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ROLE OF SATVAVAJAYA CHIKITSA IN THE MANAGE-MENT OF PSYCHO-SEXUAL DISORDERS

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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 Satvavajaya chikitsa. Satvavajaya 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 manas Klaibya.*

Key word: *Klaibya, Sexual Dysfunction, Satvavajaya, 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 harmony and happiness 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 *bahudosavastha*as a whole and *sukraksaya* in specific, *manodosa*, and *sukravahasrotodusti*. 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 *sukra* and to please the mind. Considering the various factors involved in the pathogenesis of *Klaibya*, particularly to overcome the *bahudosavastha*, specially the aggravated *manasdosa* 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 Napunsakta. *Acharya Caraka* vividly described the condition *Klaibya* as follows:

संकल्पप्रवणो नित्यं प्रियां वष्यामपि स्त्रियम् ।
न याति लिंगशैथिल्यात कदाचिद्याति वा यदि
श्वसार्तः स्विन्नगात्रश्चमोध संकल्प चेष्ठितः
म्लानशिश्न निर्बीजः स्यादेतत क्लैब्य 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 सत्यपि ध्वजोत्थाने मैथुनाशक्तिः(Ca. Su. 28/18 Ck)

i.e. though there is erection but unable to perform sexual intercourse.

अप्रहर्ष इति स्त्रिविषयडनभिलाषः (Su.Su, 24/90, 91)

Means lack of desire for female partner.

अप्रहर्ष आनन्दाभाव (Su. U. 39/26 Dal)

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.

क्षिप्रम् मुच्चाति बध्नाति शुक्रम् । (Ca. Ci. 18/34)

Classification of *Klaibya*

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

	Caraka[2]		*Susruta*[3]		*Bhavaprakasa*[4]
1	*Bijopaghataja*	1	*Manasa*	1	*Manasa*
2	*Dhvajabhangaja*	2	*Saumyadhatuksayaja*	2	*Pittaja*
3	*Sukraksayaja*	3	*Sukraksayaja*	3	*Sukraksayaja*
4	*Jarasambhavaja*	4	*Pumsatva-Upaghataja*	4	*Medhrarogaja*
		5	*Sahaja*	5	*Virya vahini*
		6	*Sthirasukranimittaja*	6	*Sukrastambhanimittajasirachedia*
				7	*Sahaja*

In addition to these, various types of *Napumsaka* are mentioned in theclassical texts. *Caraka* has mentioned eight types of *Napumsakaviz*. *Dvireta,Pavanendriya, Samskaravahi*, *Narasanda, Narisanda, Vakri, Ersyabhirati, Vatikasanda* [5](Ca Sa 2).

Susruta has described five types of *Napumsakaviz*. *Asekya, Saugandhika, Kumbhika, Irsyaka, Sanda (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 napunsakta. Among the psychological causes Avisvasas, Soka, Cinta, Bhaya, Trsa, Krodha, Irsya, Bhaya, Utkanta, and Udvegain 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 *sukradosha* 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 *Bhesaja* and *Kala* should administer all the

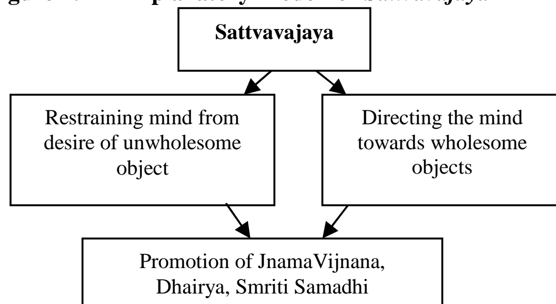
aforesaid therapeutic measures keeping in view the strength of his body, *Dosas, Agni*. If the impotency is caused by *Abhicharya* then such a patient, then such a patient should be treated with *Deva-vyapasraya Chikitsa*. [2]

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 (*Arthas*) [6] (Ca. Su. 11/54). *Sattvavajaya* is aimed at the control of mind i.e. one should keep himself established in his oneself 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.

''सत्ववाजय पुनरहितेभ्योऽर्थेभ्योमनोनिग्रहः /'' (Ch. Su. 11/54)
''मनसोज्ञानविज्ञानधैर्यस्मृतिसमाधिभिः /'' (Ch. Su. 1/58)
''धीधैर्यात्मादिविज्ञानंमनोदोषौषधंपरम् /'' (As.Hr.Su.1)

Thus, the term *Sattvavajaya* implies to that modality which is therapeutic for mental or emotional stresses and disturbances. This is secured best by restraining the mind from desire for unwholesome objects, directing it towards wholesome objects and the cultivation of *Jnama*, *Vijnama*, *Dhairya*, *Smrti* and *Samadhi*. All these measures help in developing control over the *Manas* or mind, which is always unstable. It is said that the body is like a chariot, the senses are like horses, and mind is like the reins; only by holding firmly to the reins one can keep control. If we do not control the five senses, horses will drag us away [8]. *Sattvavajaya* therapy (directed towards these) enables one to have control over himself. "*ChittamIndriya Sarthi*". In this way it is similar to the discipline of yoga, which is defined as "*Yogastucittavrttinirodhah*" (Yoga Su. 1/2). One can explain the term *Sattvavajaya* with the help of the following model [9] (Figure. 1)

Figure 1: An Explanatory Model for *Sattvavajaya*



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

''प्रषाम्यत्यौषधैः पूर्वोदैवयुक्तिव्यपाश्रयैः /
मनसोज्ञानविज्ञानधैर्यस्मृतिसमाधिभिः / /'' (Ch. Su. 1/58)

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 andother 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 Vinagana* (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:

Ñ The partners are treated together;

Ñ They are helped to communicate better, about their sexual relationship;
Ñ They receive education about anatomy and physiology of sexual intercourse;
Ñ 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. [11]

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 techniqu**e 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.

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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. [11]

Discussion: *Klaibya* mostly caused by psychogenic factor like, *Bhaya*, *Krodha*, *Irshya*, *Anekha* etc. That is called *Manas Klaibya*. In Ayurveda, *Manasika* 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 explation), *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 [12]. 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.

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