a flaccid penis. In Ayurvedic classic male sexual dysfunctions are very broadly described under the heading of Klaibya and Napumsaka. Acharya Caraka vividly described the condition Klaibya as follows:

संकल्पणमध्ये निख्या ग्रामसंधृवर्त्य धर्मतिः।
न गाती निर्माणसिद्धां कदाचिदाश्रयसि व यदि
क्षयमार्केवर्षणमागमार्कर्षणम संक्लं वाचितः।
म्याशाक्षर निर्मीः न्यायतें व स्मरायतें लक्षणम्।।

(Ca. Ci. 30/155-157)

“A person’s persistent inability to perform sexual intercourse with the beloved, willing and submissive partner, though having persistent desire due to the ‘lack of erection’ and if at all attempted ends into failure without ejaculation due to ‘flaccidity of penis’ associated with breathlessness and perspiration, is considered as Klaibya. From the foregoing description, it is clear that lack of erection and lack of rigidity are the cardinal features of Klaibya. Hence, it is more appropriate to use the term “Erectile dysfunction” or male erectile disorder in particular for describing Klaibya rather using the broad term sexual dysfunction. The other conditions coming under the heading of sexual dysfunction like desire disorders, orgasm disorders, ejaculatory disorders have been separately mentioned by using specific terms and in different conditions. Hence it will be more appropriate to use those terms and conditions to describe these specific sexual dysfunctions.

The terms like Aharsa and Apraharsa have been used along with Klaibya while describing the Sukrapradosaja Vikara by Acharya Caraka and Sushruta respectively. It indicates that Aharsa and Klaibya are not one and the same, but they come under the purview of sexual dysfunction as they are mentioned under SukrapradosajaVikara. They denote two different conditions which can be made clear by going through the interpretations given by different commentators. 

अहर्षणम च सायमिनिः प्रजीत्यां ज्ञेयामात्रतिः।
सुक्रार्धम तस्य बुद्धमस्व अर्धमनवस्याः।।

(Ca. Su. 28/18 Ck) i.e. though there is erection but unable to perform sexual intercourse.

अहर्षनार्थ विनानसामायानायां दाप्त्रसिद्धात्रिः।
सुक्रार्धम रोगायुक्तसंयोगायाम्यात्रिः।।

Means lack of desire for female partner.

आहर्षन वातावरणस्यस्यसिद्धात्रिः।
सुक्रार्धम अवस्थायाम्यात्रिः।।

Means lack of orgasm or pleasure.

Hence, Aharsa and Apraharsa are more appropriate terms to describe maledesire disorders and male orgasm disorders respectively. Further the condition Sukragata Vata is more appropriate to describe male ejaculatory disorders, as both early and delayed ejaculations are mentioned as its cardinal features.

सिस्तः मुद्यातिः क्षमासि धर्मतु।।
(Ca. Ci. 18/34)

### Classification of Klaibya

According to various classic of ayurveda many type of Klaibya are described (table) which are mentioned following

<table>
<thead>
<tr>
<th>Caraka&quot;</th>
<th>Susruta&quot;</th>
<th>Bhavaprakasa&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bijopaghataja</td>
<td>1 Manasa</td>
<td>1 Manasa</td>
</tr>
<tr>
<td>2 Dhvajabhanga</td>
<td>2 Saumnadhatusayaja</td>
<td>2 Pitaja</td>
</tr>
<tr>
<td>3 Sakrakshaya</td>
<td>3 Sukrakshaya</td>
<td>3 Sukrakshaya</td>
</tr>
<tr>
<td>4 Jarasambhavaya</td>
<td>4 Pumatsava-Upaghataya</td>
<td>4 Medhroga</td>
</tr>
<tr>
<td>5 Sahaja</td>
<td>5 Virya vahini</td>
<td>5</td>
</tr>
<tr>
<td>6 Shirasukranimittajita</td>
<td>6 Sukrastambhanimitattajasisirachedi</td>
<td></td>
</tr>
<tr>
<td>7 Sahaja</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

In addition to these, various types of Napumsaka are mentioned in the classical texts. Caraka has mentioned eight types of Napumsakaviz. Dvireta,Pavanendriya, Samskaravahi, Narasanda, Narisanda, Vakri, Ersyabhirati, Vatikasanda [Ca Sa 2].

Susruta has described five types of Napumsakaviz. Aseeya, Saugandhika, Kumbhika, Irsyaka, Sandra (Narasanda and Narisanda). On reviewing the various ayurvedic classics, psychological and life style related factors are appears to be major cause of the Klaibya and napumsaka. Among the psychological causes Avisvasas, Soka, Cinta, Bhaya, Trsa, Krodha, Irsya, Bhaya, Utkanta, and Udvegavan excess are the main factors that cause Klaibya roga.

Further acharya charak has clearly described that sexual education is very important to both partner for a good sexual life. It means sexual uneducation, myths and misconcepts are also major causes of psychosexual disorder.

### Management of Klaibya

Vrisya basti, Vrisya ksheer, Vrisya ghrita, aphrodisiac recipes and rejuvenating recipes and all treatment which described for sukrodosa and kshata kshina are also helpful in treatment of sexual dysfunction. To the patient suffering from impotency as a result of sexual indulgence and disharmony among the Dhatus, the physician well versed in Bhuesa and Kala should administer all the
aforesaid therapeutic measures keeping in view the strength of his body, Dosas, Agni. If the impotency is caused by Abhicharya then such a patient, then such a patient should be treated with Deva-vyaparasraya Chikitsa. [2]

Sattvavajaya-The Ayurvedic Psychotherapy:
Sattvavajaya Chikitsa in Ayurveda refers to one of the three broadbased approaches to therapy. It is specifically indicated for the treatment of mental illnesses. Charaka defines it as a method of restraining or withdrawal of the mind from unwholesome objects (Arithas) [6] (Ca. Su. 11/54). Sattvavajaya is aimed at the control of mind i.e. one should keep himself established in his ownself after knowing the real nature of the Soul and attaining the height of spiritual wisdom [7] (Ca. Sa. 3/31). Sattvavajaya in principles is full-fledged Psychotherapy, which has been described in Ayurvedic literature. Caraka was the first scholar to use the word "Sattvavajaya". His definition gives lot of scope for expansion and applied consideration.  

"सत्ववजय युनधियोपमास्मिनान्यपायां गुणः।
"मनसोपमास्मिनान्यपायां गुणस्मिनान्यपायां।
"मनोक्षयाधिकारिक्ष्योपमास्मिनान्यपायां।
"सत्ववजयोपमास्मिनान्यपायां समाप्तिर्मानस्त।"

Before directing treatment to sexual problem, it is important to consider whether couple therapy is more appropriate because the sexual problem is secondary to a problem in the relationship. If it is appropriate to focus treatment on the sexual problem, advice and education may be all that is needed. If sex therapy is appropriate, it should be directed to both partners whenever possible. The usual approach, which owes much to the original work of Masters and Johnson (1970), has four characteristics features:

- The partners are treated together;

There are three types of therapy spiritual, rational and psychological for the treatment of mental disorders.

"प्रामाण्यार्थः पूर्वत्तकावितर्याश्चत्थः।
"मनोक्षयाधिकारिक्ष्योपमास्मिनान्यपायां।
"सत्ववजयोपमास्मिनान्यपायां समाप्तिर्मानस्त।"

The former ones i.e. the physical disorders are specifically treated by the remedial measures of divine and rational nature while the mental diseases are treated with the help of promoting spiritual knowledge, specific knowledge, mental restraint, memory, concentration and other similar yogic practices as a part of Ayurvedic Psychotherapy.

Dimensions of Sattvavajaya
1. Trivarga Anveksana
2. Psycho-supportive Techniques
3. Promotion of Jnana (Cognition)
4. Promotion of Vijnana
5. Promotion of Samddhi like State (Yogic Psychotherapy)
6. Pratidvanda Cikitsa (Replacement of Emotions)
7. Aswasana (Reassurance)
8. Suhrt Vakya (Friendly Advice and Guidance)
9. Ishta Vinaganaga (Changing the thought process)
10. Psychoshock Therapy (Mano KsobhaCikitsa)

Psychosexual Therapy: Sexual dysfunction arises from varying combinations of a poor general relationship with the partner, low sexual derive, ignorance about sexual technique and anxiety about sexual performance. Other important factors are depressive and anxiety disorders. Some of these factors will now be considered. Anxiety is an important cause of sexual dysfunction. Sometimes anxiety is an understandable consequence of earlier frightening experience such as man’s failure in his first attempt at intercourse, experience of sexual abuse. Sometimes the anxiety relates to frightening accounts of sexual relationships received from parents or other people.[10]

Before directing treatment to sexual problem, it is important to consider whether couple therapy is more appropriate because the sexual problem is secondary to a problem in the relationship. If it is appropriate to focus treatment on the sexual problem, advice and education may be all that is needed. If sex therapy is appropriate, it should be directed to both partners whenever possible. The usual approach, which owes much to the original work of Masters and Johnson (1970), has four characteristics features:

- The partners are treated together;

![Diagram of Sattvavajaya](image.png)
• They are helped to communicate better, about their sexual relationship;
• They receive education about anatomy and physiology of sexual intercourse;
• They take part in a series of graded tasks.

1. Treatment as a Couple: Although better results are obtained when the couple are treated together, some help can be given to a patient who has no regular partner. Such patient can at least discuss their difficulties and possible ways of overcoming them. Discussion of this kind can sometimes help to overcome social inhibitions.

2. Communication: Communication is not only the ability to talk freely about specific sexual problems; it is also concerned with increasing understanding of the other should know instinctively how to give pleasure during intercourse, so that failure to please is attributed to lack of concern or affection rather than to ignorance. Such failure can be overcome by helping the partners to express their own desires more frankly.

3. Education: Education stresses the physiology of the sexual response. For example, if the problem is anorgasmia in women, the doctor may explain the longer time needed for a woman to reach sexual arousal, and may emphasize the importance of foreplay, including clitoral stimulation, in bringing about vaginal lubrication. Suitably chosen sex education books can reinforce the therapist’s advice. Such counselling is often the most important part of the sexual dysfunction. To combat myths and misconcepts that may interfere with realistic understanding of the relevant problems (such as masturbation, size of penis, nocturnal emission etc.), Couples are given information about basic physiology and the psychology of sexual functioning.

4. Graded Task: These begin with tender physical contact the couples are encouraged to caress any part of the other person’s body except the genitalia in order to give enjoyment (Masters and Johnson call this the ‘sensate focus’). Next, the couple may engage in mutual masturbation, but not in penetration at this stage. At both stage the partners are encouraged to discover the experience most enjoyed by the other person and then to provide this experience. They are strongly discouraged from checking their own state of sexual arousal because this checking generally has an inhibiting effect. Such checking is a common habit in people with sexual disorder and has been called the ‘spectator role’. Graded tasks are not only directly beneficial; they also help to uncover hidden fear or area of ignorance that need to be discussed.

Behavioural Approach: Specific behavioural strategies are useful for specific types of sexual dysfunction.

a. Anxiety Management: Includes systemic desensitization and relation exercise. These exercises are useful when anxiety is a significant causal factor, especially with sexual arousal disorder and early ejaculation disorder.

b. Specific Techniques: Couples can learn methods of increasing or decreasing sexual stimulation for disorders that affects the excitement phase or premature ejaculation, respectively. For premature ejaculation, the squeeze method and the stop-start technique are used in conjunction with sensate focus technique and efforts to improve communication. With this approach, partners can recognize in themselves and each other the stages of progression toward orgasm and then use a behavioural technique to exercise control.

c. Anxiety Management: Includes systemic desensitization and relation exercise. These exercises are useful when anxiety is a significant causal factor, especially with sexual arousal disorder and early ejaculation disorder.

d. Specific Techniques: Couples can learn methods of increasing or decreasing sexual stimulation for disorders that affects the excitement phase or premature ejaculation, respectively. For premature ejaculation, the squeeze method and the stop-start technique are used in conjunction with sensate focus technique and efforts to improve communication. With this approach, partners can recognize in themselves and each other the stages of progression toward orgasm and then use a behavioural technique to exercise control.

Psychodynamic Methods: Inner psychological struggles, unconscious fantasies, and dynamic relationship issues are addressed through conventional psychotherapeutic intervention only as these are issues are encountered in the form of resistance to the others elements of sex therapy. For example, when couples do not follow through with exercises or cannot otherwise participate in therapeutic work, this problem is progressively explored. These patients may benefit from a degree of insight into their behavioural patterns. If this limited psychodynamic approach is not effective, then more traditional forms of individual or couples
therapy may be indicated as an adjunct or an alternative.\[14\]

**Discussion:** Klaibya mostly caused by psychogenic factor like, Bhaya, Krodha, Irshya, Anekha etc. That is called Manas Klaibya. In Ayurveda, Manasaka diseases is treated by Satvavajaya chikitsa which is described in above, due to this reason Manas Klaibya is treated with Satvavajaya chikitsa (Ayurvedic psychotherapy). The Satvavajaya chikitsa like psycho-supportive technique like Aswasan (reassurance and explanation), Suhritvakya (guidance and reassurance) promotion of Jnana (sexual knowledge) and promotion of yogic psychotherapy (Bhramri, Nadisodhan Pranayama) are reduce anxiety and minimize the mental fluctuation \[13\]. All logical knowledge relevant portion of disease introduce to patient and clarify his doubt and provide deeper insight into his problems and pelvic exercise also use for controlling premature ejaculation by producing voluntary control on sphincters. Ayurvedic psychotherapy enhancing good interrelation with partner and remove myths, misconcepts regarding sexual knowledge. Because this disorder caused by negative emotions, prevalence of depressive disorder, deterioration of couple non sexual relationship and childhood abuse etc.

**Conclusion:** Male sexual dysfunction is very common disorder which is caused by psychological causes like depression, anxiety, myths and misconcepts regarding to sexual knowledge. Satvavajaya chikisa gives strength to the mind. It calms down both the mind and the senses, which allow the body’s natural healing mechanism to release stress from the nervous system Satvavajaya (Ayurvedic Psychotherapy) is the most effective therapy for the management of the Klaibya (ED) without any adverse & side effects, instead promoting a greater degree of relief in the symptoms.

**References**
