Men’s Sexual Health After Midlife

Barbara Bartlik, M.D.
Marion Zucker Goldstein, M.D.

The purpose of this column is to help the clinician evaluate and treat men who are experiencing sexual dysfunction after midlife. It is a companion piece to a column on women’s sexuality that appeared in the June 2000 issue of Psychiatric Services (1). This column describes the normal physiologic sexual changes that occur as men age as well as the physiologic causes of male sexual dysfunction. The psychological, cultural, and relationship factors that may contribute to the premature loss of sexual functioning in older couples are also described. Medical treatments and sex therapy techniques that have been found to be useful are reviewed. An overview is provided of important issues for the clinician in addressing sexuality with older patients.

Background
The majority of studies on sex and aging confirm that most individuals in late life retain sexual interest and ability. However, as one might suppose, the frequency of sexual activity declines in the later years. In a review of the literature, Kaplan (2) concluded that 70 percent of healthy 70-year-old men and women continue to have sex at least once a week. However, another study showed that 95 percent of men between the ages of 46 and 50 had weekly intercourse, compared with only 28 percent of men between the ages of 66 and 71 (3). In many instances, medications, illnesses, partner availability, relationship problems, erection difficulties, or age-related changes in sexual responsiveness are responsible for discontinuation of sexual activity. With the proper guidance and education, many older people can adapt to these changes and continue to function sexually.

Age-related biologic changes
This section examines age-related biologic changes in male sexual response.

 Desire phase
In both men and women, sexual desire is linked to levels of testosterone. In men, testosterone levels begin to decline in the fifth decade and continue to do so steadily throughout later life (4).

Excitement phase
As men age, penile sensitivity is reduced. In addition, achieving an erection takes longer and requires more intense, more continuous, and more lengthy physical stimulation. Moreover, erections are not as firm as earlier in life (2,5).

Orgasm phase
As men age, contractions of orgasm are less intense and less numerous (5). Thus orgasms are more brief, and the ejaculate is expelled with less force. The volume of semen in the ejaculate is also diminished (5). Furthermore, older men may not experience ejaculation every time they have intercourse (5).

Resolution phase
Following orgasm, detumescence occurs more rapidly in older men (4). The refractory period, or the amount of time that must pass before a man is capable of another ejaculation, significantly increases with age, from several minutes or hours to as long as 48 hours (2).

Loss of sexual desire
Not uncommonly men past midlife experience a reduction in sexual desire secondary to lowered levels of testosterone. Supplemental testosterone has been shown to markedly improve libido in older men (6). It also has a positive effect on erection in younger hypogonalad men (7) and appears to benefit cognition, muscle strength, bone mass, hemoglobin levels, cardiovascular function, mood, and general energy level as well. There is concern that the risk of prostate cancer is increased with testosterone supplementation. However, a causal relationship has not been demonstrated (8). Men treated with testosterone who were studied retrospectively did not show evidence of an increased risk of prostate cancer (7).

Patients with low sexual desire and erectile dysfunction should be evaluated for the presence of an endocrine disorder, including diabetes, hypothyroidism, hyperthyroidism, hyperprolactinemia, hypopituitarism, and hypogonadism (7). Hormonal studies that may be helpful include levels of prolactin, first-morning free and total testosterone, thyroxin, and thyroid-stimulating hormone (9). If testosterone is low, luteinizing hormone and follicle-stimulating hormone levels should be obtained to determine whether the problem is at the pituitary level. If prolactin is elevated, further evaluation is warranted, including hypothalamic-pituitary imaging (9).

Diminished libido is often secondary to another sexual disorder such as erectile dysfunction. Understandably, men who struggle with erection problems lose sexual desire. This loss may occur with a specific partner or it may
Erectile dysfunction

By definition, erectile dysfunction is the inability to achieve or maintain an erection of sufficient rigidity for satisfactory sexual relations (12). Erectile dysfunction is common among older men. According to the consensus statement on impotence issued by the National Institutes of Health, the rate of erectile dysfunction among men aged 65 and older is 15 to 25 percent (13). These figures would be higher if men with mild cases were included. The Massachusetts male aging study found that 52 percent of men between the ages of 40 and 70 had some degree of erectile dysfunction (14).

Common causes of erectile dysfunction are diabetes, side effects of medication, arteriosclerosis, heart disease, hypertension, endocrinopathy, traumatic injury, herniated disc, and surgical complications (9,15). Some of the medications that may impair erection include certain antihypertensives, medications to counter hair loss, antidepressants, mood stabilizers, benzodiazepines, and heartburn medications (9,15). The antidepressants that are not likely to produce sexual side effects are nefazodone (Serzone), bupropion (Wellbutrin), trazodone (Desyrel), and mirtazapine (Remeron) (1). The antihypertensives that are least likely to produce sexual side effects are the ACE inhibitors (16). For diabetic men, good control of glucose reduces the risk of erectile dysfunction (17).

Because the risk of erectile dysfunction is higher for men who smoke cigarettes and drink alcohol to excess, educating patients about these risk factors is important (14).

Medical evaluation and treatment

Men who in later life develop erectile dysfunction that is persistent and not situational should be referred to a urologist for a medical evaluation (15). After a thorough history and physical examination, laboratory tests that should be considered include a complete blood count, urinalysis, renal function tests, lipid profile, fasting blood sugar, and the hormonal studies noted above (9). In the urological setting, a number of tests are available to assess erectile functioning, such as nocturnal penile tumescence monitoring and intracavernosal injection with vasoactive medication (2). Often treatment is initiated before such testing is completed (9).

Numerous treatment options are available for men with erectile dysfunction. Briefly, these include oral medications, such as sildenafil citrate (Viagra), yohimbine (Yocon), and apomorphine (Uprima); Food and Drug Administration approval is pending for apomorphine (18). Although testosterone supplementation primarily affects libido, it may improve erectile functioning in some men (8). Vacuum erection devices and constrictive bands are helpful for men with less severe symptoms (19).

Intracavernosal injection therapy is very effective, but unless patients are given proper education and encouragement, discontinuation rates are high (20). Transurethral suppositories are also effective. Prosthetic penile implants (15), although they have been improved, are reserved for refractory cases.

Psychosexual therapy for erectile dysfunction

Men with erectile difficulties often react with feelings of failure and loss of self-esteem. These feelings may be compounded by their partner’s disappointment or anger. To prevent exacerbation, it is often advisable to address erectile dysfunction as soon as it is brought to the clinician’s attention. If the patient and his partner are interested and willing to undergo specific sex therapy, referral to a trained professional is recommended.

Often psychosexual therapy is useful in helping couples adjust to the various medical treatments that can be prescribed for erectile dysfunction. For example, the partner may object to the treatment recommendation, whether it is a pill, a suppository, an injection, or a vacuum device, ostensibly because it is “too mechanical,” “too frightening,” or “too unnatural” or because it takes “too long.” In speaking with the partner, it may become clear that she has other, more pertinent objections to the treatment, of which she may or may not be consciously aware, such as a fear that she will be left for a younger woman, ambivalence about resuming sex at all, or a multitude of other concerns.

Not uncommonly, a modicum of sex therapy or counseling given simultaneously with the course of urological treatment can improve the outcome. Many urologists provide this treatment themselves or assign it to a nurse. For more complex problems, referral to a specialist in sex therapy is advisable.

Some common sex therapy treatment interventions that are particularly helpful for older men with erectile disorder are listed below (2).
Sex in the morning when erection is more likely. Avoid times when the male partner is stressed or tired.

Ample amount of vigorous penile stimulation, manually or orally, before and for intervals during intercourse as needed.

Positions in which vaginal tension is increased for heightened penile stimulation.

Spending more time on sexual activities other than intercourse. For instance, rather than relying on intercourse alone, as was customary when the couple was younger, it may be helpful for both partners to achieve orgasm via other techniques. Some older individuals need encouragement to try new sexual activities outside of their usual repertoire.

Encouraging the partner to experience sexual pleasure after erectile difficulty has occurred. Encouragement often serves to reduce both the partner’s frustration and performance pressure. Not uncommonly, such encouragement results in a pleasurable experience for both partners.

Taking turns at giving or receiving sexual pleasure. For example, one time for him and then another, different time for her.

Disorders of ejaculation

Premature ejaculation
Men who struggled in their youth with premature ejaculation often find that the condition remits spontaneously in later years (4). Men who develop premature ejaculation late in life may be compensating for a psychologically based erectile dysfunction and should be referred for a urologic evaluation.

Delayed ejaculation
Male orgasmic disorder, previously termed retarded ejaculation, is a condition in which a man can maintain an erection but cannot achieve orgasm despite adequate amounts of sexual stimulation (12). Lifelong delayed orgasm may worsen with age. In addition, the condition may develop as a side effect of medication, particularly selective serotonin reuptake inhibitors. Peripheral nerve damage to the penis or damage at the level the S2–S4 nerve roots can also delay orgasm.

These factors should be considered during the evaluation of a patient with an ejaculation disorder (4,15). Treatment of male orgasmic disorder can be a challenge and often involves helping the patient become more comfortable with obtaining the type of stimulation he needs in the presence of his partner. Because these patients often have atypical masturbatory styles, such as the face-down position, treatment may also involve masturbatory retraining. Sympathetic stimulants such as decongestants have occasional benefits.

Retrograde ejaculation
Retrograde ejaculation is a condition in which orgasm occurs, but the ejaculate is propelled into the bladder. It may occur in response to antipsychotic medications, such as thioridazine, chlorpromazine, and clozapine, or after surgery in which the sympathetic nerves leading to the bladder neck have been damaged (15). It is a common complication of transurethral prostatectomy (15). Sympathomimetic medications may help, but more often than not, patients and their partners will become more comfortable with the condition once they understand its cause.

Psychosexual therapy
Older patients who have functioned well in the past but are having difficulty adjusting to age-related physical changes often respond well to educationally oriented counseling with their health care provider. If counseling is not effective, they may respond to brief psychosexual therapy with a specialist in this field (2). A sex therapist will usually meet with a couple together, although individual sessions may also be scheduled. Sex therapists may come from a variety of disciplines, including psychiatry, psychology, social work, nursing, or the clergy. They have received additional training in sex therapy and are usually certified in that field.

After obtaining a detailed sexual history, the therapist prescribes behavioral homework assignments that specifically address the couple’s sexual problems. The couple then carries out the assignments at home and reports back on the next visit.

talking about sexuality with patients

In interviewing patients who are past midlife, it helps to keep a nonjudgmental attitude and to convey that it is normal and desirable to have sex in the later years (21). At the same time, it is important not to give the impression that remaining sexually active is essential to maintaining quality of life, because many older individuals prefer to be celibate. It also helps when the clinician is comfortable with discussing sexual functioning in some detail.

The guide for sexual history taking described in the companion piece to this column (1) can be adapted for men. It often helps for the clinician to echo the patient’s own language in describing sexual activity rather than to use clinical terms with which the patient may not be comfortable. When discussing sexuality with patients, it is important not to assume anything, particularly about sexual orientation or preferred activities.

Conclusions

This column helps familiarize clinicians with the sexuality of the older male. The aim is to improve doctor-patient communication and increase clinicians’ knowledge of available therapeutic interventions. We have summarized the physiologic sexual changes that occur as men age and have explained available options in terms of medical and mental health treatments for older men with sexual dysfunction. Mental health practitioners can do much to improve the quality of life of older patients by inquiring about sexual beliefs, behaviors, and symptoms. Patients appreciate knowing that their clinician is concerned about their sexual health and open to discussing these issues.

References

4. Meston CM: Aging and sexuality: in successful aging. Western Journal of Medicine

Continues on page 306


