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SPECIAL ARTICLE

COMMON SEXUAL DISORDERS: A CLINICAL REVIEW

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ABSTRACT

Sexual disorders are highly prevalent in community. They are multifactorial conditions with anatomical, physiological, medical, psychological, social and even cultural components contributing to their presentations. The intervention methods for most of these conditions include psychoeducation, sex therapies and psychophysiological techniques; and the success rates are reported to be high. In spite of the above fact these disorders are under recognised and treated. This article presents a brief overview of assessment methods, description and management of common sexual disorders in psychiatric clinics.

INTRODUCTION

Even though sexual difficulties are highly prevalent,[1] they are less frequently reported by patients and under-recognised by the clinicians for many reasons.[2] The various factors for under recognition include stigma, hesitation in patients to reveal, discomfort even by the doctors to explore/assess, and the cultural issues. For these reasons, evaluation of these issues needs greater sensitivity and emphatic approach from the clinicians. This over-review on sexual disorders aims to discuss the issues around clinical assessment of common sexual dysfunctions and provides summary of suggested management approaches. It does not include sexual deviances. Exhaustive account on the aetiology and detailed descriptions are beyond the scope of this article.

Assessment methods

Sexual problems are not often proactively assessed in routine clinical practice. Physicians consistently underestimate the prevalence of sexual concerns in their patients.[2] They are often reluctant to address sexual issues for reasons like embarrassment, feeling ill prepared, less well equipped because of lack of training, belief that the sexual history is not relevant to the chief complaints and time constraints.[3] Only 35% of primary care physicians report that they often (75% of the time) or always take a sexual history.[4] Studies show that training in human sexuality and routinely taking sexual histories can increase physician comfort with addressing sexual health.[5] In addition, often clinics do not provide adequate privacy.

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Assessment of a sexual dysfunction requires a careful history from the patient with a corroborative history from the partner, if available. A thorough history is the most important factor in the evaluation and should encompass following points: knowledge about sex, puberty, menstrual history, sex education, masturbation and fantasies, relationships with members of opposite sex, especially their duration, intensity and sexual contact and enjoyment, engagement, marriage, any homosexual feelings and experiences, and where appropriate, deviant sexual experiences and fantasies, including sexual abuse in childhood or adolescence.[6] A pre-consultation questionnaire in local language, anatomically correct dolls, same gender chaperon, simple terminology that the patient can understand, "inform-then-probe" type of questions can help in the assessment procedure. Assessment should also reflect contri buting relationship problems, psychiatric and organic disorders.

The sexual disorders can be categorized as episodic or persistent, acute or chronic, generalized (anytime, any person, anywhere) or situation specific (specific partner or situation related, performance-related and psychological distress or adjustment related), primary/lifelong or secondary/acquired (onset after a period of normal functioning), and psychogenic versus organic or combined biological and psychological factors. This will help in management plan and to prognosticate.

Physical examination and investigation

Physical examination (both systemic and local) is an integral part of assessment for sexual dysfunction. It should be carried out for all persons to look for evidences of any physical factors contributing to sexual problems. Laboratory investigations should be arranged where they are appropriate. There are several specific investigations to help in the evaluation however most are only a supplement and do not a substitute to a sexual history.[7]

Management principles

Psychoeducation including sex-education are the mainstay of the intervention in sexual problems. These are effective in ameliorating most of the sexual problems. Besides providing basic and factually sound information, psychoeducation clarifies sexual myths, misconceptions and prejudices.[8] Inadequate management of the misconceptions will hinder therapeutic progress, affect compliance and keep the person vulnerable for recurrences. Sex-education gives information on anatomy of sexual organs, physiology, various methods to improve sexual communication between partners, and addresses specific individual doubts. It is also used to inform couples about how factors like mood, preoccupation with thoughts, fatigue or hunger may contribute to the perception of the quality of sexual experience. Education becomes very important tool for the intervention of sexual problems. Most of the patients' problems can be dealt by clarifying doubts and giving information. Once the patients are effectively educated and informed the intervention for the sexual dysfunctions can be more fruitful. In addition, sex therapies, psycho-physiological techniques, medications and in some cases surgical interventions are used. Treatment of contributing psychiatric and physical disorders is also essential.

Sexual Desire Disorders

Hypoactive Sexual Desire Disorder

Hypoactive sexual desire disorder (HSD) manifests as deficiency or absence of sexual fantasies and desire of sexual activity, associated with marked distress or interpersonal difficulty.[9,10] Pharmacologic, cognitive-behavioural and psychodynamic approaches are used for management; however, there is no consensus. An eclectic approach involving behavioural, cognitive and psychodynamic marital techniques has been found to be useful.[11] Ensuring adequate couple relationship is another essential element of any psychosexual intervention of HSD.[12] Libido enhancing techniques are used additionally to improve erotic stimulation. Uncontrolled studies suggest drugs such as bupropion, trazodone, fenfluramine, nomifensine and yohimbine are beneficial in some patients with HSD. Presently, role of hormonal therapy for psychogenic HSD has not been adequately demonstrated.[12]

Sexual Aversion Disorder

It presents as an aversion to and active avoidance of genital sexual contact or a particular aspect of sexual experience. An exposure to sexual stimuli elicits negative subjective reactions which range from lack of pleasure to extreme psychological distress. For diagnosis, sexual aversion should not be expounded by another major psychiatric disorder, except another sexual dysfunction and performance anxiety.[9,10]

The principal therapeutic approach is systematic in-vivo exposure, where an individual is progressively exposed to the feared stimuli to delink the relation between sex and sense of fear. Systemic desensitization may be useful as the disorder has phobic avoidance for sexual intercourse.[13]

Excessive Sexual Desire

Satyriasis in men manifests as excessive pathological heterosexual interests. Sexual desire is considered pathological, once it disturbs one's functioning or other's life. A few psychiatric conditions e.g. mania and physical conditions with limbic system damage (e.g. Kluver Bucy syndrome, anterior temporal lobe tumours, and extra-temporal lesions) are documented to cause high sexual desire. Controlled treatment strategies are unavailable at present; however, preliminary studies indicate estradiols and medroxyprogesterone acetate and cyproterone acetate to be useful in hypersexuality.[14]

Sexual Arousal Disorders

Erectile Disorder

An inability of the male to attain and maintain penile erection sufficient enough to permit satisfactory sexual performance suggests erectile dysfunction.[15] The severity of ED varies widely from complete lack of erection to full erection during some part of sexual act.[10]

There is strong evidence base suggesting sildenafil to be effective and safe in ED, irrespective of type of ED.[16] The typical dose is 50-100 mg to be taken an hour before intercourse. However, for older patients and patients with hepatic or renal dysfunction, starting dose should be smaller (25 mg).[16] Tadalafil (10 mg, at least 30 minutes before sexual activity; up to 20 mg maximum per day) and vardenafil (10 mg, approximately 25-60 minutes before sexual activity, maximum 20 mg per day) are effective too. Other oral drugs with documented benefits include apomorphine, yohimbine, oral phentolamine, trazodone and a combination of sildenafil and doxazosin.[13]

Intracavernosal medications are preferred when there are contraindications to sildenafil-like medications. The reported response rates for intracavernosal papaverine (61%), a combined preparation of papaverine/ phentolamine (60-90%) and injection alprostadil (PGE1) (70-96%) have been encouraging.[17] The alprostadil urethral suppository has recently been documented to have an efficacy rate of 65% in ED, and it is preferred in organic ED.[13,18] Further options for treatment of ED include vacuum constriction device, penile prostheses and vascular surgery.[19]

Individual-oriented psychodynamic approach is preferred in primary or lifelong ED. Couple therapy is the choice for secondary type, where ED occurs because of interpersonal factors. The behaviour therapies commonly used include relaxation and desensitization, operant conditioning, flooding, aversive conditioning. Cognitive therapies are chosen to modify maladaptive nega-

tive cognitions contributing to ED. The modified Masters and Johnson technique has a cognitive-behavioural approach.[20] The reported improvement rate varies from 20 to 81%.[13]

Female Sexual Arousal Disorder

Failure of genital response in females is experienced as failure of vaginal lubrication, together with inadequate tumescence of the labia. Disorders of arousal are not limited to diminished vaginal lubrication, but also include decreased clitoral and labial enjoyment, and lack of vaginal smooth muscle relaxation.

It is essential to establish that the woman is receiving adequate cognitive and physical sexual stimulation. Methods to reduce factors that may inhibit sexual arousal have also been suggested, like cognitive restructuring, relaxation training, systematic desensitization of anxiety provoking situations and addressing relationship issues that generate negative affects.[21]

Physical treatment of patients with arousal disorders is limited to the use of commercial lubricants; although vitamin E and mineral oils have also been suggested.[22] Estrogen replacement, when appropriate, especially in postmenopausal women is an effective therapy. Estrogen containing vaginal creams or estradiol containing vaginal rings (which has little systemic absorption) are considered to be good options. Sildenafil, L-arginine, prostaglandin E1 and phentolamine are also being investigated in female sexual dysfunction.[21] Methyltestosterone is used sometimes in combination with estrogen to enhance lubrication and increase clitoral sensitivity.[23]

Orgasmic Disorders

Male Orgasmic Disorder

This disorder manifests as a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement resulting in distress or interpersonal difficulty.[9,10] Psychological intervention remains the principal treatment approach. Performance anxiety is dealt through sex therapy. Orgasmic triggers are introduced to facilitate the process. Psychotherapeutic intervention has been documented to show improvement rate up to 73%.[13,24] Uncontrolled observations suggest sympathomimetics, cyproheptadine (4-12 mg) and yohimbine (2.7-12.8 mg) taken 1-2 hours before sexual relationship improve orgasm in some cases.[25]

Female Orgasmic Disorder

Women who are orgasmic by many means but are non-orgasmic during intercourse, are described in a subcategory of situational orgasmic dysfunction called as coital anorgasmia or coital orgasmic inadequacy. Random orgasmic dysfunction refers to women who have experienced orgasm in different type of sexual activity but only on an infrequent basis.[21] Sex education is preferred initial approach. Sensate exercises are employed to reduce anxiety, increase awareness of physical sensations and transfer communication skills from verbal to nonverbal domains.[20,21,22]

Premature Ejaculation

Premature ejaculation (PE) is defined as a persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before person wishes it.[9,10] Specific intervention for psychogenic PE mainly encompasses psychosexual therapies and medications. Physiological relaxation training, sensual awareness training, pubococcygeal muscle control technique and pelvic floor rehabilitation training are helpful.[26] Cognitive and behavioural pacing techniques are also effective therapeutic strategies for PE. These include stop-start[27] and squeeze techniques.[20] Cognitive arousal continuum technique teaches how to systematically observe one's thoughts, actions, feelings, scenarios, and sequences, and to rank them depending upon their arousal potential for effective management of the level of sexual arousal.

Several controlled studies have shown that fluoxetine, paroxetine, sertraline and clomipramine are helpful. Clomipramine is effective in doses 25-50 mg and it can be administered on 'demand basis' 12-24 hours before anticipated sexual activity. A comparative study of fluoxetine, sertraline, clomipramine and placebo showed clomipramine and sertraline to be associated with the greatest increase in ejaculatory latency. Besides, sildenafil and topical application of local anesthetics such as lignocaine and/or prilocaine appear moderately effective in retarding ejaculation.[13]

Sexual Pain Disorders

Dyspareunia

Genital pain during sexual intercourse is known as dyspareunia. At times, pain may precede or follow intercourse, and repeated experience of pain can lead to secondary sexual avoidance.[13] The most commonly used treatments, singly or in combination, are couple education about sexuality and communication, systematic desensitization, in fantasy and in-vivo, vaginal exercises and vaginal self dilatation. In in-vivo desensitization, intercourse is banned until clients have completed a series of increasingly close approximations to penetration, while also learning better or additional ways of performing the behaviour.[21]

Substance-Related Sexual Dysfunction

Alcohol, opiates, cocaine and cannabis negatively affect the sexual response.[28] Smoking is closely linked to sexual dysfunction; having a strong negative impact on male sexual life.[29] Alcohol and cannabis intake often cause ED. The potential causes of alcohol-induced

sexual dysfunction are its direct sexual inhibitory effects, neuropathy and testicular atrophy with hypogonadism. Marijuana use is reported to be associated with painful sex.[30] Opiates intake is correlated with low sexual drive, delayed ejaculation and erectile difficulty, and cocaine use with reduced sexual desire.[13]

Sexual Dysfunction as Side Effect of Medications

Numerous medications including psychotropics cause sexual dysfunctions. ED commonly occurs with antihypertensives, antidepressants, antipsychotic agents, benzodiazepines, antiandrongens, etc.[7] Nifedipine, alpha-blockers and antipsychotics are reported to cause ejaculatory problems, whereas antipsychotic agents, benzodiazepines and antiandrogen agents (cyproterone acetate and medroxyprogesterone) are related with low libido.[13] Removal an offending agent and selecting an alternate agent with less potential to cause sexual side effects are the main approaches for managing drug-induced sexual dysfunctions. Depending upon the nature of problems, pharmacological agents e.g. sildenafil and psychosexual therapies may be used.[13]

Priapism

Priapism is a prolonged, usually painful, erection unrelated to sexual stimuli. It occurs as a side effect of medications such as intracavernosal injection of vasoactive substances, antihypertensives, anticoagulants, abusive substances, trazodone, thioridazine, clozapine, risperidone and olanzapine.[31] It can also occur with haematological disorders, perineal injury, spinal cord injury, penile malignant infiltration, etc. Priapism can cause permanent penile damage and erectile dysfunction if it persists for 4-6 hours. Treatment usually includes pain control, vigorous hydration, cold compresses and special interventions such as aspiration of blood from the corpus or injecting an alpha-adrenergic agent, phenylephrine, epinephrine and ephedrine.[13,31]

Sexual Dysfunctions in Physical Disorders

Many physical disorders are associated with sexual dysfunctions. Treatment of the physical disorder is an important step for the management of associated sexual dysfunctions. Psychological interventions such as counselling and supportive interventions might benefit some, despite organic nature of the problem.[32,33] Sildenafil is proven beneficial in ED in urological setup, following post-radical prostatectomy, particularly with nerve sparing surgery, diabetes mellitus, spinal cord injury and cardiac diseases.[13] Other treatment options include Medicated Urethral System for Erection, transurethral alprostadil, vacuum-device therapy, penile prosthesis implantation through surgical procedures.[19]

Sexual Dysfunctions in Psychiatric Disorders

Sexual dysfunctions are extremely common complaints in psychiatric disorders.[34,35] A high percentage of men and women suffering from depression reports sexual problems. In women, sexual desire is predominantly affected while in men both desire and erectile function tend to be impaired.[36] Low sexual desire has also been documented in schizophrenia and schizoid personality disorders.[37] Elevated sexual desire is seen mania;[14] whereas clinical signs of compulsive sexual behaviour can include anxiety, depression, somatic complaints, alcohol or drug use or dependency.[38] Sexual aversion is noted in depression, posttraumatic stress disorder and obsessive-compulsive disorder.[9] ED have been noted in depression and schizophrenia; and anxiety, adjustment, somatoform and personality disorders. Besides it is a common side effect of many psychotropics. Ejaculatory problems, both premature and delayed ejaculation, have been reported in many psychiatric problems. Orgasmic problems are noted in depression and schizophrenia. Dyspareunia is seen in somatisation and conversion disorders.[13,32] Sexual disorders as comorbidity of major psychiatric disorders are often missed. Interventions for the primary psychiatric problem and replacement of offending medications if any help in most instances; however psychosexual therapies and specific medications may be needed in some. Recognition of sexual dysfunction associated with psychiatric disorders and its treatment is critical for patient satisfaction and medication compliance.[39]

CONCLUSION

Sexual disorders lead to considerable personal distress, interpersonal difficulties and mental ill health, mostly anxiety and depression. Most of the sexual problems can be easily recognised and managed in psychiatric practice. It is essential that clinicians should proactively check for these problems. Most of the sexual disorders can be managed with psycho-education and psycho-physiological techniques. Reported therapeutic success rates are promising.

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