

# Male Sexual Dysfunction

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## Abstract

Although sexual dysfunction problems are more common in women than in men, almost everywhere in the world, men are more likely to seek help. Most rely on their own strength, search for help over the Internet, seek for solutions, search for charlatans, and unproven treatments. Experts' help does not seek, as they are justified, considering that the doctor will be embarrassed, that the doctor has no time or that he does not actually have a cure for these problems. People know little about how to help in the case of sexual problems and most of them just heard for only drug registered for erectile dysfunction and often do not know that there are other treatment options and medications for other sexual problems. The most common sexual problems in men are premature ejaculation, erectile dysfunction, reduced sexual desire and postponed ejaculation. Other problems (eg different paraphilias, anorgasms, anejaculation, sexual addiction) are much less frequent.

## Introduction

The diagnostic investigations and treatment opportunities for women with sexual health concerns are limited, in large part, due to the lack of current global government-approved agents for any sexual health concerns (desire, arousal, orgasmic and sexual pain-related dysfunctions) of pre-menopausal women or for non-sexual pain concerns of post-menopausal women [1]. There are, in contrast, more than 20US government-approved treatment strategies for men with both some male sexual dysfunctions. The availability of safe and effective medicaments for men with sexual health problems has, in part, motivated clinicians to better understand the nature of men's sexual health concerns. This has led to more clinical diagnostic procedures for men with sexual dysfunction.

Recent public health attention in some parts of the world to problems like testicular and prostate cancer (especially affecting younger and older men, respectively), erectile dysfunction (a problem that grows with time and the appearance of pharmaceutical solutions), and premature ejaculation address certain reproductive health concerns by men, regardless of sexual orientation [2]. Yet emphasizing male analogues to female gynecological problems will only take us so far in developing our conceptual toolkit regarding male sexualities. To give texture and vigor to the study of men, sexuality, and reproduction we must find ways to extend and develop the feminist and queer literatures on sexuality, including bisexuality, so that if male hetero sexualities are no longer seen as compulsory, neither are they necessarily and generally understood as compulsive.

The WHO (World Health Organization) defines reproductive health as a 'state of complete physical, mental and social well being and not merely the absence of disease or infirmity in matters related to the reproductive system and to its functions and processes' [3]. Thus, it also includes sexual health, the purpose of which is enhancement of life and personal relations and not merely counseling and care related to reproduction and STI (sexually transmitted infections). This holistic approach is important in the promotion of gender-sensitive and woman-centered health.



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The 12 pillars of reproductive health care include adolescent reproductive health and sexual behavior, the status of women in society, family planning, maternal care and safe motherhood, abortion, reproductive tract infections, HIV/AIDS, infertility, reproductive organ malignancies, nutrition, infant and child health and environmental and occupational reproductive health.

The role of community gynecologists and reproductive health care doctors in the UK is to manage the provision and delivery of such services, to oversee and co-ordinate school sex education, co-ordinate screening for sexually transmitted infections, deliver contraceptive and legal abortion services, screening for breast and cervical cancer and management of psychosexual dysfunction and menopausal problems. This transition from providing only family planning services to delivering a package of integrated and comprehensive reproductive health care across the boundaries of disciplines is gaining momentum.

## Psychiatric Disorder

Many psychiatric disorders are associated with sexual dysfunctions [4]. Impairment of sexual functioning in a person with mental illness could be possibly part of her/his mental illness symptomatology (e.g. lack of sexual desire in depression), adverse reaction to medication used for treatment of her/his mental illness (e.g. delayed ejaculation or anorgasmia associated with serotonergic antidepressants), result of substance abuse (e.g. low sexual desire due to chronic cocaine abuse), or due to chronic physical illness (either independent of mental illness or as a result of adverse reaction to medications used for mental illness, for example metabolic syndrome or diabetes mellitus due to some antipsychotics) and/or its treatment. Impairment of sexual functioning could, of course, occur due to one of the secusesora combination of two or more.

The exact diagnosis of the underlying cause of sexual impairment is not always possible and thus treatment may either target the underlying cause, or be symptomatic, for example using treatments that work for a specific sexual dysfunction in general (e.g. using medication such as sildenafil (Viagra) for erectile dysfunction). The diagnosis is usually established during a careful clinical interview. The clinician has to ask very specific questions focused on particular

parts of sexual functioning, for example on sexual desire, arousal (erection), orgasm (ejaculation) and pain associated with sexual activity. It is imperative to obtain a baseline evaluation of the patient's sexual functioning during the first visit. This will be helpful later, in cases of sexual dysfunction possibly associated with any medication prescribed. There are no specific tests for sexual dysfunction(s). However, certain laboratory tests may help in some clinical situations. For instance, measuring the level of prolactin may help confirm suspected sexual dysfunction during the treatment with an antipsychotic drug.

The most common complaint of depressed patients is decreased libido (up to 72% of patients in one study). It seems that the more severe the depression, the greater the loss of libido. Impairment of other aspects of sexual functioning, for example erectile dysfunction, impaired arousal in women, delayed ejaculation/orgasm and anorgasmia have also been reported in depressed individuals, although less frequently than decreased libido. Depressed individuals may also be anxious and anxiety is also associated with impairment of sexual functioning. It is important to note that while their sexual functioning may be impaired, good sexual functioning is important for them. The situation is also complicated by the fact that most medications used to treat depression have been associated with sexual dysfunction.

Changes of sexual functioning also occur frequently in bipolar patients—30–65% of manic patients may display hyper sexuality, while some may report decreased libido. Some patients suffering from bipolar or cyclothymic disorder (mild depression and hypomania) may also report episodes of promiscuity or extra relationship affairs.

## Drug Effects

Sexual dysfunction is typically the consequence of multiple contributory factors, rather than of one single factor [5]. The use of prescribed medication and recreational drugs should always be considered in a comprehensive biopsychosocial assessment of sexual dysfunction in both men and women. Drug effects are commonly cited as a cause of sexual dysfunction, but the evidence for this is limited and often anecdotal. Underlying conditions for which drug treatments are prescribed may also cause or contribute to sexual dysfunction.

As a general rule, if there is a temporal relationship between the introduction of a new drug therapy, and the onset of a change in sexual response, or sexual dysfunction or dysfunctions, then it is more likely that the newly introduced drug is a causal or contributory factor; where a drug has been introduced more than a month before the onset of sexual symptoms, this is less likely. Prescribers should enquire about their patient's sexual function before they prescribe a drug known to be associated with sexual dysfunction; this information may lead them to prescribe a drug less likely to affect sexual function in patients with pre-existing dysfunction, as well as helping them to more readily identify drug-induced dysfunction.

## Sexual Dysfunction

Male sexual disorders have been investigated to a greater extent than FSDs [6]. The etiology of male sexual disorders includes psychological and organic problems. Epidemiological studies have

revealed that organic problems are the leading cause of sexual dysfunction in men. Sexual disorders in men may cover a range of areas involving ED (erectile dysfunction), orgasmic disorders, and premature ejaculation. Impotence is defined as inability to perform sexually in the broadest sense. It is too broad a term to be useful in diagnosis. Libido is a term derived from psychoanalytical theory that describes sexual desire, drive, or interest in both sexes. Lack of libido in men may underlie many instances of impotence. ED is defined as the consistent inability to obtain or maintain an erection of sufficient rigidity to enable satisfactory sexual intercourse. Disorders of semen delivery include lack of emission (deposition of seminal fluid in the prostatic urethra), an ejaculation (lack of ejaculation), and retrograde ejaculation (ejaculation through an incompetent bladder neck into the bladder). Anorgasmia is the persistent inability to achieve orgasm despite adequate sexual arousal.

ED may result from psychogenic and/or organic causes. In most cases, however, the etiology of ED involves an organic problem. It is estimated that about 80% of cases of ED result solely or predominantly from organic causes. Organic ED is the persistent inability to achieve or maintain satisfactory erection primarily as a result of organic or physical factors. In contrast to psychogenic ED, there is often a gradual deterioration of sexual function over months or years. Typically, the patient first notes a mild decrease in penile rigidity, then a decrease in the frequency of erections, followed by sporadic failure of erection with fatigue. Nocturnal erections gradually disappear, as do early morning erections on awakening. In organic impotence, full erection may be achieved, but it frequently subsides quickly. Finally, many patients complain of a partial erection that is insufficient for vaginal penetration. Typically, libido and ejaculatory function are unaffected in organic ED, at least in the early stages.

A large number of diseases and conditions may lead to organic ED, including peripheral and central neurological lesions, hypogonadism and other hormonal disturbances, hypercholesterolemia and pelvic atherosclerotic disease, microvascular disease, diabetes, hypertension, veno-occlusive dysfunction, Peyronie's disease, and drug therapies (especially antihypertensive agents; refs).

The normal physiological changes ageing men and ageing women experience affecting sexual function, include in women for example, a drop in oestrogen levels resulting in less lubrication and possibly discomfort during sex, and in men erectile dysfunction increases with age with both leading to changes in sexual function [7]. However, generally the increase in sexual dysfunction observed in some older people can be attributed to health problems rather than ageing processes. For example, endocrine, vascular and neurological disorders may independently interfere with optimum sexual functioning. Pharmacological treatment or surgery for these disorders may enhance or impair sexual drive and or performance. Older adults with significant health problems, who are cared for in specialist nursing homes are generally discouraged from engaging in sexual activity or sexual expression, or through using tranquilizers. Treatment for sexual dysfunction is relatively effortless, and can involve pharmaceutical or behavioral interventions. Older people with sexual dysfunction may benefit from therapeutic interventions of, for example, hormone replacement therapy or Viagra. However, there is some controversy over the safety of long- term hormonal

therapy in women, with the American College of Physicians recommending postmenopausal hormone treatment to alleviate bone loss and protect against cardiovascular disease, and the Women's Health Initiative publishing the results of its randomized controlled trial stating no protective effects of hormone use on cardiovascular disease.

### Sex Crimes

Some researchers suggest that certain biological factors, such as hormones, contribute to why individuals engage in sex offending behaviors [8]. Perhaps most common within this category is the role of high testosterone levels, which are found to be associated with increased sex drive and aggression. Additionally, some biological theories suggest that certain individuals may be predisposed toward problematic sexual behaviors because of physiologically or biologically predetermined sexual appetites or sexual preferences. These offenses are often viewed as opportunistic crimes committed by individuals who could not control their behaviors or sexual desires. Previous research on rape offenders, focusing on the role of brain dysfunction, innate mating rituals, sex hormones, neurotransmitters, and the limbic system in promoting sex crimes has found little empirical support for uncontrollable sexual desires of offenders. Findings from these studies suggest only limited support for the role of biology in sexual offending. This biological approach provides some understanding to causes of sex offending; however, psychologists have offered alternative explanations for criminal rape.

In a psychological spectrum, sex offenders' behavior originates with issues in childhood that affect their attachments to others, social skills development, and personality traits. These antisocial behaviors could be products of sexual and physical abuses and neglect during childhood, which impede the development of proper attachments to others, and normative social skills. These experiences can also result in uninhibited or improper responses to opportunities and situations in which offending may occur.

### Conclusion

What man can expect when he tells a doctor about a sexual problem? First, he can expect a lot of questions. Sometimes men are surprised not only about sex but about their health, mood, relationships with partners, and communication. Sexuality is influenced by a number of factors, so it is important to evaluate everything when a problem occurs. This is called biopsychosocial approach. Namely, different biological factors can interfere with sexual function. So lack of testosterone, blood vessel problems, nerve damage or spinal cord or diabetes can cause sexual problems. And numerous medicines (antihypertensive, antidepressants, antipsychotics, antacids, etc.) can lead to sexual difficulties. On the other hand, different psychological moments such as anxiety, depression and chronic stress also affect sexual function.

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