Practical Psychiatry in Medicine

Part 8. Sexual Dysfunction

In recent years, sexual behavior has received a great deal of attention in both professional and lay circles. Indeed it has been said that a "revolution" has occurred in the Western world, particularly in the United States, in attitudes toward and mores concerning sexual behavior. People have become "liberated" in the sense that they are freer to talk and write about sex and perhaps to engage in sexual behavior, in or out of marriage, than was the case in their parents' and grandparents' times. This liberation doubtlessly stems from several factors, among them the widespread availability of "the pill" and the Zeitgeist of the mid-20th century with its almost obsessional emphasis on freedom of expression, sexual and otherwise.

This new-found sexual freedom has not, of course, eradicated disorders of sexual function, but it does seem to have contributed to a greater readiness on the part of individuals and couples to recognize sexual problems and to seek help for them. The pioneering and widely publicized work of Masters and Johnson has significantly contributed to our understanding of normal sexual functioning and to the understanding and management of sexual disorders.[4,5] In view of these changes in society's attitude toward sex and the widely recognized effectiveness of "sex therapy," it is to be expected that patients will frequently consult their family physician about sexual problems believing that he will be able to help them or refer them to specialists in this field.

Some Basic Features of Human Sexuality

Like other aspects of human behavior, sexual functioning is determined by a combination of hereditary or constitutional factors on the one hand and environmental or experiential ones on the other.

Sexual Identity and Gender Role

Anatomic or biologic sexual identity as male or female is determined by the individual's chromosomal complement, XX for the female and XY for the male, with corresponding male and female genital and gonadal development. A rare but important exception is seen in the testicular feminization or androgen insensitivity syndrome characterized by XY chromosomes, undescended testicles, female external genitalia, female secondary sexual characteristics, and female gender role. Persons with this syndrome are women in terms of psychologic identification and social role.

As a rule, gender role matches anatomic sex. This is to be expected since the rearing persons take their cue from the anatomic sex of the infant in assigning the role of male or female to him or her. However, for reasons that are not entirely clear, there may on rare occasions be a disparity between anatomic sex and gender role development resulting in transsexualism or gender role dysphoria; this is often a painfully conflictful state which leads the individual to seek treatment in the form of psychotherapy and sometimes, if psychiatric treatment has failed, sex reassignment surgery. Gender role problems may also arise when congenital abnormalities of the external genitalia result in anatomic ambiguity and hence in gender assignment in infancy that proves to be inappropriate as the individual matures.

Psychosexual develpment cannot be divorced from the overall psychologic or emotional development of the individual. For example, a satisfying, fulfilled sexual life depends in part upon successful resolution of the oedipal stage of development with consequent freedom to relate to and love another individual as a truly separate person and not as a symbolic representation (substitute) of an infantile object choice. Neurotic conflicts regarding object choice, sexual fantasies, or one's own

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adequacy can seriously interfere with the development of intimate relationships and can lead to avoidance of sexual activity or to a reduction of sex to its purely physical components.

The Sexual Response Cycle

The sexual response cycle refers to the various stages of sexual response that occur in males and females in which orgasm is achieved. This was elucidated by Masters and Johnson.[5]

The first phase is that of excitement characterized by erection in the male and vaginal lubrication in the female. This is followed by the plateau phase characterized in the male by increased penile tumescence, contraction of the cremasteric muscles with consequent positioning of the testes close to the perineum, and in the female by further vascular engorgement and reddening of the labia minora. Orgasm is the third phase and in both sexes consists of a highly pleasurable, rapid release from the preceding sexual tension. In the male, the first stage of orgasm consists of an awareness of ejaculatory inevitability followed by urethral contraction and a sensation of semen moving through the urethra. In the female, orgasm begins with a momentary suspension of arousal followed by sensual radiations from the clitoris into the pelvis and a sensation of warmth spreading from the pelvic region to the rest of the body. Resolution or relaxation follows. In the male there occurs a refractory period in which further arousal and erection do not occur. Women do not have this refractory period and thus are capable of having several orgasms in succession.

This is a general outline of the sexual response cycle; there is much variation from one individual to another and within a given individual at various times. The rate of arousal and rate of passage from one phase to another can vary. In addition, not everyone has an orgasm each time. Knowing about these variations can help allay a patient's apprehensions about being abnormal. The mutual sharing of pleasuring and the intimate communication of sexual interest are more important than achieving some stereotypical norm of performance.

Assessment of Sexual Functioning

The physician may discover the existence of sexual problems in several ways.[2,6] The patient may directly present with an overt complaint of sexual dysfunction, he may indirectly do so by presenting with symptomatic complaints that suggest the presence of sexual problems, and, finally, the physician may learn of sexual problems in the course of routinely obtaining the sexual history.

Here it may be said that including an inquiry into the patient's sexual experiences as part of the initial, routine medical history is a way of letting the patient know that the physician is interested in and willing to help with sexual problems. This in itself may help the patient feel freer to bring up questions or concerns about his or his partner's sexual functioning.

In eliciting the sexual history (whether this is initiated by the physician or the patient) the physician uses a nonjudgmental, matter-of-fact approach. He does not shy away from asking relevant questions but does so in a respectful and tactful manner, one which takes the patient's sensitivity into account and which helps to allay tension or embarrassment. The physician must take care to use terms the patient understands, which sometimes is best done by using terms which the patient himself has introduced as long as their meaning is clear to both parties. In history taking it is always important to allow enough time so that one can unhurriedly listen to the patient's detailed description of his experiences and ask appropriate questions; this is particularly the case when sexual problems are being reviewed. Generally it is helpful initially to direct one's questions toward those areas which are least personal or least apt to arouse anxiety. When the physician suspects that the patient is troubled with feelings of embarrassment or inadequacy, he may make a casual comment which lets the patient know that many people have had the sort of experience or feeling or problem that he has.

When a sexual dysfunction problem has been presented or elicited, the physician proceeds to obtain a detailed history of its development. This should include the life situation concurrent with the onset, remissions, and exacerbations of the complaint. Particular attention should be paid to the quality of the emotional relationship between the

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patient and his or her sexual partner and to possible correlations between changes in that relationship and sexual functioning of both partners. Of considerable diagnostic importance is a history of situational variance in sexual functioning such as the presence of impotence or anorgasmia with one partner but not another or during attempted intercourse as compared with masturbation.

It was mentioned earlier that the patient may not complain openly of a sexual difficulty but may instead present with symptoms which are the byproduct of sexual dysfunction or which serve as a means of seeking help. Examples of such complaints include headaches, backaches, or some other discomfort which tend to occur in the evenings or on weekends when the spouse is at home, or which tend to remit when the spouse is away on a trip. Such indirect presentation may or may not pose considerable difficulties to the interviewer depending in part upon the degree to which the patient is consciously aware of the associated interpersonal and sexual problems. In the presence of considerable anxiety and defensiveness the physician approaches the issue at the level presented by the patient, eg, at first dealing with the physical symptoms, later broaching the interpersonal situations connected with the symptoms, and eventually the sexual aspects of the patient's problems. This approach often requires a number of interviews and the physician must be prepared to allow the patient to "retreat" to a nonanxiety topic, such as a physical complaint, when the patient's discomfort leads him or her to this type of defensive operation.

During the assessment process it is often extremely valuable to interview the patient's sexual partner separately or conjointly with the patient. This step of course can only be taken after it has been discussed with the patient and then only with the patient's consent and cooperation. When a couple is experiencing sexual difficulty, it is not uncommon for the individual whose sexual function is the least impaired to be the one who seeks help, since his or her self-esteem is less threatened than that of the more dysfunctional partner.[6]

It is of considerable importance in the planning of management to assess etiologic factors as far as is feasible to do so. Some sexual dysfunction problems appear to stem from lack of information or actual misinformation about sexual anatomy and physiology. In other instances, a current interpersonal problem or emotional difficulty such as depression may seem to be the primary issue of which the sexual dysfunction is but one manifestation. It is always important to make careful inquiry into alcohol and drug usage and to be alert to a history of physical illnesses such as diabetes which may interfere with sexual function. Sometimes a single instance of performance failure in males will give rise to fear of another failure sufficiently intense that performance is in fact blocked, a very unpleasant sort of self-fulfilling prophecy. Occasionally, sexual dysfunction arises from unconscious and deeply rooted psychologic conflict which is only approachable therapeutically by intensive psychotherapy.

The assessment of sexual dysfunction always includes a general medical evaluation to rule out organic processes which may interfere with sexual function.

Common Sexual Problems

The most common sexual problems which the primary physician is apt to see are those experienced by married couples.[3,4] It is difficult to define precisely what is good or adequate sexual function because what constitutes a satisfactory situation for one couple may be quite unsatisfactory for another. For most practical purposes sexual dysfunction refers to sexual functioning that is less than satisfactory for one or both members of the couple. It should be pointed out that even when the sexual dysfunction problem is clearly assigned to only one member of the couple, both members of the marital couple are involved, ie, both are affected by the disability, both will be affected by therapeutic outcome, in some instances both have contributed to etiology and not uncommonly both may need to participate in the treatment process.

Sexual Dysfunction in Men

The most common sexual disorders in men are impotence, premature ejaculation, and retarded ejaculation.

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Impotence

This refers to the inability to achieve an erection sufficient for penetration or to maintain an erection until intercourse is completed. (Completion of intercourse usually refers to ejaculation. However, older males not infrequently discontinue intercourse without having achieved ejaculation. The patient with retarded ejaculation may "give up" and discontinue intercourse because of discouragement or fatigue even though continuing to maintain penile erection.)

Most cases of impotence, at least in young and middle-aged males, are psychologically caused ("functional"), but organic causes must be ruled out. Impotence secondary to organic disease is usually characterized by complete impotence or progressively worsening impotence and the disability is relatively unaffected by situational factors. On the other hand, a history of being able to achieve an erection with one sexual partner but not another or during masturbation but not intercourse favors the diagnosis of functional disorder. Similarly, the occurrence of full and firm, nocturnal, full-bladder erections in an impotent male favors the functional diagnosis.

Ejaculatory Disorders

Premature ejaculation refers to the repeated experience in which ejaculation occurs during foreplay, at the time of penetration, or after only a few thrusts following intromission. This condition is almost always on a psychogenic basis although inflammatory, irritating conditions affecting the glands, prepuce, urethra, or prostate have been cited as possible contributing factors.

In retarded ejaculation the male finds it very difficult to achieve ejaculation or does not ejaculate at all during intercourse while usually being able to ejaculate by masturbation. This condition too is usually psychogenic but can be mimicked by retrograde ejaculation which may be associated with urologic procedures. Thioridazine administration may produce ejaculatory inhibition as may intoxication with CNS depressants such as alcohol.

Sexual Dysfunction in Women

The most common types of sexual dysfunction in women are anorgasmia, dyspareunia, and vaginismus.

Anorgasmia

This condition is characterized by inability to experience orgasm despite apparently adequate stimulation. Some patients with this condition are unable to have orgasm during either coitus or masturbation. Others are able to achieve orgasm during masturbation only. This condition is seldom primarily caused by organic factors although physical illness, including gynecologic disorders, may provide a basis for anxious concern which interferes with the individual's freedom to function sexually.

Dyspareunia

Painful sensations which prevent coitus or make enjoyment of it impossible are commonly secondary to local pathology such as inflammatory conditions involving the vulva or vagina, torn uterine ligament, pelvic inflammatory disease, and endometriosis. These and other organic factors must be carefully excluded. A history of dyspareunia which is markedly affected by situational factors such as being present with one partner but not another supports the diagnosis of a psychogenic disorder.

Vaginismus

In this condition there is contraction of the pelvic musculature which renders penetration of the vagina difficult or impossible. Here too it is important that local physical disorders be excluded. Ability to function better under some circumstances as compared with others supports a functional diagnosis.

In addition to the above specific dysfunctions, one or both members of the marital couple may complain of a general decline in sexual interest, activity, and degree of satis-

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faction derived from their sexual relationship. The source of the difficulty may be related to deficient sexual techniques but more often than not the problem arises from disturbance and conflict in the relationship between the two persons. Occasionally, of course, the loss of interest by one partner may be accompanied by an extramarital affair with all of the complications which may be associated with that situation.

Management[3,4,6]

The management of sexual dysfunction is determined by careful assessment of those factors which have contributed to etiology. As a general rule it is necessary to involve both members of the couple in the therapy.

If, during a thorough review of the couple's sexual history, the physician has concluded that one or both of them lack basic information about sexual functioning, and that this lack has contributed to faulty techniques and/or in appropriate expectations, the physician may adopt what is basically an educational or information-giving approach. This approach of course must be carried out in a respectful, unhurried fashion, usully over a period of several office visits, and with due attention to the possibility that problems other than lack of information may be contributing to the couple's difficulty. A decade ago there was a commonly held myth (perhaps disseminated by alleged experts on sex) that the truly well-adjusted couple regularly experienced simultaneous orgasms. One of the present authors heard a well-known therapist confidently assert to a mixed audience that there is no such thing as a frigid woman, only inadequate men! However, most persons who are uninformed or misinformed about sexual matters may be so because they have been somehow personally inhibited from learning about this aspect of life, perhaps because of early environmental influences. It is not unusual for the man to be more or less unaware of the importance of foreplay because he is apt to reach the stage of arousal far more quickly than does his partner. Neither party may have thought it of much importance to learn what is particularly pleasurable to his or her partner. Through engaging the couple in discussions of their sexual experiences the physician has an opportunity not only to supply information and correct distortions but also to convey to the couple that sexual function is a legitimate topic in which to be interested, and that they can learn from each other if they are willing to communicate.

A common experience of men who are impotent is that fear of failure actively interferes with performance. With anorgasmic women there is often an inhibition of enjoyment of physical, sensuous stimuli and a self-defeating overemphasis on the goal of achieving orgasm to the exclusion of simply enjoying the sexual experience. In the Masters-Johnson approach, or one of its modifications, the couple is instructed to engage in activities in which they give each other pleasure through kissing, petting, and caressing, but to avoid genital contact. The latter prohibition removes the fear of failure and counteracts excessive emphasis upon the goal of orgasm. The vicious circle of failure and tension is thus broken. After a period of mutual pleasuring, the couple is instructed to include genital touching and caressing and eventually is led by graded exercises to sexual intercourse. In the case of premature ejaculation a special technique, the "squeeze" technique, can be used. This allows the man to have relatively prolonged experiences with sexual play and eventually coitus before he ejaculates.

In those instances in which it is judged that a simple educational approach is not sufficient and that a Masters-Johnson type of treatment approach is indicated, the physician should refer the patient to a psychiatrist or some other specialist who has had experiences in treating sexual disorders.

Not uncommonly, sexually dysfunctional couples have difficulties in their relationship with each other, of which the sexual dysfunction is one manifestation. For this reason, it is the usual practice for the therapist(s) to engage the couple in exploration of their feelings, attitudes, and behavior toward each other, and to supplement the more mechanical aspects of sexual therapy with counseling for interpersonal difficulties. It is not rare for sexual dysfunction in one or both members of the couple to be based on deeply rooted, unconscious conflict. When this is the case more intensive psychoanalytically oriented psychotherapy or psychoanalysis is indicated.

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The Paraphilias

The paraphilias include a variety of sexual behaviors which may or may not be looked upon as abnormal or as constituting a problem by the individual who engages in the behavior. Included in the paraphilias are the following.

Sexual Orientation Disturbance

This refers to homosexuality about which the individual is anxious or in conflict. Not infrequently the practicing homosexual is content with his or her sexual orientation. Sometimes, however, the overtly homosexual person is seriously troubled because he or she wishes to be married someday and have a family or, in the event that the person is already married, has encountered serious difficulty in the sexual relationship with the spouse. Strong homosexual inclinations which are unconscious constitute latent homosexuality and may set the stage for homosexual panic if strong homosexual feelings erupt into consciousness. Mild or fleeting feelings of attraction to persons of the same sex are not uncommon among psychologically healthy adults.

Sexual Deviations

Sexual deviation refers to a group of sexual behaviors which includes sadomasochism, pedophilia, fetishism, voyeurism, exhibitionism, and transvestism. Incest is also included in this category. These behavior problems are symptoms of serious emotional disturbance. In some instances, the sexual behavior poses a threat to others and may require legal as well as therapeutic intervention.

Gender Dysphoria Syndrome

In this syndrome the individual, male or female, is markedly discontented with the gender role corresponding to his or her anatomic sex. The patient may dress in clothes belonging to the opposite sex not for sexual excitement or pleasure as with the transvestite but because of a desire to live as a member of the opposite sex.

Management of the patient with one of the paraphilias requires referral to a psychiatrist or a sexual therapy clinic specializing in the evaluation and treatment of these and other sexual disorders.

Sexual Problems Associated with Physical Illness

Patients with chronic illnesses and those recovering from acute illnesses such as myocardial infarction usually want to continue or resume sexual activity. In most instances they can and should do so. In all patients it is obviously desirable that resumption of sexual activity be a planned part of medical management so that anxiety related to performance capability or to the physical effect of sexual activity can be minimized.

After recovery from a myocardial infarction, men can usually resume sexual activity commensurate with their tolerance of other physical exercise. Though there is a myth that postcoronary men have a high risk of dying during intercourse, this is actually a rare occurrence. There does seem to be some risk associated with who the man's sexual partner is rather than the fact of having intercourse. The stress of coitus with a new partner, as in an extramarital affair, is evidently more risky than intercourse with the marital partner.[7]

In discussing sexual activity with a man recovering from a coronary, his recent and present level of activity should be ascertained. Graded exercises under the supervision of a physiotherapist are often useful in rehabilitation of the patient. When the patient is able to tolerate such exercise as climbing two flights of stairs, he can begin to use this exercise capacity for sexual activity. It may be advisable for the patient to resume sexual activity gradually rather than all at once, eg, petting, perhaps masturbation, then intercourse. In intercourse he might use a position other than male superior, since the isometric

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contraction of arm and shoulder muscles in this position is strenuous.[7]

Diabetes can be a cause of impotency due to autonomic nervous system degeneration; this is generally irreversible. Occasionally the impotence improves with better control of the diabetes. More commonly, though, the man so afflicted will have to replace intercourse with other sexual activities. If the couple is still interested in having a sex life, they may try oral and manual techniques; although the man cannot have a full erection he may still be able to have an orgasm.

Paraplegia and arthritis cause reduction of motility. In addition, the paraplegic has little or no sensory input that he is aware of from the genital area. Nonetheless, reflex activity at the spinal cord level can lead to a firm erection, and paraplegics can derive pleasure from sexual activity. Helping the patient to be aware of this potential should be part of his rehabilitation program. The general approach to helping paraplegics and other patients with neuromuscular or musculoskeletal disabilities includes good communication between sexual partners, and experimentation and innovation with feasible positions and techniques.[2]

Hysterectomy can be followed by sexual difficulties for a couple.[8] The woman may become depressed after this surgery, and either she or her spouse may believe that hysterectomy signifies loss of sexuality or femininity. Counseling before and after surgery is wise; it may prevent some problems entirely and can greatly limit the severity of others.

Altered Sexual Functioning Associated with Medications

The historic quest for true aphrodisiacs is an ancient one indeed and it would appear that in every age there have been false claims and rumors of agents that enhance libido and ability to perform. Our age is no exception. In general, the efficacy of drugs in enhancing sexual interest and activity is not very impressive.[1]

Some agents such as alcohol, amphetamines, hallucinogens, and cannabis in low to moderate amounts may transiently produce an apparent increase in sexual interest and activity by decreasing inhibitions. Cannabis, amphetamines, hallucinogens, and cocaine may also be associated with a heightened awareness of sensual experiences. However, these effects are difficult to measure, many reports of drug effects are anecdotal, and it is difficult to rule out placebo effect in many instances. The administration of L-dopa to patients with parkinsonism is sometimes associated with increased sexual activity; this may be due in part to overall improvement in the patient's condition.

In contrast with the relative ineffectiveness of drugs in improving sexual function, a number of agents can clearly have an adverse effect on sexual desire, potency, and ejaculation. Long-term addiction to heroin, morphine, and the barbiturates frequently produces a marked decline in sexual interest. Some decrease in libido may also be observed with the use of antipsychotic drugs, especially when employed in high doses.

Impotence can occur with the use of alcohol in large amounts, the phenothiazines, and sometimes with anticholinergic agents.

A small percentage of patients receiving thioridazine (Mellaril) report absence of ejaculate which is probably due to retrograde ejaculation. Premature ejaculation is commonly present following withdrawal from opiates in persons addicted to them.

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