The impact of psychological factors on erectile dysfunction

"Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love" (World Health Organization [WHO], 1975).

The notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the "enhancement of life and personal relationships, not merely counselling and care related to procreation or sexually transmitted diseases" (Bancroft, 1989). These statements from WHO are surely just as apposite now, even in the age of evidence-based medicine, as they were over 30 years ago. Note that WHO also considered it to be a human right to be free from "psychological factors inhibiting sexual response" and from "organic disorders, disease and deficiencies". Is it not then our duty, as clinicians in the general field of medicine, to ensure that people with sexual dysfunction and their partners have these rights restored to them by our interventions?

The past few years have seen a growing recognition of the impact that sexual issues can have on overall quality of life. It is now increasingly acknowledged that sexuality is a significant and integral element of total health that must be considered in the care of all people at all stages of various disease trajectories (Jackson et al, 2002; Corona et al, 2009).

The goal of sexual rehabilitation is to restore the individual's ability to engage in intimate interpersonal relationships. It incorporates the restoration of self-esteem, self-concept and confidence, as well as bodily function or adaptation to physical or body image change. When appropriate and desired, sexual rehabilitation includes restoring the physical ability to engage in sexual activity. This will be based on the individual's perception of their sexuality and what is important to them at that time. The key to a good outcome is improved assessment of individuals, comprehensive documentation of problems, realistic expectations of sexual outcomes, and appropriate interventions at the stage that is of most benefit (Bancroft, 1989; Fedele et al, 1998).

The treatment experience invariably begins before the point of diagnosis and clearly, needs can change over time. Through the identification of issues and feelings, and by understanding what helped or hindered adaptation and coping, it is hoped that realistic expectations of sexual outcomes can be given.

The following article explores the need to address sexual dysfunction and the potential links between erectile dysfunction (ED) and hypogonadism in diabetes. Paul Downie discusses the role of testosterone in the wider aspects of sexuality and health and the need to address this in a more proactive way. Studies have shown that testosterone administration in men with diabetes has significantly improved glycaemic control, insulin resistance and visceral adiposity (Corona et al, 2009).

ED is commonly associated with diabetes. Men with diabetes tend to develop ED at an earlier age than men who do not have diabetes, and their ED is often more severe and less responsive to conventional oral treatments (Corona et al, 2004; Lewis et al, 2004). Because ED can be the presenting sign of many significant health problems, it is important that GPs routinely enquire about sexual function; men with sexual dysfunction may not volunteer this information, and those who do seek medical help, often delay doing so.

For men with suspected ED, initial evaluation should include a clear assessment of the nature of the sexual problem, a full medical history, including current medication, focused physical examination, and appropriate investigations. People with ED should be encouraged to attend with their partner, and family, social and cultural issues that may affect them should also be considered. ■

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