SimplePsych

Sexual Disorders

Slides: B Chow
Edits: L Jia

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Sexual Dysfunction

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- Medication-Induced Sexual Dysfunction

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Introduction

- Sig disturbance in **sexual response** or **sexual pleasure**
  - ? Inadequate sexual stimulation → may be lack of knowledge

- Subtypes
  - **Lifelong** → present from first sexual experiences
  - **Acquired** → after relatively normal sexual function
  - **Generalized** → in all situations, partners
  - **Situational** → only in certain types of stimulation, situations, partners

- 5 Factors *("PRICMe")*
  - **1) Partner** → sexual problems, health status
  - **2) Relationship** → communication, discrepancies in desire
  - **3) Individual vulnerability** → body image, sexual/emotional abuse, psychiatric comorbidity, stressors
  - **4) Cultural/religious** → prohibitions, attitudes
  - **5) Medical** → prognosis, course, treatment

Introduction

- Aging → may have **normative decrease** in sexual response

- Biological underpinning to sexual response
  - But complex interaction: biological, psychological, sociocultural

- Need to **rule out**
  - Nonsexual mental disorder → mental dx
  - Substance effects → sub/med-induced sexual dysfunction
  - Medical condition → no psychiatric dx
  - Severe relationship distress
  - Partner violence
  - Other stressors

V or Z code

Delayed Ejaculation

Delayed Ejaculation – Diagnostic Criteria

A. **Almost always** (75-100%), in **partnered** sexual activity, **without desiring delay**, of either:
   1. Marked **delay** in ejaculation
   2. Marked **infrequency or absence** of ejaculation

B. Duration **~6 months**

C. Signification distress

D. Not better explained (*see slide 3*)

Delayed Ejaculation – Specifiers

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** mild distress over sx
  - **Moderate:** moderate distress over sx
  - **Severe:** severe/extreme distress over sx

Delayed Ejaculation – Diagnostic Features

- Marked delay in or inability to achieve ejaculation
  - Presence of **adequate sexual stimulation** + **desire to ejaculate**
  - Often self-report

- "Delay" → not precisely defined, no consensus

Delayed Ejaculation – Associated Features

- Prolonged thrusting to achieve orgasm
  - Point of **exhaustion** or genital **discomfort** → cease effort
  - Men may **avoid sexual activity** due to repetitive difficulty
  - Partner may **feel less sexual attractive**

- **Consider the 5 factors**
  - Partner
  - Relationship
  - Individual vulnerability
  - Cultural/religious
  - Medical

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Delayed Ejaculation – Prevalence

- Lack of precise definition → prevalence unclear
- **Least common male sexual complaint**
- **<1% of men** report difficulty reaching ejaculation for >6 months
- Only 75% of men report always ejaculating

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Delayed Ejaculation – Development & Course

- Lifelong → begins with early sexual experiences, continues
  - Minimal evidence about course of acquired delayed ejaculation

- Prevalence
  - Relatively **constant until ~age 50** → then incidence increase significantly
  - **Age 80s** → TWICE as much difficulty (vs age <59yo)

Delayed Ejaculation – Risk & Prognostic Factors

- Genetic & Physiological
  - Age-related loss of **fast-conducting peripheral sensory nerves**
  - Age-related **decrease sex steroid secretion**
  - May be assoc with delayed ejaculation in men age >50

Delayed Ejaculation – Cultural Issues

- More common among **Asian men**
  - Compared to Europe, Australia, US
  - May be due to cultural or genetic differences

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Delayed Ejaculation – Functional Consequences

- May contribute to **difficulties in conceiving**
- Assoc with **psychological distress** in one/both partners

Delayed Ejaculation – Differential Diagnosis

- Another medical condition
  - Situational aspect → suggestive of **psychological basis**
  - Interruption of nerve supply to genitals → from **traumatic surgical injury**
    - Lumbar sympathetic ganglia, abdominoperitoneal, lumbar sympathectomy
  - Ejaculation → **autonomic nervous system control**
    - Hypogastric (sympathetic), pudendal (parasympathetic)
    - Affected by neurodegenerative diseases **(MS, diabetic/alcoholic neuropathy)**
  - Differentiate from **retrograde ejaculation** (after TURP)

- Substance/medication use
  - Antidepressants, antipsychotics, α-sympathetic drugs, opioids

- Dysfunction with orgasm
  - Distinguish delayed ejaculation, **sensation of orgasm, or both**
    - Ejaculation occurs in genitals, orgasm is primarily subjective
    - Usually occurs together
  - **Anhedonic ejaculation** → normal ejaculation, decreased pleasure

Delayed Ejaculation – Comorbidity

- May be more common in **severe MDD**

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Erectile Dysfunction

Erectile Dysfunction – Diagnostic Criteria

A. Almost always (75-100%) in sexual activity, 1+/3 of following
   1. Marked difficulty **obtaining an erection**
   2. Marked difficulty **maintaining an erection** (until completion of sex)
   3. Marked **decrease in erectile rigidity**

B. Duration **~6 months**

C. Significant distress

D. Not better explained (*see slide 3*)

Erectile Dysfunction – Specifiers

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** mild distress over sx
  - **Moderate:** moderate distress over sx
  - **Severe:** severe/extreme distress over sx

Erectile Dysfunction – Diagnostic Features

- **Repeated failure to obtain/maintain erections** during sex
  - Present for **~6 months**
  - **Majority of occasions** (>75%)

- May be situational or generalized

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Erectile Dysfunction – Associated Features

- Psychological effects in men
  - Low self-esteem
  - Low self-confidence
  - Decr sense of masculinity
  - Depressed affect
  - Fear/avoidance of future sexual encounters

- Psychological effects in partner
  - Decr sexual desire
  - Decr sexual satisfaction

- **Consider the 5 factors**

Erectile Dysfunction – Prevalence

- Prevalence unknown
  - Sig **age-related increase** in prevalence + incidence **after age 50**

- Age <40-50 → **2%** frequent problems
- Age 40-80 → **13-21%** occasional problems
- **Age >70-80** → **40-50%** significant problems

- Erectile difficulties in first sexual experience
  - **20% of men fear**
  - **Only 8% actually experience** hindrance due to erectile problems

Erectile Dysfunction – Development & Course

- Erectile failure on first sexual attempt
  - Previously **unknown partner**
  - Concomitant **drugs or alcohol**
  - **Not wanting** to have sex
  - **Peer pressure**

- Natural history of lifelong ED → unknown
  - **Most spontaneously remit** (without professional intervention)
  - Some may continue to be **episodic**
  - Assoc with psychological factors that are **self-limiting or tx-responsive**

- Acquired ED → usually **biological** (DM, CVD) → **persistent**

- Distress → lower in older men (vs younger men)

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Erectile Dysfunction – Risk & Prognostic Factors

- Temperamental
  - College students → **neurotic** personality traits
  - Men age >40 → **submissive** personality traits
  - **Alexithymia** → common in "psychogenic" erectile dysfunction
  - Common in men with **depression, PTSD**

- Course modifiers
  - **Age**
  - **Smoking tobacco**
  - **Lack of physical exercise**
  - **Diabetes**
  - **Decreased desire**

Erectile Dysfunction – Cultural Issues

- Varies across countries
  - ?cultural expectations vs genuine differences in frequency

Erectile Dysfunction – Diagnostic Markers

- Differentiate organic vs psychogenic erectile problems
  - **Nocturnal penile tumescence, erectile turgidity during sleep**
  - Assumes if adequate erections **during REM sleep** → psychological
- Vascular integrity
  - Doppler U/S, intravascular injection of vasoactive drugs
  - **Dynamic infusion cavernosography** (invasive)
- Peripheral neuropathy
  - **Pudendal nerve conduction studies**, somatosensory evoked potentials
- Endocrinological factors → serum testosterone
- Diabetes → fasting serum glucose
- CAD → serum lipids

Erectile Dysfunction – Functional Consequences

- Can interfere with **fertility**
- **Individual or interpersonal distress**
- Fear/avoidance of sexual encounters
  - Interferes with development of **intimate relationships**

Erectile Dysfunction – Differential Diagnosis

- Nonsexual mental disorders → closely assoc with MDD
- Normal erectile function → ?excessive expectations
- Substance/medication use → temporal relationship

- Another medical condition
  - Difficult to determine if FULLY explained by medical condition
  - Organic → **generalized, gradual onset** (except traumatic nerve injury)
  - Psychological → **situational, inconsistent, after stressor, age <40**

- Other sexual dysfunctions
  - May coexist with **premature ejaculation**
  - May coexist with **male hypoactive sexual desire disorder**

Erectile Dysfunction – Comorbidity

- Psychiatric
  - Premature ejaculation, male hypoactive sexual desire disorder
  - Anxiety, depressive disorders

- Common if **lower urinary tract sx related to BPH**

- Vascular, neurological, endocrine diseases
  - Dyslipidemia, CVD, DM
  - Hypogonadism
  - Multiple sclerosis

Female Orgasmic Disorder

Female Orgasmic Disorder – Diagnostic Criteria

A. Almost always (>75%), in sexual activity, either of:
   1. Marked **delay, infrequency, absence** of orgasm
   2. Marked **reduced intensity** of orgasm

B. Duration **~6 months**

C. Significant distress

D. Not better explained (*see slide 3*)

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Female Orgasmic Disorder – Specifiers

- *Specify if:*
  - **Never experienced an orgasm under any situation**

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** mild distress over sx
  - **Moderate:** moderate distress over sx
  - **Severe:** severe/extreme distress over sx

Female Orgasmic Disorder – Diagnostic Features

- Difficulty experiencing orgasms, or reduced intensity of orgasm
  - **Wide variability** in type + intensity of stimulation
  - Between women, same woman different occasions

- Clitoral stimulation
  - If orgasm through clitoral stimulation, but not penile-vaginal → NO DX
- If inadequate stimulation → NO DX

Female Orgasmic Disorder – Associated Features

- **NO specific assoc** with personality traits or psychopathology
  - Some have greater difficulty communicating about sex issues
- Sexual satisfaction **NOT strongly assoc** with orgasm
  - Many women have high levels of satisfaction despite rare/no orgasms
- More often related to problems with **sexual interest/arousal**
- **Consider the 5 factors (PRICMe)**

Female Orgasmic Disorder – Prevalence

- Prevalence → varies widely = **10-42%**
  - Multiple factors → age, culture, duration, severity
  - Only proportion of women also report distress
  - Variation in symptom assessment

- **~10% of women NEVER** experience orgasm throughout life

Female Orgasmic Disorder – Development & Course

- First orgasm
  - Any time between prepubertal → adulthood
  - **More variable age of first orgasm** (vs men)

- Experienced orgasm increases with age
  - Wider variety of stimulation, more knowledge about bodies

- Orgasm consistency
  - **More consistent with masturbation** (vs partnered sexual activity)

Female Orgasmic Disorder – Risk & Prognostic Factors

- Temperamental
  - **Anxiety, concerns about pregnancy**

- Environmental
  - Strong assoc → **relationship problems, physical + mental health**
  - Sociocultural factors → gender role expectations, religious norms

- Genetic & Physiological
  - **Multiple sclerosis, pelvic nerve damage** (radical hysterectomy), **SCI**
  - **Vulvovaginal atrophy** → more likely to report orgasm difficulties
    - Vaginal dryness, itching, pain
  - **SSRIs** → delay/inhibit orgasm
  - *NOT consistently associated with menopause*
  - May be genetic contribution

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Female Orgasmic Disorder – Cultural Issues

- Regarding lack of orgasm as problem → varies
  - Cultural, between individual women

- Sociocultural + generational differences in orgasmic ability
  - Northern Europe → 17.7% unable
  - Southeast Asia → 42.2% unable

Female Orgasmic Disorder – Diagnostic Markers

- Physiological changes
  - Changes in hormones, pelvic floor musculature, brain activation
  - **Significant variability**

- **Based on SELF-REPORT**

Female Orgasmic Disorder – Functional Consequences

- Strong assoc with relationship problems
  - Unclear **if risk factor or consequence**

Female Orgasmic Disorder – Differential Diagnosis

- Nonsexual mental disorders → MDD (if explains, not FOD dx)
- Substance/medication induced sexual dysfunction
- Another medical condition → not FOD dx
- Interpersonal factors → not FOD dx
- Other sexual dysfunctions → does not rule out dx
  - Female sexual interest/arousal disorder can co-occur
  - NOT FOD dx if
    - Orgasm difficulties short-term, infrequent, not distressing
    - Inadequate sexual stimulation

Female Orgasmic Disorder – Comorbidity

- Female sexual interest/arousal disorder → may co-occur
- Nonsexual mental disorders → indirect orgasm difficulties

Female Sexual Interest/Arousal Disorder

Female Sexual Interest/Arousal Disorder – Diagnostic Criteria

A. Lack of sexual interest/arousal, 3+/6 of following
   1. Decr **interest in sexual activity**
   2. Decr **sexual/erotic thoughts or fantasies**
   3. Decr **initiation of sexual activity, unreceptive to partner's attempts**
   4. Decr **sexual excitement/pleasure during sex**, almost always (>75%)
   5. Decr sexual interest/arousal in **response to sexual/erotic cues**
   6. Decr **genital/nongenital sensations during sex**, almost always (>75%)

B. Duration **~6 months**

C. Significant distress

D. Not better explained (*see slide 3*)

Female Sexual Interest/Arousal Disorder – Specifiers

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** mild distress over sx
  - **Moderate:** moderate distress over sx
  - **Severe:** severe/extreme distress over sx

Female Sexual Interest/Arousal Disorder – Diagnostic Features

- Consider interpersonal context → **"desire discrepancy"**
  - Lower desire than partner → not sufficient for dx
  - Sexual desire + arousal freq coexist → short-term changes common

- **A1) Interest** (prev *hypoactive sexual desire disorder)*
- **A2) Thoughts/fantasies/memories** (consider age-normative decr)
- **A3) Initiation/receptivity** (consider beliefs/preferences of couple)
- **A4) Excitement/pleasure during sex** (common presenting issue)
- **A5) Response to cues** ("responsive desire", ?adequacy of stimuli)
- **A6) Physical sensations during sex** (genital, nongenital)

- NO DX if better explained by self-identification as **"asexual"**

Female Sexual Interest/Arousal Disorder – Associated Features

- Frequently associated features
  - Difficulties experiencing orgasm
  - Pain during sex
  - Infrequent sex
  - Couple-level desire discrepancy
  - Relationship difficulties
  - Mood disorders

- Contextual features
  - Unrealistic expectations/norms
  - Poor sexual techniques
  - Lack of sexuality information
  - Normative beliefs about gender roles

- **Consider the 5 factors (PRICMe)**

Female Sexual Interest/Arousal Disorder – Prevalence

- Prevalence = **UNKNOWN**
  - Marked variation → age, culture, duration, distress
  - Varies in duration (**persistent less common**)
  - **Less distress in older women** (sexual desire may decr with age)

Female Sexual Interest/Arousal Disorder – Development & Course

- **Lifelong vs acquired**
- Adaptive + normative changes across lifespan
  - Partner-related, interpersonal, personal → **may be transient**
- **Longer duration relationships** → more likely sex without desire
- **Vaginal dryness** → related to age + menopause

Female Sexual Interest/Arousal Disorder – Risk & Prognostic Factors

- Temperamental
  - Negative cognitions + attitudes
  - Past hx of mental disorders
  - Differences in propensity for sexual excitement/inhibition

- Environmental
  - Relationship difficulties, partner sexual function
  - Developmental hx (attachment, childhood stressors)

- Genetic & Physiological
  - Medical conditions → DM, thyroid dysfunction
  - Genetic factors – strong influence
  - NO difference found on vaginal photoplethysmography

Female Sexual Interest/Arousal Disorder – Cultural Issues

- Marked variability
  - Low sexual desire **more common among East Asian women**
  - May reflect less interest in sex in those cultures (M+F)
  - Diagnosis must take into account ethnocultural factors

Female Sexual Interest/Arousal Disorder – Gender Issues

- Only diagnoses in females

- Males → *male hypoactive sexual desire disorder*

Female Sexual Interest/Arousal Disorder – Functional Consequences

- **Decreased relationship satisfaction**

Female Sexual Interest/Arousal Disorder – Differential Diagnosis

- Nonsexual mental disorders → MDD (if explains, NO DX)
- Substance/medication use
- Another medical condition → if explains, NO DX
- Interpersonal factors → if explains, NO DX
- Other sexual dysfunction → does not rule out this dx
  - Common for **multiple** sexual dysfunction dx
  - Chronic genital pain → lack of desire
  - Lack of interest/arousal → impaired orgasm ability
  - If self-identification as **asexual** → NO DX
- Inadequate/absent sexual stimuli → if explains, NO DX

Female Sexual Interest/Arousal Disorder – Comorbidity

- Psychiatric issues
  - Comorbidity with other sexual difficulties = **COMMON**
  - Sexual distress, dissatisfaction with sex life
  - Depression, anxiety

- Medical conditions
  - **Thyroid problems, urinary incontinence, arthritis**
  - **IBD, IBS**

- In adults, use of alcohol
  - Low desire comorbid with → depression, sexual/physical abuse

Genito-Pelvic Pain/Penetration Disorder

Genito-Pelvic Pain/Penetration Disorder – Diagnostic Criteria

A. Persistent/recurrent difficulty, 1+/4 of following
   1. **Vaginal penetration** difficulties
   2. **Vulvovaginal/pelvic** pain during intercourse
   3. **Fear/anxiety** about vulvovaginal/pelvic pain
   4. **Tensing/tightening of pelvic floor muscles**

B. Duration **~6 months**

C. Significant distress

D. Not better explained (*see slide 3*)

Genito-Pelvic Pain/Penetration Disorder – Specifiers

- *Specify if:*
  - **Lifelong**
  - **Acquired**

- *Specify current severity:*
  - **Mild**
  - **Moderate**
  - **Severe**

- *(No generalized/situation specifier)*

Genito-Pelvic Pain/Penetration Disorder – Diagnostic Features

- **A1) Difficulty having intercourse**
  - Range → inability for vaginal penetration in ALL or SOME situations
  - Most common = **penetration difficulty with partner**
  - May have difficulty in gynecological exams
- **A2) Genito-pelvic pain**
  - Different locations, intensities → superficial or deep
  - Qualify → burning, cutting, shooting, throbbing
  - Not linearly related to distress/interference → provoked or spontaneous
  - May persist after intercourse, occur during urination
  - Typically reproduced during gynecological exam
- **A3) Fear/anxiety of pain**
  - Common in women who regularly experience pain during intercourse
  - May lead to avoidance of sexual/intimate situations (similar to phobia)
- **A4) Tension of pelvic floor muscles**
  - Reflex-like spasms to “normal/voluntary” guarding (possible penetration)

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Genito-Pelvic Pain/Penetration Disorder – Associated Features

- Freq assoc with other sexual dysfunctions
  - Esp **female sexual interest/arousal disorder**
  - (desire/interest can be preserved in sexual situations without penetration)
- Often behavioral avoidance of sexual situations
  - Also avoidance of gynecological exams
- Common to present for tx when **wishing to conceive**
- Associated relationship/marital problems
  - Feelings of **diminished femininity**
- **Consider the 5 factors (PRICMe)**

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Genito-Pelvic Pain/Penetration Disorder – Prevalence

- Prevalence = UNKNOWN

- **15% of NA women** → pain during intercourse
  - Frequent reason for referral to sexual dysfunction clinics

Genito-Pelvic Pain/Penetration Disorder – Development & Course

- Development = UNCLEAR
  - Do not seek tx until problems in sexual functioning, attempted sex
  - Difficult to characterize → **lifelong vs. acquired**
  - Determine if any consistent period of symptom-free intercourse

- Early clinical signs
  - **Tampon difficulty/avoidance** = PREDICTOR of later problems

- Course
  - If well established (>6 months) → lower rates of spontaneous remission
  - Peak = **early adulthood + peri/post-menopausal period**
  - Increase symptoms in **post-partum period**

Genito-Pelvic Pain/Penetration Disorder – Risk & Prognostic Factors

- Environmental
  - Sexual/physical abuse → predictor of dyspareunia, vaginismus (DSM-IV)
    - Controversial

- Genetic & Physiological
  - Often **onset after vaginal infection** → pain even after resolution
  - Tampon insertion pain → important risk factor for disorder

Genito-Pelvic Pain/Penetration Disorder – Cultural Issues

- **Inadequate sexual education, religious orthodoxy**
  - Predisposing factors for vaginismus (DSM-IV)
  - Controversial (high rates in Muslim Turkey, but not supported in most lit)

Genito-Pelvic Pain/Penetration Disorder – Gender Issues

- **Only given to women**

- Men may have similar problems
  - Urological chronic pelvic pain syndrome → not sufficient research yet
  - Use other specified/unspecified sexual dysfunction

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Genito-Pelvic Pain/Penetration Disorder – Functional Consequences

- Often interference with **relationship satisfaction**
- May interfere with **ability to conceive** (via intercourse)

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Genito-Pelvic Pain/Penetration Disorder – Differential Diagnosis

- Another medical condition
  - **Lichen sclerosis, endometriosis, PID, vulvovaginal atrophy**
    - Medical treatment often does not alleviate GPP/PD
    - No reliable diagnostic tools to determine if primary GPP/PD
  - **Post-menopausal pain** with intercourse
    - May be due to vaginal dryness, vulvovaginal atrophy (decr estrogen levels)

- Somatic symptom and related disorders
  - If **somatic symptom disorder** → diagnose both
  - If **specific phobia** → diagnose both

- Inadequate sexual stimuli
  - **Inadequate foreplay/arousal**
  - **Erectile dysfunction, premature ejaculation**
  - GPP/PD dx may not be appropriate

Male Hypoactive Sexual Desire Disorder

Male Hypoactive Sexual Desire Disorder – Diagnostic Criteria

A. Persistent/recurrent deficiency, with both:
   1. **Sexual thoughts or fantasies**
   2. **Desire for sexual activity**

B. Duration **> 6 months**

C. Significant distress

D. Not better explained (*see slide 3*)

Male Hypoactive Sexual Desire Disorder – Specifiers

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** mild distress over sx
  - **Moderate:** moderate distress over sx
  - **Severe:** severe/extreme distress over sx

Male Hypoactive Sexual Desire Disorder – Diagnostic Features

- Consider interpersonal context
  - **"Desire discrepancy"** → not sufficient for diagnosis
  - Need both: low desire for sex + deficient sexual thoughts/fantasies

- Duration ~6+ months
  - Ensure not adaptive response to adverse life conditions

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Male Hypoactive Sexual Desire Disorder – Associated Features

- Erectile or ejaculatory concerns → sometimes associated
  - May lead to losing interest in sexual activity
- May still have sexual activities (despite low sexual desire)
  - But may **no longer initiate** or be **minimally receptive**
- **Consider the 5 factors (PRICMe)**

Male Hypoactive Sexual Desire Disorder – Prevalence

- Prevalence = varies by country, assessment method

- Problems with sexual desire
  - Younger men (ages 18-24) = 6%
  - Older men (ages 66-74) = 41%

- Persistent lack of interest for ≥6 months
  - Men **ages 16-44 = 1.8%**

Male Hypoactive Sexual Desire Disorder – Development & Course

- Lifelong vs acquired

- Normative age-related decline in sexual desire
  - Variety of triggers
  - **Erotic visual cues** → more potent in younger men

Male Hypoactive Sexual Desire Disorder – Risk & Prognostic Factors

- Temperamental
  - Mood + anxiety symptoms → strong predictors of low desire
    - 50% of men with past psych hx→ **moderate-severe loss of desire**
    - (vs only 15% of men without psych hx)
  - Feeling about self, perception of partner's desire towards him
    - Feeling emotionally connected, contextual variables

- Environmental
  - **Alcohol** → incr occurrence of low desire
  - Gay men → **self-directed homophobia**, **interpersonal** problems, **attitudes**, lack of adequate **sex education**, early life **trauma**

- Genetic & Physiological
  - Endocrine disorder → **hyperprolactinemia, hypogonadal men**
  - **Age**
  - May be a critical threshold of low testosterone for low desire

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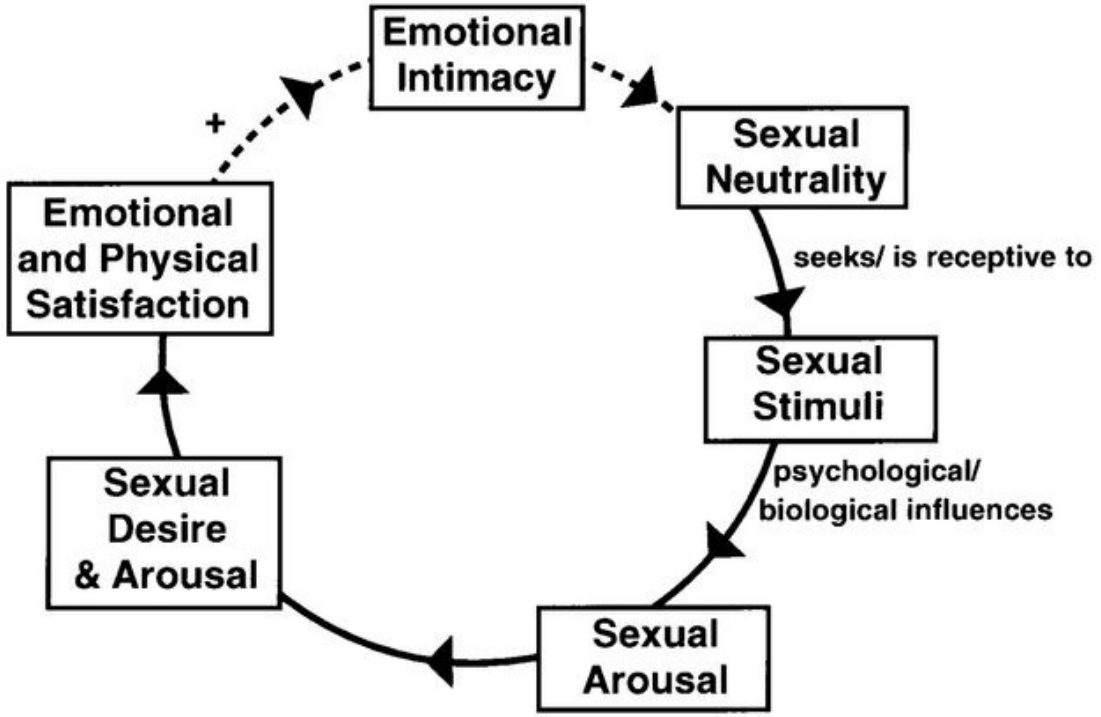
Male Hypoactive Sexual Desire Disorder – Cultural Issues

- Marked variability in rates of low desire (age 40-80)
  - Northern European men → **12.5%**
  - **Southeast Asian men → 28%** (HIGHER)

- Higher rates of low desire in East Asian men
  - Similar with East Asian women
  - ? Guilt about sex

Male Hypoactive Sexual Desire Disorder – Gender Issues

- Desire disorder + arousal → SEPARATE in men
  - Combined in women
  - Men report



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Male Hypoactive Sexual Desire Disorder – Differential Diagnosis

- Nonsexual mental disorders → MDD (if explains, NO DX)
- Substance/medication use
- Another medical condition → if explains, NO DX
- Interpersonal factors → if explains, NO DX
- Other sexual dysfunction → does not rule out this dx
  - Up to 50% also have **erectile difficulties**
  - Slightly fewer have **early ejaculation difficulties**
  - If self-identification as **asexual** → NO DX

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Male Hypoactive Sexual Desire Disorder – Comorbidity

- Common comorbidities
  - **Depression, other mental disorders**
  - **Endocrinological factors**

Premature (Early) Ejaculation

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Premature (Early) Ejaculation – Diagnostic Criteria

A. Ejaculation, **within ~1 min** of penetration, **before desired**

B. Duration **~6 months**, **almost always (75%)**

C. Significant distress

D. Not better explained *(see slide 3)*

Premature Ejaculation – Specifiers

- *Specify whether:*
  - **Lifelong**
  - **Acquired**

- *Specify whether:*
  - **Generalized**
  - **Situational**

- *Specify current severity:*
  - **Mild:** within 30-60 seconds
  - **Moderate:** within 15-30 seconds
  - **Severe:** within 15 seconds or prior to sexual activity

Premature Ejaculation – Diagnostic Features

- Ejaculation prior to, shortly after penetration
  - 60 second cut-off → dx of lifetime premature diagnosis
  - Insufficient data if cut-off time applicable for acquired premature ejaculation

- Ejaculation latency = elapsed time before ejaculation
  - Estimated vs measured highly correlated (if short duration)
  - **Self-reported ejaculation latency** → sufficient for diagnosis

Premature Ejaculation – Associated Features

- Sense of lack of control over ejaculation
  - Apprehension about **anticipated inability to delay** ejaculation

- **Consider the 5 factors (PRICMe)**

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Premature Ejaculation – Prevalence

- Prevalence → varies widely by definition
- Reported concerns → **20-30%** of men, age 17-70 (global)
- New definition (within 1 minute) → **only 1-3% of men**
- Prevalence may incr with age

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Premature Ejaculation – Development and Course

- Lifelong → starts during initial sexual encounter, then persists
  - **Relatively stable** throughout life

- Acquired → **later onset (in 40s or later)**, less known
  - **Reversal of medical conditions** → restore ejaculation latency

- Ejaculation latency → **decr with age in 20%**
  - Age, relationship length → negatively associated with prevalence of PE

Premature Ejaculation – Risk & Prognostic Factors

- Temperamental
  - More common in anxiety disorders → esp **social anxiety disorder**

- Genetic & Physiological
  - Lifelong → moderate genetic contribution
    - **Dopamine + serotonin transporter gene** polymorphisms
  - Acquired → medical conditions (reversible)
    - **Thyroid disease, prostatitis, drug withdrawal**
  - PET → **mesocephalic transition zone + VTA**

Premature Ejaculation – Cultural Issues

- Cultural perception of normal ejaculatory latency = varies
  - Cultural, religious, genetic factors

Premature Ejaculation – Gender Issues

- May be differences in perception between partners
  - May be **incr concerns by females** about partner's early ejaculation
  - ? Reflection of changing societal attitudes about female sexual activity

Premature Ejaculation – Diagnostic Markers

- Research setting
  - **Timing device used by sexual partner**
  - Time between intravaginal penetration to ejaculation
  - Not ideal for real-life situations

Premature Ejaculation – Functional Consequences

- In the individual
  - Decr self-esteem
  - Sense of lack of control
- In the sexual partner
  - Personal distress
  - Decr sexual satisfaction
- Partner relationship
  - Adverse consequences
  - **Difficulty in conception** (if ejaculation prior to penetration)

Premature Ejaculation – Differential Diagnosis

- Substance/medication-induced sexual dysfunction
  - If due **exclusively** to substance use/withdrawal/intoxication → NOT PE

- Ejaculatory concerns that do not meet diagnostic criteria
  - **Desiring longer latency,** but normal ejaculatory latency otherwise
  - **Episodic PE** (only first encounter, new partner)
  - NOT PE

Premature Ejaculation – Comorbidity

- Erectile problems → difficult to determine which was first
- Anxiety disorders
  - Social anxiety disorder
- Medical conditions → acquired PE
  - Thyroid disease, prostatitis
  - Drug withdrawal → **esp opioid withdrawal**

Substance/Medication-Induced Sexual Dysfunction

Sub/Med-Induced Sexual Dysfunction – Diagnostic Criteria

A. Clinically significant **sexual dysfunction**

B. History, physical exam, lab findings of both:
   1. Symptom **onset during/after** substance use/intoxication/withdrawal
   2. Substance/medication **capable of producing symptoms**

C. Not better explained by other sexual dysfunction
   1. **Symptoms precede** substance/medication use
   2. **Symptoms persist** after substantial period of cessation
   3. **Other evidence** (history of non-substance/medication-related episodes)

D. Not exclusively during **delirium**

E. Significant distress

Sub/Med-Induced Sexual Dysfunction – Specifiers

- *Specify substance:*
  - **Alcohol**
  - **Opioid**
  - **Sedative, hypnotic, anxiolytic**
  - **Amphetamine (or other stimulant)**
  - **Cocaine**
  - **Other (or unknown) substance**
- *Specify if:*
  - **With onset during intoxication**
  - **With onset during withdrawal**
  - **With onset after medication use**
- *Specify current severity:*
  - **Mild:** 25-50% of occasions of sexual activity
  - **Moderate:** 50-75% of occasions of sexual activity
  - **Severe:** >75% of occasions of sexual activity

TABLE 1 Diagr

	Sexual dysfunctions
Alcohol	I/W
Caffeine	
Cannabis	
Hallucinogens	
Phencyclidine	
Other hallucinogens	
Inhalants	
Opioids	I/W
Sedatives, hypnotics, or anxiolytics	I/W
Stimulants**	I
Tobacco	
Other (or unknown)	I/W

Sub/Med-Induced Sexual Dysfunction – Diagnostic Features

- Temporal relationship
  - Substance/medication **initiation, dose increase, discontinuation**

DSM5

SimplePsych

Sub/Med-Induced Sexual Dysfunction – Associated Features

Intoxication	Withdrawal	Medications
• Alcohol • Opioids • Sedatives, hypnotics, anxiolytics • Stimulants (incl cocaine) • Other	• Alcohol • Opioids • Sedatives, hypnotics, anxiolytics • Other	• Antidepressants • Antipsychotics • Hormonal contraceptives

- Antidepressants
  - MOST common SE = difficulty with **orgasm or ejaculation**
    - Problems with desire or erection → less frequent
    - 30% of sexual complaints → clinically significant
  - **Bupropion, mirtazapine** → NOT assoc with sexual SE

- Antipsychotics
  - **Sexual desire, erection, lubrication, ejaculation, orgasm**
  - Both typical + atypical agents → but less common if **prolactin-sparing**

Sub/Med-Induced Sexual Dysfunction – Associated Features

- Mood stabilizers
  - **Lithium, anticonvulsants** → possible sexual SE
  - **Gabapentin** → orgasm difficulty
  - **Benzodiazepines** → erectile + orgasm difficulties
  - Lamotrigine → less likely
  - Buspirone → no reports

- Non-psychiatric medications
  - Sexual SE assoc with **cardiovascular, cytotoxic, GI, hormonal agents**

- Illicit substances
  - Decr sexual desire, erectile dysfunction, orgasm difficulty
  - More common in **methadone** (less in buprenorphine)
  - **Chronic alcohol + nicotine abuse → erectile problems**

Sub/Med-Induced Sexual Dysfunction – Prevalence

- Prevalence, incidence = unclear, underreporting
- Antidepressants → **25-80%** (depends on specific agent)
  - MAOIs, TCAs, serotonergic/combined antidepressants
- Antipsychotics → **50%**
  - Unclear difference in incidence among different antipsychotics
- Non-psychiatric medications → unknown prevalence/incidence
  - Higher rates with **methadone, high-dose opioids** for pain
  - **Heroin abuse = 60-70%** (higher than amphetamines, MDMA)

Sub/Med-Induced Sexual Dysfunction – Development & Course

- Onset → as early as **8 days** after taking agent
  - Unknown time to onset for antipsychotics, illicit drugs
  - **Nicotine, alcohol** → can appear after years of use
  - Can occur with **opioid cessation**

- Course
  - Mild-mod orgasm delay → **30% spontaneous remission, within 6 mos**
  - **Serotonin reuptake inhibitor-induced** → may persist after cessation
  - Disturbances may increase with age

Sub/Med-Induced Sexual Dysfunction – Cultural Issues

- May be interaction among:
  - Cultural factors
  - Effects of medication on sexual function
  - Response of individual

Sub/Med-Induced Sexual Dysfunction – Gender Issues

- Gender differences may exist

Sub/Med-Induced Sexual Dysfunction – Functional Consequences

- May result in **medication non-compliance**

DSM5

Sub/Med-Induced Sexual Dysfunction – Differential Diagnosis

- Non-substance/medication-induced sexual dysfunction
  - Many mental conditions assoc with sexual dysfunction
    - Depression, bipolar, anxiety, psychotic disorders
    - Differentiate **if sub/med-induced or manifestation of underlying disorder**
  - Establish close relationship of sexual SE
    - Onset soon after, dissipates with cessation, recurs with reintroduction
  - May be difficult to diagnose with certainty

Other Specified Sexual Dysfunction

Other Specified Sexual Dysfunction

- Does not meet full criteria
- Clinician choose to communication specific reason

- **i.e. Other specified sexual dysfunction, Sexual Aversion**

Unspecified Sexual Dysfunction

Unspecified Sexual Dysfunction

- Does not meet full criteria
- Clinician choose NOT to communication specific reason