BMJ

ABC of sexual health: Assessing and managing male sexual problems

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BMJ 1999;318;315-317

ABC of sexual health

Assessing and managing male sexual problems

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Assessing problems

Men are more likely than women to present with and receive treatment for sexual problems. Nevertheless, they usually find them very difficult to talk about, and an initial perception that their problem is being dismissed can considerably delay or prevent their seeking further help. Time spent establishing as clearly as possible the nature of the problem is well spent, as it should lead to more effective treatment and may be therapeutic in itself. Likewise, talking to the partner can reveal a very different picture and can substantially alter management as well as have a therapeutic impact.[1]

Sometimes quite simple interventions—information, reassurance, contraceptive advice, or an opportunity to talk to a member of the primary care team with some basic problem solving or non-directive counselling—can resolve problems that have been a source of considerable distress to patient and partner. Suggesting sources of self help information such as books on sexuality can also be valuable.

When the problem persists despite primary care intervention, further help from other services can be sought, although the provision of services for sexual problems in Britain is variable and rarely enough to meet demand. Optimum assessment and treatment is provided in a multidisciplinary setting, but such clinics are scarce and most patients will be referred to services that have a particular approach. The choice of where to refer a patient will therefore have a critical effect on treatment and, possibly, outcome.

"I'd say loosen his flies but who listens to sex therapists?"

What constitutes a sexual problem?

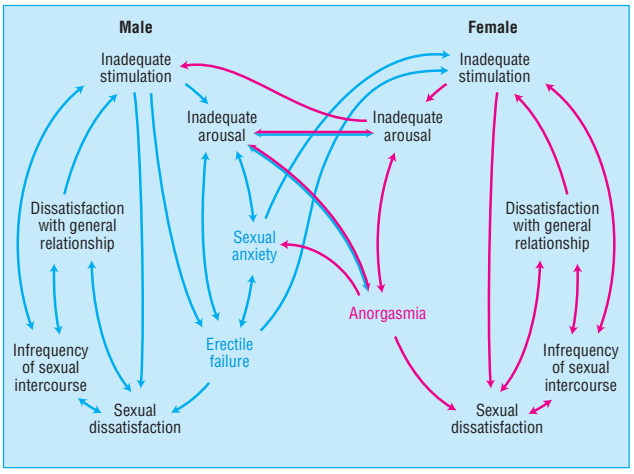
- Physiological dysfunction
- Altered experiences
- Own perceptions and beliefs
- Partner's perceptions and expectations
- Altered circumstances
- Past experiences

Classification of sexual dysfunction

The accepted diagnostic categories for sexual dysfunction described in ICD-10 (international classification of diseases, 10th revision) and DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth revision) do not reflect the reality of sexual dysfunctions in the clinical setting. When these classifications are used it must be remembered that

- Sexual dysfunctions are not all or nothing phenomena but occur on a continuum both in terms of frequency and severity. With our current knowledge, any cut off is inevitably arbitrary
- It is rarely possible to identify cases with a purely organic or purely psychogenic aetiology. Indeed, with our growing knowledge of psychoneuropharmacology and endocrinology, the distinction between organic and psychogenic becomes increasingly blurred
- Comorbidity of sexual dysfunctions is common. For example, nearly half of men with low sexual desire have another sexual dysfunction, and 20% of men with erectile dysfunction have low sexual desire.

In addition to the intrapersonal complexity of sexual problems, the patient's partner and their relationship probably have a more profound effect on sexual health than on any other aspect of health. In up to a third of patients with sexual problems, the partner also has a sexual dysfunction. The interactions between various aspects of sexual problems experienced by a couple are complex, often circular, and rarely reveal simple causal or consequential relationships.



The complex interactions of effects of sexual relationship and general relationship between partners. (Adapted from Gregoire A, Prior JP. *Impotence.* Edinburgh: Churchill Livingstone, 1993)

Inhibited sexual desire

Abnormalities of sexual desire, and indeed sexual desire itself, are difficult to define.[2] The factors considered by clinicians and patients when gauging desire include sexual fantasies, arousal, thoughts, and activity. Given the confusion over the meaning of the concept, it is not surprising that views differ over the term that best describes it. The ICD-10 uses the term sexual desire, and other terms include sexual drive and sexual interest, but "libido" is no longer favoured.

Sexual fantasies, the desire for sexual activity, and distress about the level of desire in a patient and his partner all contribute to the construct of inhibited sexual desire. It is more commonly reported in women than in men (by both women and men) in the general population and in clinic populations. Differences in sexual desire often lead to considerable distress for a couple and can be a source of major conflict in the relationship.

Inhibited sexual desire is often associated with other sexual dysfunctions in the patient or partner. The lifetime prevalence of depression and anxiety disorders is increased. There is a strong association with emotional distance and conflict within a relationship, although it is impossible to determine whether this is cause or consequence from the studies available. Indeed, it is probably meaningless to attempt to do so from population studies given the great individual variability and the very gradual, transactional nature of change in these aspects of relationships.

Characteristic cognitive features have been identified in many cases—for example, the belief that desire does not gradually develop during a sexual encounter but must either be present at the start or does not occur at all, and the belief that subtle feelings such as warmth or tenderness are not sexual and that sexual arousal cannot take place without intense, overtly erotic feelings.

Sexual desire in men can be inhibited by a wide range of physical factors. This can be due to the general effects of illness such as a severe bout of flu or chronic renal failure or to specific effects such as those seen in alcoholism, liver disease, testosterone deficiency, and prolactin secreting pituitary tumours (which may occur in as many as 10% of men presenting with inhibited sexual desire). It is also often a side effect of drugs such as antihypertensives, antidepressants and antipsychotics, anticonvulsants, and cytotoxic agents.

Most studies of outcome indicate that response to psychological intervention for inhibited sexual desire is very poor.[3]

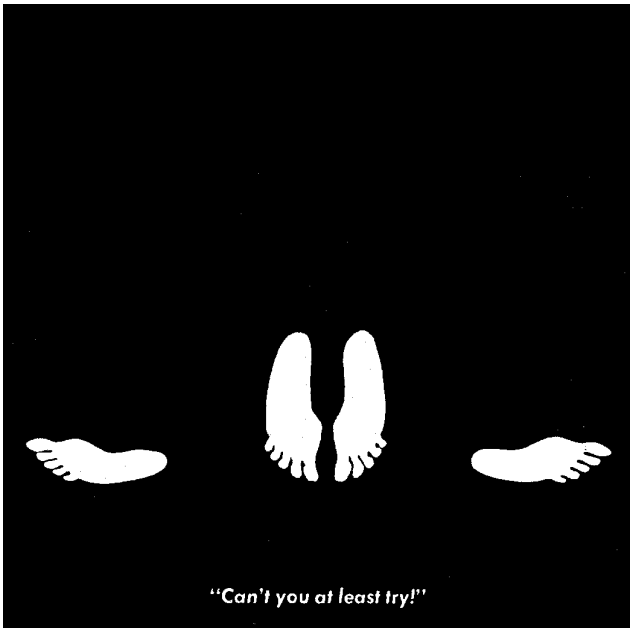
Erectile dysfunction

Erectile dysfunction is dealt with in more detail in the next article of this series. It occurs in 10-15% of men but varies with age, with some degree of dysfunction being experienced by 40% of men at age 40 and by 70% at age 70. In most cases there are both organic and psychological aetiological factors, and assessment and treatment must take account of this.

Various treatments are available, but data on their relative effectiveness and long term outcome are still lacking. Although it is clear that there is no ideal treatment, there is usually one that is both effective and acceptable to the man and his partner. Sildenafil represents an important advance but seems to be a victim of its own success, with concerns about costs leading to limitations on prescription as well as there being evidence of misuse.[4]

Premature ejaculation

Premature ejaculation is an inability to control ejaculation sufficiently to permit both partners to enjoy sexual intercourse.



Differences in sexual desire often lead to considerable distress for a couple and can be a source of major conflict in the relationship

Sexual desire can be inhibited by physical factors such as the effects of illness. (*Francis Matthew Schutz in his Bed* (circa 1755-60) by William Hogarth)

"A hard man is good to find" Mae West

Treatments for erectile impotence

- Simple measures—education, advice, self help books
- Psychological—therapy for couples or for single men individually or in groups
- Oral drugs—sildenafil
- Topical vasodilators
- Intracavernosal drugs—prostaglandin E_1
- Vacuum devices
- Prosthetic implants
- Surgery for venous leakage

This may result in ejaculation shortly after penetration or, in severe cases, before penetration.

Sometimes the true problem is an erectile difficulty that necessitates prolonged stimulation in order to achieve adequate erection, and there is therefore an apparently short period before ejaculation. About 20% of men complain of premature ejaculation, and in the vast majority of cases there is no evidence of any physical underlying cause. Premature ejaculation is commoner in younger men, and it is likely that there is a process of learning to control ejaculation with increasing sexual experience. Anxiety undoubtedly plays an important role in hastening ejaculation in some men.

Psychological interventions are aimed at reducing performance anxiety and improving ejaculatory control—such as by the "pause and squeeze" technique. Reported success rates are conflicting, and long term follow up suggests that benefits are not maintained.[5]

Drug treatment with specific serotonin reuptake inhibitor antidepressants such as sertraline 50 mg daily are effective in delaying ejaculation and improving sexual satisfaction in patient and partner. Recent studies indicate that intermittent use can be as effective as continuous use, and this should reduce the rates of undesirable side effects such as nausea and decreased desire.

Retarded and absent ejaculation

Retrograde, absent, or retarded ejaculation caused by drug side effects are seen fairly frequently in clinic populations, although many sufferers do not spontaneously complain but simply stop their medication. Common causes include antidepressant and antipsychotic drugs as well as prostatectomy. Cases not associated with these obvious causes are rare.

Psychological treatment focuses on reducing anxiety and increasing arousal. Increased genital stimulation is important, and patients sometimes need encouragement and "permission" to pursue this, including using aids such as a vibrator. One successful option for treating antidepressant induced anorgasmia is the adjunctive use of cyproheptadine (2-16 mg) before sexual intercourse. However, this is a serotonin antagonist and has been reported to cause relapse of the depression in some cases.

Dyspareunia

Genital pain before, during, or after intercourse is rare in men, occurring in about 1% of clinic samples. The cause can be physical, such as genital infection, phimosis, and prostatitis, or psychological. There are at present no outcome studies of psychological treatments for this distressing problem.

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The ABC of sexual health is edited by John Tomlinson, physician at the Men's Health Clinic, Winchester and London Bridge Hospital, and formerly general practitioner in Alton and honorary senior lecturer in primary care at the University of Southampton.

The cartoon "I'd loosen his flies. . ." is reproduced with permission of Punch Publications. The painting by Hogarth is reproduced with permission of the Bridgeman Art Library. The cartoon "Can't you at least try?" is by Neville Spearman.

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3 Hawton K. Treatment of sexual dysfunctions by sex therapy and other approaches. *Br J Psychiatry* 1995;167:307-14.
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The "pause and squeeze" technique can be used to try to improve ejaculatory control. (Illustration for *The Book of Lust* (1920-30) by Pierre Lacombière)

Sources of further help for patients*

Relate—Local availability of services and waiting lists vary across the country. A fee is charged. Will usually see people individually but prefer to see couples together. Offer marital as well as sexual counselling

Family planning clinics—Sometimes also offer psychosexual counselling services

Brook advisory centres—Usually provide advice and sexual counselling. Particularly suitable for young adults

Urology clinics—Usually assess only organic causes and provide physical treatments, mainly for erectile dysfunction

Psychiatry departments—Now rarely do any work with sexual problems as priority is given to serious mental illness. Some psychiatry departments have special clinics for sexual problems

Sexual dysfunction clinics—The better clinics are multidisciplinary and can assess both psychological and organic aspects of a problem and can provide psychological and physical treatments. These clinics probably offer the best service, but there are few of them and waiting lists tend to be long

*List of clinics available from the honorary secretary, British Association of Sexual and Marital Therapy, PO Box 62, Sheffield S10 3TS

Recommended further reading

- Bancroft J. *Human sexuality and its problems*. 2nd ed. Edinburgh: Churchill Livingstone, 1989
  Although this book is now a little old and in need of revision in some areas (such as management of erectile dysfunction), it remains one of the best comprehensive textbooks in the subject
- Gregoire A, Prior JP. *Impotence: an integrated approach to clinical practice*. Edinburgh: Churchill Livingstone, 1993
  A comprehensive textbook covering psychological and physical aspects of erectile disorders and their management
- Baldwin D, Thomas S. *Depression and sexual function*. London: Martin Dunitz, 1996
  Available from Bristol Myers Squibb Pharmaceuticals