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FAMILY HEALTH DAMAGE THROUGH MEDICAL CONDITIONS INDUCED MALE INTIMATE PARTNERSHIP DYSFUNCTION

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Assessing and managing family health and birth rates is a complex issue both clinically and socially. The predictability of demographic and epidemiological developments is the result of sociological, psycho-behavioral and medical analyzes. The latter have benefited in recent years, worldwide, from the contribution of specialists in couple issues, whose specific expertise can assess and improve (if necessary) dysfunctions of family health in clinical, social, emotional and reproductive. For more than 20 years, the Association for Sexuality Medicine was accredited in Romania, than it has been affiliated, since 2005, to the European Society of Sexual Medicine (ESSM). It is a strictly professional, interdisciplinary organization, bringing together doctors, psychologists, sociologists, lawyers, with the sole purpose of improving and correcting the dysfunctions of the intimate relationship, offering solutions to improve the quality of life of the family couple.

Male intimate disabilities, already presented above, are a key contributor to the family emotional and social disorder and the more common they are, the greater the impact on the health of the group that it belongs to.

Keywords: family health, intimate couple dysfunction, male sexual dysfunction.

INTRODUCTION

Health policies for preventing diseases and / or reduce the rate of chronic complications are made, for single individuals as well as for couples, all over the world. In this context, in modern civilized societies, family health is seen as a priority for community health management strategies. During the last three decades the abilities and performance of the intimate couple's relationship have been approached more and more actively, according to the idea that „the individual's sexual health is a mirror of the general health of the population which he belongs to"[1]. Epidemiologically speaking, nations around the world face significant public health challenges aimed at optimizing intimate couple (family) health, such as reducing the spread of human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS), sexually transmitted infections, unintended pregnancies or sexual violence, also in terms of mitigating the social and economic impacts of these clinical conditions on local budgets. The specific affecting of the couple's intimate relationship is a relatively new form of interest in modern medicine, both, from a medical point of view and as a demographic perspective. It thus, outlines the undesirable influence of sexual dysfunction and infertility on family health and on the dynamics of birth, as well as of some specific diseases able to induce these two inabilities[2]. Unfavorable psycho-social conditions, which produce tensions and even conflicts, between the members of marital or only circumstantially couple, bring, in addition, a different or congruent etiology in the appearance of a dysfunction in the intimate couple relationship, through stress-related mechanisms, depression, or anxiety.

There are, at least, four elements which interact each other in the way of areas and/or characteristics shaping the typology and the level of the family health withal intimate couple relationship between the two partners: social context, community context, relational context and individual context[3,4]. Damage of the intimate relationship of the couple represents the impairment of the sexual life of the partners and,

implicitly, of the couple itself. Since the last quarter of the twentieth century, the expertise in this field has developed considerably, becoming officially titrated at this level of doctors and psychologists, sociologists or lawyers. Thus, professional concerns were abled and systematized through accepted skills in sexology, sexual medicine, andrology, family planning, psycho-emotional counseling or specific socio-legal rights, for the already mentioned categories of professionals.

Even the following presentation details clinical conditions of the male side impairment in the couple life it would be useful to mention before that some other risk factors such as socio-demographic, education, instruction, culture, spirituality and economic states, recognized as harming the family health through affecting its intimate relationship by men sexual disability point of view. Randomized demographic studies for this purpose are performed. Some of them showed that the prevalence of male sexual dysfunction rises in correlation to the decreasing of the education level and to the professional stress emphasis (eg. self-employment situation)[5]. Male sexual dysfunction, disturbing the health of the family, was seen in regard to the economic level, spiritual-religious orientation and even addictions (eg. ethanol). Large studies covered wide geographical area, on all continents, from socio-economically developed countries (France, USA, Japan, etc.)[6–8] to less favored (Nigeria, Malaysia, Pakistan, etc.)[5, 9, 10], or specifically cultural-religious ones (Iran, Qatar, Ethiopia, etc.)[11–13], outlining the complex context of the elements that influence family health, through the prism of the couple's relationship and the psycho-medical-social interest that this subject incites.

Generally acknowledged, however, as an active side for the initiation and maintenance of the family (couple) intimate relationship, male sexuality once affected can disturb the balance of family health. If aging is its most obvious and unchangeable risk factor for that, there also are clinical states in which the couple's relationship suffers by male sexual dysfunction during the young adulthood and in the first half of the middle age, when in a family couple the vigor of the intimate activity and reproductive function should contribute, both, to its clinical and social comfort.

MALE SEXUAL DYSFUNCTION *VERSUS* INTIMATE COUPLE DYSFUNCTION

Male sexuality is undoubtedly a complex physiological process and it is an important aspect of the quality of life of the individual[14]. Maintaining normal male sexual function generally depends on coordinating almost the entire physiology of the human body, but in the foreground the nervous system, cardiovascular system, endocrine system and erectile cavernous system. When only one or more of the above elements, or extra added psycho-social relationships, are altered, performance or interest in a "*normal"* sex life is greatly reduced. Therefore, male sexual dysfunction (MSD) is considered a true disease with multifactorial etiology and intricate pathogenesis. It affects the whole process of sexual activity, from the sexual erogenous reaction to the erection itself, then to penetration, and, finally, to the seminal emission (ejaculation). Thus, MSD may also involve a decrease in reproductive capacity and infertility, with influences, at least in a population group, not only on family health but even on birth rate[15, 16]. In general population, infertility affects up to 12% of men. Sexual dysfunction can occur in men of reproductive age thus being able to be a cause of infertility in some cases. In infertile men, decreased sexual desire and lack of sexual satisfaction, both expressing lack (loss) of libido, are common types of sexual dysfunction, ranging from 8.9% to 68.7% (according the trials on different ethnicity populations). Erectile dysfunction and/or premature ejaculation, assessed with validated methods, have a prevalence of one in six infertile men, whereas orgasmic dysfunction is recorded in one of ten infertile men. On the other hand, backwards, infertility or psychological imbalances can underlie an unreported male sexual dysfunction. In addition, apart from psychogenic causes, as will be seen below, some physical health disorders may be common causes for both male infertility and MSD in the so called couple intimate unhealthy family.

MSD BY LACK (LOSS) OF LIBIDO

Many situations such as severe or prolonged stress, major mental trauma, mental depression or anxiety syndrome, on the one hand, or particular clinical conditions (diabetes, chronic kidney disease, neurological diseases, somatic disabilities, etc.) with a negative influence on biorhythms or socio-behavioral stereotypes may be associated with decreased male libido. Libido is an individual's overall sexual drive or sexual *desire* for *sexual activity*. It is often an important factor in the

initiation and maintenance of *intimate relationships* in humans as well as for the couple cohesion too. Mostly, psychogenic or social unconfortable situations contributes to the libido alterations. Nevertheless some disease can also induce this inconvenient.

Male hypogonadism (decreased serum testosterone levels) occurred by reducing the gonadotropin-releasing hormone (GnRH) and/or gonadotrophins secretion at the hypothalamic-pituitary level (central type hypogonadism) or, independently appeared, by testicular damage (peripheral type hypogonadism) always causes a lack of libido. Sexual desire and impulse are psycho-neuro-endocrine conditioned behavioral phenomena that require the anatomical and physiological integrity of all these compartments. Otherwise, in dealing with family health issues, the existence in the couple's romantic relationships of tensions or conflicting states also can generates libido disorders through a form of a so called psycho-somatic mechanism induced hypogonadism.

There is a significant clinical experience with pharmacological treatments able to impaired male libido. Studies have shown that some medicines used as treating hypertension (angiotensin converting enzyme inhibitors or some beta-blockers) may be linked to a decrease in libido. Subsequent observations have shown that there are other preparations that have this negative potential: hormone therapy used in the prostate cancer, corticosteroids, opioid analgesics, H_2 receptor antagonists for gastric hyperacidity, anabolic, antidepressants, etc.[17].

Metabolic disease are an important risk condition for loss of libido. Type 2 diabetes and metabolic syndrome are recognized as having as their chronic complication the central hypogonadism with negative consequences on libido. If in the general male population of middle age the prevalence of hypogonadism is about 6%, it ends up was reported in diabetic men at 25–40%, for the same group of age (according to various epidemiological studies)[18]. Obesity is another condition with a high risk of male libido down and for hypogonadism. Obesity, as well, associates psychological factors related to decreased of self-esteem, due to awareness of unattractive physical appearance, generating social isolation and emotional internalization with inhibitions of erotic aplomb and, implicitly, of libido. However, obesity is also worth mentioning as a favorable clinical condition for infertility, the modified seminal morphology (azoospermia, oligospermia, teratospermia) being 2–3 times more common in obese men than in normal weight male persons, these frequency being comparable to those of chronic alcohol users. Thereby obesity is a real risk to the age group of young adults with high body mass index, creating undesirable consequences for the onset of couple infertility, in families being in the fully procreation period[19].

MSD INDUCED BY ERECTILE DYSFUNCTION

Although it is not the most common form of DSM, altered stiffening of the corpora cavernosa at the onset of intimate intercourse, known as erectile dysfunction (ED), is perceived as the most eloquent sexual dysfunction by both adult partners of a family or conjuncture couple. ED confers, moreover, the most intense discomfort in the intimate relationship of the couple and seriously disrupts her health [20]. It reduces the tone and vigor of the sentimental-affective ties, not only to the male partner, but to the female partner as well, thus reaching a quasi-permanent own failure and dissatisfaction state.

Defined as being a "constant inability to obtain and maintain a phallic rigidity indispensable to achieve a satisfactory intimate relationship for both partners throughout the actual intimate relationship"[21], DE has an extremely varied etiology and, contrary to uninitiated opinions, the psychological factor is considered to be causal in only about 1/3 of cases (30%). Almost 2/3 of men with ED (60%) describe an organic etiology, not involving, strictly at the onset of ED, no psychogenic mechanism. There is also a small percentage, of 10%, which admits mixed, psycho-organic causes. Considered probably a paradox, large trials have stipulated that there are no direct urological causes in the early onset of ED (before 50 years old), except, of course, pelvic urological surgery or in perineal and genital neighboring topography area[22].

The increased risks of ED, as a complication, in the metabolic and endothelial-vascular pathology are remarkable. The main pathophysiological mechanisms of ED, consists in altering the functional triumvirate between the nerve endings, the cavernous syncytial endothelial layer and the penile smooth muscle. In type 2 diabetes, for example, after 10 years of history of diabetes, over 50% of men have ED, while in middle-aged hypertensives ED in about 75% of cases was found. Alterations of the terminal nerves of the

autonomic nervous system (in diabetes) and the arterial endothelium of both, *vassa nervorum* in the genital area, and of the penile cavernous syncytia (in diabetes and in hypertension as well) are the pathogenesis of the increased risk of ED in these two very common diseases[23].

Moreover, in depressive states or anxiety syndromes, in families, (couples) in which cohesion, tolerance and adhesion are flawed, ED is also could be find. There are situations of emotional conflict, in which the so-called "social health" is affected, the occurrence of ED being an additional factor of disruption. When we talk about families recently jointed, still without children, the birth rate can be compromised. The family "social non-health" can induce inhibitions and interpersonal distancing with a tendency to extramarital sexual experimentation. During the medical evaluation, ignoring the risk of ED as a chronic complication in permanent monitoring diseases either, somatic (metabolic, vascular, endocrine, neurological etc.) or psychiatric (depression, schizophrenia, paraphilia, etc.), can be a serious mistake by the part of the attending physician. As it is also possible by a superficial anamnesis that can vitiate that man from the contribution of the titrated specialist with expertise in sexology and andrology. The medical-social and emotional dysfunction of the family, (couple) will seriously reduce the chances not only for a harmony of intimacy but for endangering birth rate also.

MSD THROUGH SEMINAL EMISSION DISORDERS

Premature (precocious) ejaculation (PE) defines a too early seminal emission, during the male orgasm, occurred long before the partner's expectation. PE is the most common form and frequent MSD, literature establishing that about 1 in 3 middle-aged men admitted to experienced PE phenomena at least sporadically. Other statistical observations revealed in very large general male population groups of subjects and age (16–75 years old) an over 70% prevalence of PE[24]. The period of time elapsed from the moment of intercourse to the time of ejaculation is called the intra-vaginal latency time (IVLT). It is accepted that a less than 3 minutes IVLT defines EP. However, a sexual intercourse shorter than 3 minutes, but able to induces orgasms and bilateral partnership satisfaction, does not fall within the PE. From a clinical and progression point of view, PE is classified as: 1) primary PE (existing since the beginning of sexual experience); 2) secondary PE (occurring late, after a period of time having a satisfactory IVLT). PE is mainly psychogenic (improper onset of sexual life, sexual abuse, self-image impairment, depression, fearing the onset of a PE, paranoid or anxious feelings) but often accompanied by an ED, in which case they outline together a MSD real and complex. PE pathogenesis mainly targets spinal nerve control defects in the parasympathetic plexus, whose tone decreases, favoring the expression of stimulation from sympathetic neurons. Psycho-nervous integration in the pathogenesis of PE has been shown to be due to defects in the physiology of neurotransmitters. Low serotonin (5-hydroxytryptamine, 5HT) reuptake at some cerebral-thalamic-hypothalamic neuron terminals and decreased activity in cerebral amygdala nerve cells is one such example of neurotransmitters malfunction that contributes to the mechanisms of PE molecular intimate pathogenesis.

Retrograde ejaculation (RE) or "dry" orgasm is the misdirection of seminal emission during orgasm into the bladder. It occurs in various neurological consequences after surgery, after urological procedures, after perineal irradiation, diabetes neuropathy, multiple sclerosis, Parkinson's disease, poly-trauma, etc.). Rarely involved in the etiology of male infertility (0.3–2%)[25], however, RE remains the leading cause of male infertility in young men under 40's having type 1 diabetes started around puberty and to whom, after about 20 years evolve with inadequate glycemic control, end up showing ER as a chronic symptom of diabetic autonomic neuropathy[26]. Most often, RE also combines organic (neuro-endothelial-endocrine) ED, accompanied by impaired self-esteem and anxiety depression, thus outlining a more complex MSD, seriously imprinting the balance of the couple's health and that family's hope for its birth rate.

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