CONTINUING MEDICAL EDUCATION

PSYCHOSEXUAL PROBLEMS AMONG MALES AND THEIR MANAGEMENT

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Psychosexual problems are quite prevalent in both sexes in all parts of the world and practically in every society and race. However, true figures regarding their incidence and prevalence are difficult to obtain because of the very nature of the problem and its psychological consequences on the individuals which prevents them from seeking help. Even the well-known workers in the field of sexual surveys have remarked that in spite of ensuring complete anonymity and confidentiality, a large number of individuals may not come forward to participate in such surveys, or may fill-in wrong information even in those questionnaires where name and address have not been asked.[1,2]

In India no worthwhile community surveys have been done covering all sections of the population. Some sporadic reports have appeared, however, which have studied the attitudes about marriage and sex in small samples of specific groups like students, housewives, working girls etc. However, these surveys do not tell us about the prevalence of sexual problems as such. Some clinic based reports are also available regarding the nature of male psychosexual dysfunctions and their frequency. Still, accurate figures are difficult to estimate as in India a large number of male patients suffering from a sexual problem tend to visit all kinds of 'sex clinics' rather than come to the hospital setting. Also, a large number of males continue to live with guilt and shame about their sexual inadequacies rather than seek a professional advice. According to Nakra et al,[3] nearly 10 per cent of all males attending psychiatry out-patient in a general hospital and 1 per cent of all male patients in a medical out-patient attend hospital primarily for a psychosexual dysfunction.

In Indian setting, males may seek professional advice for a number of sexual problems like potency disorders, misconceptions about normal sexual function, and some of the uncommon problems like homosexuality and trans-sexualism or transvestisism. However, for the present review, only dysfunctional problems will be discussed leaving deviations and perversions aside. The common sexual dysfunctions seen among males include : (1) Psychological reaction to masturbation, (2) Dhat syndrome, (3) Impotence, (4) Premature ejaculation, and (5) Retarded or inhibited ejaculation.

Psychological reaction to masturbation

Masturbation is the typical example of an activity which is essentially a preparatory practice both before and after puberty. It is seen in many of the higher animals, and in man it is a commonly used substitute for intercourse, especially in the social strata where premarital intercourse is taboo. According to different surveys, 90-95% of normal adult human males may indulge in masturbatory practices some time in their life-time. Though by itself masturbation cannot be termed as a dysfunction,

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yet many young men may have years of their lives made unhappy by a continuous struggle against something they consider morally sinful or physically harmful. Their concern about persistent habit and repeated failures to control it, may lead to neurotic reactions with hypochondriacal fears which may delay maturation and prevent the development of an assured and self-reliant personality. A lot of ill-conceived and unfounded damaging effects of masturbation on bodily and mental powers are spread by the un-scientific books and the so-called 'sex-specialists' who may blame masturbation for any and every physical or mental ill-health. They only succeed in compounding a young man's shame and guilt rather than help him professionally. Besides multiple somatic symptoms and hypochondriacal pre-occupation about bodily functions, some men develop marked apprehensions about their potency. The patient feels that he will not be able to satisfy the partner in heterosexual contact despite normal desire and erection. This he attributes to either some imagined defect in his genitalia or to deleterious effect of masturbation and night emissions. As is obvious, masturbation by itself requires no treatment. However, where anxiety, tension and fears are considerable, this problem may be redressed by giving the patient a clear knowledge and insight into the biological facts. Such a process of re-education is the most important part of the treatment of neurotic reactions which at times may require prolonged counselling. Drug therapy with anxiolytics may be useful in the initial stages of an anxiety state associated with this problem.

Dhat syndrome

Dhat (semen) syndrome is different from the above described problem, though many patients may give history of indulging into masturbation prior to development of this problem. Essentially 'Dhat syndrome', a term coined by Wig[4] is a collection of many physical and psychological symptoms which the patient attributes to the involuntary passage of semen or semen-like fluid per urethra either during micturition, forced defecation or otherwise also. This passage is not associated at that time with masturbation or any other sexual activity, though the patient may blame his past or present masturbatory habits for this. Symptom-wise, there is a constant pre-occupation with this passage in addition to a host of neurotic and hypochondriacal fears including anxiety, headaches, aches and pains, generalized weakness and lethargy, loss of concentration and easy mental fatiguability. In the typical form, the syndrome is commonly seen in the Indian setting and is essentially a culture-bound syndrome. According to the Sushruta Samhita, the origin of word Dhat has come from the sanskrit word Dhatu meaning elixir which constitutes the body. In ancient Indian literature, seven types of Dhatus are described and semen is considered as the most important Dhatu among all. The word Dhatu has been given so much importance in the Indian culture in determining bodily immunity or susceptibility to diseases that it has become synonymus with semen.[5] The findings of some recent studies[5,6] suggest that patients of Dhat syndrome are generally young adults, and the onset of symptoms in most cases is in late teens or early adulthood. Though they seek treatment primarily for involuntary passage of semen, a significant number of them may complain of impotence or premature ejaculation. Nearly half of these cases have moderate degree of depressive symptoms.

The treatment is on the lines of re-education, counselling and reassurance. Follow-up of these patients is very poor as in Singh's study, 64 per cent patients did not come again after the first visit.[6]

Impotence

The term sexual impotence refers to the inability of a man to achieve a quality of phallic

erection sufficient to enable him to have a successful coitus. It may be either primary or secondary. In primary impotence the man has never been able to achieve a satisfactory erection for intercourse. In secondary impotence, the man had been potent earlier, and has developed the impotence subsequently. The diagnosis of impotence should not be used to refer to an occasional erective failure caused by extreme fatigue, excessive alcohol or some other transient unfavourable circumstances; such reactions are quite common in otherwise normal men. If however, the erective failure becomes a frequently repetitive pattern, say a failure in 25 per cent of coital attempts,[6] a diagnosis of secondary impotence is warranted. To avoid confusion, the clinician should limit the term impotence to failure in erection and should not use the term to refer to premature ejaculation. For prevalence kindly refer to table I. Worth-noting fact here is that with advancing age, the prevalence of impotence shows a gradual rise. However, in spite of advancing age, many men remain sexually potent and active, depending upon the availability of a partner.

Table I. Prevalence of impotence according to age (Kinsey et al, 1948).[1]

Age (in years)	Frequency in per cent
20	0.1
30	0.8
40	1.9
50	6.7
60	18.4
70	26.0
80	75.0

Impotence is caused by a variety of psychological or physical causes. However, there is general agreement that most of the causes of impotence or ejaculation disturbances are psychogenic in nature, though a good clinical practice requires that physical factors be ruled out before instituting treatment on psychological lines.

Among the patients who complain of impotence, the majority are found to suffer from an anxiety state. Successful coitus demands the cooperation of lower and higher regulatory centres, which are themselves under the influence of emotion. Excessive mental excitement, or an anticipatory anxiety, feelings of excessive respect, or disgust for the partner, inhibitions due to prejudices, sexual taboos or misconceptions may lead to failure at the first attempt at coitus, followed by a vicious circle of further anxiety and further failures. If the physical urge is very strong, these psychological obstacles will be overcome some time; the vicious circle will then be interrupted and normal sexual habits will develop. Otherwise, the barrier may grow and become almost insurmountable. Fears of venereal disease, pregnancy or impotence itself, attributed to past masturbatory practices, may play their part in preventing erection or causing premature ejaculation. Lack of sufficient privacy or fear of being discovered especially during premarital sexual activity may also be important reasons. Anticipatory anxiety is the usual cause of impotence or frigidity during the honeymoon. In other instances, the initial erectile failure is triggered by the resistance or vaginismus of a frightened virgin woman. As is evident, personality characteristic and situational factors play a major role in the causation of secondary impotence. One such factor is excessive indulgence in alcohol. Other factors are economic or occupational tensions, depressive reactions, marital discord, loss of attraction for the partner, and specific traumatic experiences like rape, venereal diseases etc. Psychological factors important in understanding impotence, can be classified and discussed as follows :[7]

(a) Predisposing factors

(i) Restrictive upbringing: A child's experience of his family's attitudes towards sex has a

profound effect on his psychosexual development. A person will have difficulties in maintaining a satisfying relationship in his married life if he grows up with the idea that sex is wrong and shameful and that the women who enjoy sex are disreputable and to be avoided for marriage. He will have double standards for judging women and experience difficulties in maintaining relationships.

(ii) Disturbed family relationships : If the relationship between the parents is characterized by friction and lack of affection, a child grows up with a poor model of men-women relationships. Incidences of disturbed, separated or broken families are higher in many cases assessed for sexual dysfunction.

(iii) Inadequate sexual information : It can contribute to many sexual myths some of which are given towards the end of this article.

(iv) Traumatic early sexual experiences : Any emotional trauma in early life may leave its tell-tale signs on a person's psyche. If the trauma has been of sexual nature, it may create sexual difficulties in later life.

(b) Maintaining factors

(i) Performance anxiety : Obsessive concern for adequate sexual performance is one of the most common reasons for the persistence of sexual dysfunction. This applies especially to men with erectile difficulties and premature ejaculation. Performance anxiety is related to an excessive need to perform well in intercourse alone with no heed being paid to other activities of sex as well as general relationship.

(ii) Anticipatory anxiety : Closely related to performance anxiety is the anticipation about the likely outcome of each sexual experience. Thus, if one failure follows another, a couple eventually expects failure and a vicious cycle is established.

(iii) Guilt : Guilt is a common feeling experienced by people with sexual problems. It interferes with satisfactory adjustment.

(iv) Loss of attraction between partners : This may lead to inadequate motivation and poor desire for sex with a particular partner. Alternatively, it may create dysfunction in the individual himself.

(v) Poor communication : For any healthy sexual adjustment, communication should also be of good quality.

(vi) Restricted foreplay : For many persons, the only and ultimate goal is intercourse alone. They forget the importance of non-genital pleasures in sex.

(vii) Psychiatric disorders : Many psychiatric disorders and their concomitant treatment produce decreased libido or at times secondary impotence.

Physical causes

Any severe or debilitating illness can be a cause of impotence and is usually associated with loss of libido. In cardio-respiratory diseases, libido may be relatively intact, but the serious impairment of cardiac or pulmonary reserve may make sexual excitement and functioning difficult. In some cases of angina pectoris, the inhibiting factor may not be an actual physiological incapacity but rather, the fear of triggering an attack of angina.

Diabetes mellitus appears to be particularly capable of causing impotence, although the mechanism is obscure. It seems to occur regardless of the duration of illness or the mode of treatment. Other metabolic diseases like myxoedema, thyrotoxicosis, pituitary disease and Addison's disease may also cause impotence. There is a gradual rise of impotence with age, especially after 60. However, the correlation

between the ageing process and impotence is not an inevitable one. Available evidence indicates that with available opportunities for coitus men can retain the capacity for satisfactory sexual intercourse well into their eighties. For further physical causes, kindly refer to table II.[7,8]

Table II. *Physical causes of impotence*

Endocrine causes
- Diabetes mellitus
- Hypogonadism
- Hyperprolactinaemia
- Hypopituitarism
- Thyrotoxicosis

Cardiovascular causes
- Ischaemic heart diseases
- Arteriosclerosis
- Hypertension

Miscellaneous
- Spinal cord transection
- Multiple sclerosis
- Renal failure
- Rectal resection
- Prostatectomy

Treatment

Impotence in man has a very old history of its origin and so are the attempts to treat it. Earlier treatments consisted of various magic potions and aphrodisiacs which worked only by their virtue of placebo effect. Then came various surgical procedures to tone up various perineal and pelvic muscles, and then various forms of internal splinting of the penis by the introduction of rigid materials into the corpora cavernosa. Mechanical external splints were also introduced and are still marketed. More recently, male sex hormones have occasionally been given by physicians who erroneously assume that impotence is the result of a deficiency of such hormones. There is no correlation between sexual ability and the level of urinary 17-ketosteroids. Impotent men may demonstrate above average levels of urinary 17-ketosteroids. Such preparations of sex hormones may work only in cases of Klincfelter's syndrome or pituitary hypogonadism, otherwise these are as good as placebos.

Contemporary methods of treatment of impotence are based on the contributions of Masters and Johnson.[9,10] Though the scope of this paper precludes details of the various steps involved in the treatment procedures by psychological methods, however a brief outline is discussed.[11,12]

While treating a case of impotence, it is highly essential to enlist the cooperation of man's wife or sexual partner. The case is treated as a couple. It is logical since man will require his potency in company of his partner and sex is an activity where understanding and cooperation of both the partners is required. Sex is not something to be enjoyed alone and the responsibility of attaining pleasure and satisfaction should not rest with the man only.

Initial history is taken to understand their relationship in extrasexual areas and if there are areas of non-cooperation, misunderstandings, mutual fears and hostilities, attempt is made to resolve them.[13,14] Information is obtained regarding their knowledge and attitudes regarding sexual matters, and also their ignorance. Many people believe that intercourse is the only pleasure-giving activity and in a couple with sexual problem, the whole attention and energy are focussed on this goal, i.e. how to achieve a satisfying intercourse. In such a situation, man comes under heavy strain as it becomes his sole responsibility to get and maintain a successful erection which he is unable to do so in the face of such a pressure and anxiety. They are advised that they should shift their attention from intercourse as it should only be one of the means for sexual enjoyment and not the only goal. They are further advised to explore the pleasure of non-genital communications (non-genital sensate focussing).[12] The man and woman are alternately assigned the

role of initiating a session of caressing, so the responsibility of their sexual interaction is shared and does not rest with one partner. Any attempt at intercourse is forbidden. The man is relieved of the pressure to perform and erection is no longer necessary. In fact, this relief in itself is good enough to allow him to have an erection. In the next stage, the couple includes genital stimulation in their sessions of physical caressing. When the couple has had enough non-genital and genital experiences and begins to understand the role of intercourse only as one of the means of sexual enjoyment and not the only goal, they are advised to try intercourse. They are further advised not to bother much about any unsuccessful attempts. Woman on superior position has been found to be better in the initial stages since this position relieves the man of burden of insertion which may be the most vulnerable moment for him. The woman takes the charge and helps him in this.

One successful and satisfying intercourse breaks the spell and gradually the couple feels quite at ease with all aspects of sexual activity.

Premature ejaculation

There is considerable controversy regarding the definition of premature ejaculation. One definition terms it as a condition in which orgasm or ejaculation persistently occurs before or immediately after penetration of the female introitus during coitus. One broader definition includes ejaculations that occur within the first 30 or 60 seconds after penetration. It is the most common sexual dysfunction in general practice.

Causes

Clinical evidence strongly suggests that difficulty in ejaculatory control tends to be closely associated with the existence of anxiety during the sexual act. In today's culture, there is a paradoxical situation for the youth. While on one hand there is increasing permissiveness and more opportunities for sexual experiences, on the other hand, there still persists sexual guilt and anxiety as well as taboos against premarital sex. The initial coital attempts of young men are likely to take place under circumstances of haste, tension, anxiety and fear of discovery, conditioning the men to finish coitus rapidly. In many instances, the initial attempts may be with a prostitute who for obvious reasons does everything she can to hasten the youth's ejaculation and get the act over. If the young man has developed an awareness about the importance of female satisfaction in coitus, such rapidity of ejaculation becomes the nucleus of further anxiety. Thus, a vicious cycle of premature ejaculation-performance anxiety-premature ejaculation sets in and is repetitively re-inforced. Psychological factors as discussed for impotence can be seen in cases of premature ejaculation also.

Treatment

Masters and Johnson have contributed significantly in the modern treatment of premature ejaculation. As outlined in the treatment of impotence, the treatment here too involves both the partners. The couple is informed that premature ejaculation is an involuntary reflex that was conditioned sometime in the past. Since anxiety about ejaculating usually exacerbates the problem, non-genital sensate focussing is introduced first to allow mutual pleasure, making ejaculation irrelevant. Once some harmony and comfort in touching has been established the couple is given instructions on use of the squeeze technique, a method of reconditioning the timing of the ejaculatory reflex or altering the threshold of sexual excitability.[11] The squeeze is administered by the woman in a dorso-ventral plane at the coronal ridge of the erect penis for 3-4 seconds, and is then abruptly released, leading to partial loss of erection. Six squeezes within every 15 minutes are sufficient. The squeeze is used at random intervals throughout the sexual play and also when the man feels his excitement

climbing toward the point of ejaculation. Once the couple has learnt and mastered this step, they are gradually allowed to reach the stage of intercourse with woman on superior position first. Sensate focussing and squeeze become part of the couple's routine sexual activity.

Although the squeeze technique is essential to the treatment of premature ejaculation, it must be stressed that it is best integrated into a process of psychotherapy that includes careful attention to interpersonal relationships, communication skills and residual areas of conflict.

Retarded ejaculation

This disorder is characterized by man's inability to achieve ejaculation and orgasm during sexual intercourse, even though the erection is satisfactory. At times, retarded ejaculation is selective : the man is able to achieve orgasm as a result of masturbation but not during coitus. There are usually severe conflicts present in these men, including deep-seated fears of women. For treatment, like other disorders, the support of the woman must be enlisted if therapy is to succeed. The couple moves to general caressing first and then to genital caressing. The wife is guided by her husband to stimulate him satisfactorily. The couple stays with manual stimulation until the husband is thoroughly comfortable in coming to orgasm in front of his wife this way. Once he is able to ejaculate internally during coitus, the spell is broken and successive attempts become easier.

Some common sexual myths[7]

* A man always wants and is always ready to have sex.
* Sex must always be initiated by men.
* Any woman who initiates is immoral.
* Sex means intercourse only : nothing else really counts.
* Talking about sex with partner is bad.
* All physical contact must lead to intercourse.
* Partners should not discuss their feelings.
* Partners spontaneously know what other partner thinks or wants.
* A man cannot say no to sex.

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