ABC of mental health

Psychosexual problems

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Relationship and sexual problems

Sexual problems must be evaluated in terms of the relationships in which they are manifest. Relationships can be classified as stable or unstable and satisfactory or unsatisfactory, and most relationship problems can be thought of as including difficulties with communication, conflict, and commitment. Difficulties tend to vary at different stages of a longstanding relationship such as marriage, accompanying the couple's advancing years. Many sexual problems occur because of threatened or actual rupture of a relationship or separation (including death of a partner).

Close relationships are shaped by the experiences and expectations of the couples and by legal and cultural influences. Three areas commonly require evaluation: implications of unmarried cohabitation rather than marriage, different traditions of relationship of different cultural groups (such as whether marriage partners should be arranged by parents or chosen by the young people), and strong religious beliefs.

Sexual problems

Four main classes of sexual problems are encountered in clinical practice—sexual dysfunctions (the most common), sexual drive problems, gender problems, and sexual variations and deviations. About 10% of patients attending general practice have some kind of current sexual or relationship difficulty. Three general points are important:

- People vary greatly in the quantity and type of sexual activity they seek to undertake, and in its importance for them
- Whenever a substantial relationship difficulty accompanies sexual dysfunction, one partner is usually the referred patient, but a joint meeting with both partners should be offered. The prognosis is poor if both do not attend for joint meetings
- While it is often easy to identify specifically sexual aspects of a problem, it is difficult to evaluate a couple's relationship from a brief assessment.

Common sexual problems seen in primary care

For practical purposes, the sexual problems seen in primary care may be grouped as

- Sexual dysfunctions
  - Primary
  - Secondary
- Sexual drive problems
- Gender problems
- Sexual variations and deviations

Classification of adult psychosexual problems*

Behavioural syndromes associated with physiological disturbances and physical factors

F52 Sexual dysfunction not caused by organic disorder or disease
Includes changes in sexual desire or enjoyment, failure of genital response, orgasmic dysfunction, vaginismus, and dyspareunia

Disorders of adult personality and behaviour

F64 Gender identity disorders
Includes transsexualism and disorders in which transvestism occurs but is not accompanied by sexual arousal

F65 Disorders of sexual preference
Includes fetishism, fetishistic transvestism, exhibitionism, voyeurism, paedophilia, sadomasochism, and rarer paraphilias such as those involving animals, rubbing against people in crowds, and making obscene telephone calls

F66 Psychological and behavioural disorders associated with sexual development and orientation
Includes disorders where uncertainty about gender identity or sexual orientation causes distress, or where the individual wishes their gender identity or sexual orientation was different

*ICD-10 (international classification of diseases, 10th edition). Adult psychosexual problems are classified together with several other types of disorder

Sexual dysfunctions

These are problems that make sexual intercourse difficult or impossible. They may be primary (intercourse never adequate) or secondary (intercourse adequate at some time in the past). Erectile and ejaculatory difficulties have similar causes and respond to similar treatments in both heterosexual and homosexual couples.

Some degree of sexual dysfunction, most often erection difficulties, occurs at some time during most established relationships

Causes of sexual dysfunction

Efficient sexual function requires anatomical integrity, intact vascular and neurological function, and adequate hormonal control. Peripheral genital efficiency is modulated by excitatory and inhibitory neural connections that mediate psychological influences and which, in turn, are affected by environmental factors.

Sexual dysfunctions are rarely caused by a single factor, although one may predominate. The question is not "Is this problem physical or psychological?" but "How much of each kind of factor operates in this case?" Similar causative factors operate in men and women, but their manifestations are more obvious in men. It is easy to overlook women's problems unless special inquiry is made.

Common sexual dysfunctions

Men

- Erectile impotence (loss of penile rigidity sufficient to allow efficient coitus)
- Premature ejaculation (ejaculation occurring sooner than is wished)

Women

- Failure to arouse or to achieve orgasm
- Vaginismus (involuntary spasmodic problem in pelvic floor muscles making penetration difficult or impossible)

Biological factors

These occur often in the course of chronic physical and mental illnesses. Hypogonadism is a well recognised cause but is not common. Sexual difficulties are rarely due to testosterone deficiency in men or menopausal or menstrual irregularities in women, though the possibility is often entertained, perhaps because doctors are less comfortable evaluating psychological and relationship factors.

It is often the case that no definite biological cause can be found in a particular patient, and other mechanisms are presumed to operate.

Common biological causes of sexual dysfunction

- Neuropathy (arteriopathy is less common)
- Hypertension
- Ischaemic vascular disease
- Side effects of drugs used to treat diabetes or hypertension
- Other drugs including antidepressants
- Alcohol

Chronic illnesses causing sexual dysfunction

- Diabetes
- Multiple sclerosis
- Cerebrovascular accidents
- Post-traumatic states including paraplegia
- Schizophrenia
- Depression
- Manic-depressive disorder

Psychological factors

During development, people acquire from their experiences of care givers and others personal models of what people are like. Traumatic experiences with adults during childhood may contribute to later sexual and relationship preferences. However, there is no specific connection between particular experiences of early abuse and later problems, and it is remarkable how often people with awful early experiences emerge relatively intact. Nevertheless, the responses of an adult to a prospective sexual partner are framed by expectations of how "a person like that" will behave.

Cognitions (thoughts) and moods (emotions) shape each person's experience of sexual arousal and behaviour. Attentional processes are important: in the common experience of spectatoring, people focus on their own performance, often expecting failure, rather than on the sensuality of lovemaking. Pain, ruminations, and worries divert attention.

Intense negative emotions tend to reduce sexual activity and performance, but the association is not close. In depression, sexual enjoyment is often diminished but occasionally increased; the preferred erotic behaviour may alter, often becoming more passive; and antidepressant drugs may adversely affect sexual response.

Some important psychological factors in sexual dysfunction

- Previous experience
- Expectation (of failure)
- Attention
- Anxiety
- Worries and ruminations
- Depression
- Pain

Environmental factors

Inanimate and animate aspects of the environment profoundly affect sexual arousal and response and, of course, determine whether intimate behaviour will take place at all, as well as its efficiency and enjoyability. This includes where and when sex takes place, the ambient temperature, who else is present or nearby, light or darkness, clothing, and so forth. Whether particular circumstances are excitatory or inhibitory is largely culturally determined.

Genital responsiveness is the final common path issuing from many interacting influences: biological, psychological, and social

Assessing sexual dysfunction

The affected behaviours should be elicited in detail—who is doing what, to whom, and in what circumstances?

The onset of a problem should be specified. A gradual onset, especially after previously satisfactory sexual activity and

with a good concurrent relationship, points to an important physical cause. However, it is often impossible to identify what physical factors are involved. The timing and circumstances of altered sexual interest, and its association with interpersonal conflicts should be noted.

Psychological causes of sexual dysfunctions should be identified positively and not merely by exclusion. Common attributional biases may cloud the issue: women tend to blame themselves for marital difficulties and the sexual complaints of their partners, or to blame their menstrual (or menopausal) status for loss of sexual interest or other difficulties. Both men and women find it easier to blame medication for sexual problems than the much more common conflicts in a relationship or family.

A physical examination is an essential part of the assessment, but the doctor should be sensitive to its potential emotional impact. It is usually best for women patients with sexual complaints to be examined by women.

Example of a case history

A businessman aged 50 consulted for gradually worsening impotence of three years' duration. His business had failed four years previously, and his wife had divorced him six months later. Three years ago a routine medical examination had disclosed important hypertension, for which a β blocker had been prescribed, and he had been advised to reduce his alcohol intake from his habitual 30 units a week.

This not uncommon type of history mentions five factors plausibly related to erectile difficulty: work and marital stress (psychological factors) and hypertension, drug treatment, and alcohol (physical factors)

Investigating sexual dysfunction

Appropriate investigations will depend on the patient's history, and specialist referral may also be considered. If the referrer is almost certain that an important physical factor is relevant, referral to a specialist urological or medical clinic may be made. However, when there is any suggestion that psychological factors are involved, then referral to a sexual and relationships clinic, if available, is likely to provide a more comprehensive service.

In cases of erectile failure, intracavernosal injection of papaverine or prostaglandin E_1 may be useful initially as an investigation under carefully controlled conditions, and both these drugs can become treatments. Patients with diabetic neuropathy usually respond well to injection, while those with arteriopathic conditions do not.

Help with sexual problems

Sexual and relationships clinics

A list of clinics is available from
The Honorary Secretary, British Association of Sexual and Marital Therapy, PO Box 62, Sheffield S10 3TS

Brook Advisory Centres

Adolescents and young adults may find the advice and counselling on sexual problems offered by Brook Advisory Centres to be particularly welcome. Telephone numbers of local centres are available from (0171) 713 9000

Leaflet

Depression and your sex life by Dr David Baldwin. Available from: Depression Alliance, PO Box 1022, London SE1 7QB (Answerphone (0171) 721 7672)

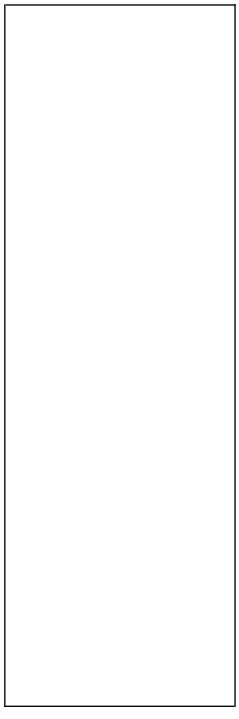
Treating sexual dysfunction

Treatment involves attention to physical, psychological, and social aspects: all should be considered in every case.

Physical treatments

An exclusively biological approach without full conversational inquiry is not satisfactory and increases the chance of treatment failure or relapse. Nevertheless, the treatment of impotence has been revolutionised in recent years by the development of improved physical methods, including intracavernosal injections; the use of a vacuum device; various creams and ointments containing nitrite, which may be beneficial when rubbed into the penis; and the operative insertion of semi-rigid rods, which may provide a semi-erection sufficient for coitus.

Many men are given androgen preparations after consultations about impotence. This is useless in the absence of androgen deficiency with signs of hypogonadism in addition to sexual changes



Psychosocial treatments

These include general counselling to allow attentive exploration of concerns and specific counselling for the cognitive distortions that may accompany mood problems. Some techniques are derived from the "Masters and Johnson" approach, which includes non-genital intimacy during an agreed ban on sexual intercourse to alleviate anxiety about performance and a "stop-start" approach to improve ejaculatory control. Treatment goals should be agreed, which can be approached gradually so as to replace experiences of failure with successes and anxiety with enjoyment. This usually entails practice ("homework") between sessions.

Specific couple therapy may be necessary to treat problems with communication or to enhance a couple's skills in resolving conflict and solving problems. These methods are well suited for use in primary care.

Sexual drive problems

Men and women often have feelings of inferiority about their sexual capacity, but this is not an illness. Loss of (or, less commonly, increase in) sexual drive or interest is common in both men and women. This may manifest in changes in thoughts, fantasies, experienced urges, inclination to initiate sexual activity, or specific changes in sexual behaviour. The term "libido" is vague and best avoided.

Gender problems

Serious problems of gender may accompany endocrinological and developmental disorders that produce ambiguous external genitalia or excessive masculinisation or feminisation.

Transsexualism is a gender identity disorder characterised by a lifelong feeling that your true gender is discordant from your phenotype. This is associated with an insistent search for gender reassignment procedures, most notably for surgical intervention to make the body more concordant with the experienced self. It affects about one in 700 people and is 10 times more common in men than women. In adults the treatment is to use social, medical, and surgical measures to help patients achieve their aims, rather than to try to alter their gender identity. Surgical procedures remain controversial but can produce considerable psychological benefit in selected cases.

Gender identity is a person's sense that he or she is male, female, or ambivalent. Core gender identity is established by the age of 4 or 5 years

Gender role is the public expression of a person's gender

Sexual variations and deviations

The paraphilias are problems arising from sexual preferences that are unwelcome to the patients, to others, or to society at large. They represent modifications of the capacity for erotic response to another adult and can be understood as a disconnection between sex and affection. Most paraphilias involve behaviours that play a small part in usual adult lovemaking—for example, exposing, sexual looking, dominating, submitting, dressing up, and regard for particular objects. In a paraphilia, however, such behaviour becomes the erotic end in itself.

While a wide range of paraphiliac activities has been described, recurring patterns include sadomasochism (the infliction or experience of pain), transvestism (cross dressing), fetishism, and various illegal activities such as exposing the genitals in public and sexual preference for prepubertal children. The assessment and treatment of paraphilias is a specialist matter. Psychological treatments are often of considerable value, but the availability of services is very patchy and awareness of local arrangements is essential.

Paraphilias may occur in people given to heterosexual, homosexual, or bisexual preferences. Homosexual preference is not a problem in itself and is best regarded as a status (like left handedness)

Further reading

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