TOOLBOX

Assessing and managing male sexual problems

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ASSESSING PROBLEMS

Men are more likely than women to present with and be treated for sexual problems. Nevertheless, they usually find these problems difficult to talk about, and an initial perception that their problem is being dismissed can considerably delay or prevent them from seeking further help. Spending time to establish as clearly as possible the nature of the problem is likely to lead to more effective treatment and may in itself be therapeutic. Likewise, talking to the partner can reveal a different picture, may substantially alter management, and can have a therapeutic effect.¹

Sometimes simple interventions—information, reassurance, contraceptive advice, or talking to a member of the primary care team for basic problem solving or non-directive counseling—can resolve sources 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 interventions, further help should be sought from other services. Optimum assessment and treatment are provided in a multidisciplinary setting; therefore, the choice of where to refer a patient will have a critical effect on treatment and, possibly, outcome.

CLASSIFICATION OF SEXUAL DYSFUNCTION

The accepted diagnostic categories for sexual dysfunction described in the international classification of diseases, tenth revision (ICD-10),² and the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV),³ 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 con-

What constitutes a sexual problem?

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

tinuum in both frequency and severity. With our current knowledge, any cutoff is inevitably arbitrary;

- It is rarely possible to identify cases with a purely organic or purely psychogenic cause. Indeed, with our growing knowledge from the fields of psychoneuropharmacology and endocrinology, the distinction between organic and psychogenic becomes increasingly blurred; and
- 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 as many as 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.

Inhibited sexual desire

Abnormalities of sexual desire—and indeed, sexual desire itself—are difficult to define.⁴

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 about the term that best describes it. The ICD-10 uses the term “sexual desire,” and other terms include “sexual drive” and “sexual interest,” but the use of “libido” is no longer favored.

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 a relationship (figure 1).

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 from the studies available, it is impossible to determine whether this is a cause or consequence. Indeed, it is probably meaning-

Figure 1 The complex interactions of the effects of a sexual relationship and general relationship between partners (adapted from Gregoire A, Prior JP. *Impotence: an integrated approach to clinical practice*. Edinburgh (Scotland): Churchill Livingstone; 1993).

less to attempt to do so from population studies because of the great individual variability and the gradual, transactional nature of change in these aspects of relationships.

Characteristic cognitive features have been identified in many patients—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 tumors (which may occur in as many as 10% of men presenting with inhibited sexual desire). Reduced sexual desire is also often a side effect of drugs such as antihypertensives, antidepressants and antipsychotics, anticonvulsants, and cytotoxic agents.

Most studies of outcome indicate that patients' responses to psychological intervention for inhibited sexual desire is poor.⁵

Erectile dysfunction

Erectile dysfunction occurs in 10% to 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 patients, there are both organic and psychological causal factors, and assessment and treatment must take account of this.

Various treatments are available, but data on their relative effectiveness and long-term effects are still lacking. Although clearly there is no ideal treatment, there is usually one that is both effective and acceptable to a man and his partner. Sildenafil citrate represents an important advance but seems to be a victim of its own success, with concerns about costs and misuse.⁶

Premature ejaculation

Premature ejaculation is an inability to control ejaculation sufficiently to permit both

partners to enjoy sexual intercourse. 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 to achieve adequate erection and, therefore, an apparently short period before ejaculation. About 20% of men have premature ejaculation, and in most men, no underlying physical cause is evident. Premature ejaculation is more common in younger men, and increasing sexual experience likely involves a process of learning to control ejaculation. 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. Repeatedly stopping sexual stimulation before ejaculation gradually teaches ejaculatory control. If this fails, squeezing the penis firmly between thumb and fingers at the level of the frenulum can inhibit ejaculation with similar effect. Reported success rates are conflicting, and long-term follow up suggests that benefits are not maintained.

Drug treatment with specific serotonin reuptake inhibitor antidepressants, such as sertraline hydrochloride (50 mg daily), is 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 the adverse effects of drugs are seen frequently in clinic populations, although many patients do not spontaneously complain but simply stop their medication. Common causes include the use of 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 permis-

Treatment of erectile impotence

- Simple measures: education, advice, self-help books
- Psychological: therapy for couples or for single men individually or in groups
- Oral drugs such as sildenafil citrate
- Topical vasodilators
- Intracavernosal drugs such as prostaglandin E₁
- Vacuum devices
- Prosthetic implants
- Surgery for venous leakage

sion to pursue this, including using aids such as a vibrator. One successful option for treating antidepressant-induced anorgasmia is the adjunctive use of cyproheptadine hydrochloride (2-16 mg) before sexual intercourse. However, this is a serotonin antagonist and has been reported to cause a relapse of depression in some patients.

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. No outcome studies have been done of psychological treatment of this distressing problem.

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