Chapter 10

Functional sexuality, sexual difficulties, and sexual dysfunctions

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Introduction

Sexuality is the expression of personal, interpersonal, and social behaviour around the biological imperative to reproduce. From nature's point of view, a man is normal if he can achieve and sustain an erection firm enough to penetrate and impregnate a female, and want to do this often enough to ensure his genetic material is reproduced. From nature's perspective, a woman is sexually normal if she can be receptive to a male for impregnation. All other sexual behaviours are personally, interpersonally, culturally, and legally determined and judged. To achieve this, most men are easily aroused and orgasmic, and most women of reproductive capacity will lubricate enough to prevent damage on penetration.

Many mammals learn how to behave sexually through observation of adult sexual behaviour as they mature, but this is not usually the case for humans. While sex education may teach the biological basics, humans are mostly educated about sexual behaviour and sexuality through innuendoes, pornography, misinformation, and experiences with other age-matched adolescents. Despite poor education about sexuality and how to achieve good sexual functioning, most adults expect to have great, life-long sex through changing life-stages and health situations. For most, this will be with a member of the opposite sex, who has different genitals, sexual thoughts, and responses.

Like many other human characteristics, libido and ease of orgasm lie along a continuum, with most people falling into an average range in the middle. Human sexuality is, however, further complicated by the attribution of meanings to thoughts and actions that are very individual (Box 10.1). For example,

Box 10.1 Influences on individual sexual function

- Individual sexual anatomy and hormonal biology
- Personality
- Family of origin role modelling
- Personal sex education and experiences
- Cultural scripts
- Religious expectations
- Partner personality and sexuality

the lack of orgasm in a partner may mean nothing to one person, but be crippling to the sexual confidence of another.

Cultural beliefs determine much of our sexual behaviour and understanding of what is 'normal' and what is 'dysfunctional'. Given the lack of sexuality education and supervised practice offered to humans in almost all societies, one should expect to find a high degree of sexual difficulty. Nearly everyone will experience an occasional sexual anxiety or difficulty through the life cycle as circumstances alter due to relationships commencing or ending, job changes, children, deaths, health issues, or major upheavals.

'Sexual Dysfunction' is the term applied to a sexual difficulty that is persistent and pervasive, a change from the 'normal' sexual response pattern of that individual, or that deviates significantly from the 'normal' response that can be expected for age, situation, health, relationship quality, sexual stimulation, has lasted more than 6 months, is causing distress to the individual, and cannot be accounted for by another disorder (American Psychiatric Association (APA) 2000; World Health Organization (WHO) 1992).

The basics for a good sexual relationship include ownership, respect, liking and knowledge of one's own sexuality, adequate knowledge of male and female bodies and sexual function, ability to communicate about sexuality, realisation that good sexuality needs to be prioritised in an ongoing relationship for the quality to be maintained, functional enough bodies, sexual organs not damaged by factors such as drugs or infection, and, of course, a willing partner with the same skills.

The basic requirements for sexual functioning in a two-person (dyadic) relationship are an attractive enough partner, good enough relationship, sexually competent/capable enough partner, expectation of some pleasure with that partner, and motivation to be sexual with that person. There is, however, a trebling potential for sexual difficulties in a relationship (each partner, plus the couple).

Understanding why we have sex beyond the reproductive imperative may contribute to validating its importance (Box 10.2).

Good sexual experiences (or individual perceptions of these) are important for positive self-esteem, and a sense of competence as a man or a woman.

Box 10.2 Some reasons humans have sex

- Biological libido or lust
- Give and receive love/affection/acceptance
- Skin hunger needs (i.e. the importance for mammals of skin-to-skin touch and affection through physical contact such as hugging and kissing)
- Gender validation
- Relieve boredom, tension, or insomnia
- Control, reward, or punish
- Affirmation of femininity/masculinity
- Recreation/fun/feels good
- Health benefits – stimulates release of oxytocin, endorphins, variety of neurotransmitters

Good love-making is also an important feature in interpersonal interactions. It aids bonding and is a source of relationship goodwill and motivation to work with the partner. Sexuality is a meta-communication tool and for most couples who stop making love there is a decrease in verbal affection, physical affection, and fun in the relationship.

The limitations of coito-centricity (reasonable for reproduction but limiting for recreation) need to be clarified. Masturbation and outercourse (that is, everything that can be done outside of penetrative sex) must be positively permitted and embellished to assist people to have better, more satisfying sex lives.

Male and female sexual function models

The Master's and Johnson's/Kaplan's models have traditionally been described as male-centred models of sexual function. In these models, desire leads to excitement and arousal. This is followed by a plateau phase, followed by orgasm and then resolution, all occurring in a linear progression. More recently, sexologists such as Basson (2001) have proposed circular models for female sexual functioning where there can be several entry/starting points for sexual activity. Here willingness to participate in love-making when not sexually interested may lead to arousal with a loving partner in a safe, relaxed and erotic environment.

While the linear models may describe a significant number of men, especially those under 40 years of age, the circular model also fits many men and especially those who are older or have medical, psychological, or sexual difficulties. Likewise, there are many women whose sexual function matches the linear description. Models are useful, but in therapy each individual/couple has to be understood as unique.

Raising sexual matters in the clinical setting

Health practitioners are not always taught how to initiate discussion around sexual concerns, and although most agree that sexual health is important and falls within their job, only a small percentage regularly include sexual health in history-taking (White 2002). Reasons health practitioners give for not raising sexual concerns include embarrassment, lack of time, inappropriateness to consultation, and fear of where the questioning might lead.

Nevertheless it is the health professional's role to raise the sexual health agenda. Health practitioners can make themselves comfortable with this process by active education, routine inclusion of sexual health enquiry, and working through personal issues around sexuality. Enquiring about sexual issues fits with checking on lifestyle, wellbeing, and medical conditions. Both patient and practitioner's comfort can be increased by establishing a clear context around the line of questioning. For example, 'Has having prostate disease changed the way you see yourself as a man?' or 'Has your condition/treatment caused any sexual difficulties for your partner?' It is

Box 10.3 A schema for sex therapy

This basic schema is used in sex therapy and is applicable to all conditions:

- Detailed psycho-relational-socio-sexual history of patient and partner
- The detailed sexual history needs to include masturbatory patterns, love-making scripts, fantasy content, sexual orientation, pornography usage
- Review of medical conditions and medications
- Physical examinations and tests as appropriate
- Sex education about normal range of male and female function
- Sex education about improved recreational sexual options including variety, erotica and toys, outercourse, masturbation, and so on
- Sensate focus and mindfulness exercises
- Relationship enhancement with improved communication skills
- Regularity and prioritising of sexual experiences
- Acceptance of individual functioning and differences, and negotiating a compromise that can work long-term for both partners
- Dealing with the partner, as there are always two patients if one has a sexual difficulty
- Acknowledging groups with particular needs, for example gay and lesbian men and women, individuals with disabilities, alternative lifestyles
- Therapy cannot take place productively if there is an active ongoing affair, drug or alcohol abuse, or violence
- A sexual difficulty/dysfunction occurring in a dyadic situation always benefits from couples therapy
- Pelvic floor (Kegel's exercises; Kegel 1948) are good for everyone

helpful to normalise situations, for example, 'It is normal for your sex life to be affected when you are grieving. Is there anything you'd like to ask me?' It is good to generalise so that the patient does not feel like they are targeted, for example, 'It is common for men to experience sexual changes when they are diagnosed with HIV. Have you noticed any changes you'd like to discuss?' Most importantly, positive open-ended questions work best. Nursing professionals, pelvic floor physiotherapists, and other health professionals will also have times when including a line of sexual function questions is appropriate.

The proactive inclusion of sexual health questioning for both sexes, across the age span, single and coupled individuals, those abled and disabled, will increase quality of holistic care and the wellbeing of individuals. Erectile dysfunction, for example, can be a very early symptom of cardiovascular disease and diabetes which, if identified, offers potential for years of preventive care. Patients who consider that medication (e.g. antidepressants) affects their sexual function may not always take it in accordance with directions, and this can have an impact on their condition (Ashton *et al.* 2005).

Sexual difficulties

Sexual difficulties may be primary (innate and lifelong) or secondary (after a period of normal functioning), and either total or situational. Cultural, religious, gender, and sexual orientation sensibilities have to be sensitively explored. Stress, fatigue, depression, health problems and medications, recreational drug and alcohol misuse, relationship issues, and sexual boredom are all common components in all sexual difficulties. The incidence of male and female sexual difficulties in Australia has been estimated in a variety of studies, as shown in Tables 10.1 and 10.2.

Hypoactive sexual desire disorder (HSDD)

HSDD, also known as inhibited sexual desire or desire disorder, is an absence of sexual fantasies and desire for sexual activity. To be classed as HSDD, the disturbance must cause marked distress or interpersonal difficulty, cannot be better accounted for by another major mental disorder (except another sexual dysfunction), and is not due solely to the effects of a substance or general medical condition (APA 2000).

Although there will be a crossover with high sex drive females and low sex drive males, there is a real gender difference between the libidos of men and women, with men having up to twenty times as much testosterone as women – testosterone is the energising, feel-good, libido-enhancing hormone. A further difficulty for women is that there is a rapid decline in testosterone

Table 10.1 Incidence of male sexual difficulties in Australia

Sexual dysfunction	*Research source*	*Population*	*Percentage*
Decreased interest in sex	Najman *et al.* 2003	876 men 18–59 years in 1999 duration > 12 months	16.5
	Richters *et al.* 2003	10 173 men 16–59 years in 2000; sexual difficulty over past 12 months duration > one month	24.9
Erectile dysfunction	Najman *et al.* 2003	As above	9.75
	Chew *et al.* 2008	1580 men 19–80+ years in WA in 2001	25.1
Premature ejaculation	Najman *et al.* 2003	As above	39
	Richters *et al.* 2003	As above	23.8
Retarded ejaculation	Najman *et al.* 2003	As above	6.75
Sex not enjoyable	Richters *et al.* 2003	As above	5.6
Peyronie's disease	Pryor and Ralph 2002	Review of international data	3–9

levels relatively early in life, so that a woman at age 40 has roughly half the testosterone she had at age 20. Men generally have a very gentle decline in testosterone levels. Their higher testosterone means men are generally proactive in seeking sex, quicker to arouse, more focused during sexual activity, and find it easier to orgasm. Women tend, especially in a settled long-term relationship, to be more receptive and comfortable with 'vanilla' sex, a term which refers to sedate, under-the-sheets, lights off, routine sex which does not have much variety or spontaneity. Vanilla sex may be very nurturing emotionally, and physically satisfying.

It is important to assess whether the issue is dissatisfaction with innate libido, with a negative change, or a discrepancy of libido between partners. Desire discrepancy is the most common dyadic presentation to sex therapists and one of the most complex to manage, due to the multiplicity of factors involved and the difficulty in encouraging or supporting individuals to change. An often confusing issue is the higher libido experienced by women in new relationships. This honeymoon effect rarely lasts beyond six months to two years, and is nature's trick to improve pregnancy rates. Ranking can also change in different relationships so that one can be the lower libido partner in one relationship and the higher libido partner in another relationship.

Anecdotally, 30% of clinical desire discrepancy cases have the male as the lower sex drive partner, a likely underestimate given the humiliation men

Table 10.2 Incidence of female sexual difficulties in Australia

Sexual dysfunction	*Research source*	*Population*	*Percentage*
Decreased interest in sex	Najman *et al.* 2003	3908 women 18–59 years duration > 12 months	34
	Dennerstein *et al.* 2008	257 women 45–55 years over 11 years starting 1991	55
	Richters *et al.* 2003	9134 women 16–59 years in 2000 with sexual difficulty over past 12 months duration > 1 month	54.8
	Hayes *et al.* 2008	356 women 20–70 years in 2005	16
Difficulty with arousal	Najman *et al.* 2003 Dennerstein *et al.* 2008 Hayes *et al.* 2008	As above	22.75 11.5 7
Orgasmic difficulty	Najman *et al.* 2003 Dennerstein *et al.* 2008 Richters *et al.* 2003 Hayes *et al.* 2008	As above	23 29 28.6 8
Dyspareunia	Najman *et al.* 2003 Dennerstein *et al.* 2008 Richters *et al.* 2003 Hayes *et al.* 2008	As above	16 14.5 20.3 1
Vaginismus	Reissing *et al.* 1999 Crowley *et al.* 2006	international data	1–42
Sex not enjoyable	Richters *et al.* 2003	As above	27.3

Box 10.3 Some useful self-help books for patients

Zilbergeld B (1980) *Men and Sex.* Fontana, London.
Pertot S (1994) *Commonsense Guide to Sex.* HarperCollins, Sydney
King R (1997) *Good Loving Great Sex.* Random House, Milsons Point, New South Wales
King R (2010) *Where Did My Libido Go?* Random House, North Sydney
King R (2004) *Management of Erectile Dysfunction in Primary Care Practice.* WrittenWord, Crows Nest, New South Wales
Schnarch D (1997) *A Passionate Marriage.* Norton, New York
Heiman J, LoPiccolo J (1988) *Becoming Orgasmic: A Sexual and Personal Growth Programme for Women.* Simon and Schuster, Brookvale, New South Wales
Spring JA, Spring M (1996) *After the Affair: Healing the Pain and Rebuilding Trust when a Partner has been Unfaithful.* Hodder Headline, Sydney
Lowy M, McCann B (2009) *Too Fast? Learn to Last Longer: Guide to Premature Ejaculation.* Longueville Media, Woollahra, New South Wales

feel at being the partner with the lower sex drive. A man's lack of interest in the current partner, sexual orientation issues, or a preference for masturbation as the less bothersome activity ('lazy lover' syndrome) may present as HSDD. Men in this category masturbate at normal frequency and do not have innate low libido. Internet porn addiction is often a feature in these men's histories and intimacy issues are common.

Bilateral comorbidity is common. The primary HSDD may be associated with anorgasmia, dyspareunia, premature ejaculation, erectile difficulty, and other conditions. Many factors can affect libido, such as poor quality lovemaking, sexual boredom, sexual trauma, fertility issues, pregnancy, infidelity, domestic violence, comorbid sexual dysfunction, oophorectomy/hysterectomy, menopause, dislike of partner, poor hygiene and self-care, and dislike of genitals/body, either the partner's or the patient's own. Medical conditions that can affect libido include depression, thyroid disease, anaemia, androgen insufficiency, hyperprolactinaemia, any chronic condition, and chronic tiredness, lethargy, and pain. Medications such as oral contraceptives, antidepressants/antipsychotics, antihypertensives, and cancer treatments may have sexual consequences. Recreational drugs (Mackay 2005) can also have sexual repercussions: alcohol can cause decreased inhibition and ability, and short-term in moderate amounts an increase in desire; marijuana can cause a decrease in sex drive; heroin can cause a decrease in sex drive in men; and cocaine can impair sexual performance in men.

Management is similar for men and women, determined by the specific psycho-relational-socio-sexual history. The end goal of therapy is to remove the contextual negatives and improve the erotic positives so that the whole experience is worth having. Determining motivation for treatment is vital, as some people go to therapy for help with breaking up. It may not be possible to ameliorate the situation if it is longstanding, if the couple have reached a very platonic stage in the relationship, or there is contempt for each other. Sometimes loss of desire for the partner is appropriate and a sane response. The medical management of libido can be controversial.

Female sexual difficulties/dysfunctions

Female orgasmic difficulty

Female orgasmic difficulty (FOD) is defined as 'a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm' (APA 2000). A diagnosis of FOD is based on the clinician's judgment that the woman's orgasmic capacity is less than what is reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. The disturbance must cause marked distress or interpersonal difficulty, and not be due to a psychiatric condition or influence from substances.

Orgasmic difficulties are common, and generally respond well to sex therapy. Clinical presentations range from orgasm with partner but not during intercourse, only by herself, only with a vibrator, with some very specific fantasy or routine, infrequently and with difficulty, to never having achieved an orgasm at all.

An orgasm is a reflex dependent on a threshold of stimulation being reached. The stimulation required can range from dreaming to the purely tactile. Most women will utilise both modalities in varying degrees. Generally, women need longer stimulation to reach the threshold than men; up to 20 minutes can be considered normal. Women can be easily sexually distractible, tend to spectator (visualise themselves as they appear to their partner), and hold negative dialogues in their heads that can slow arousal. Shyness and lack of sexual assertiveness often stop women correcting or sharing preferred sexual options with their partners, thereby disabling positive sexual learning in a relationship. Masturbation can be an excellent vehicle for learning about one's body, and women who hold negative beliefs about touching their genitals may be less likely to be easily orgasmic. Ageing, menopause, and parity can weaken pelvic floor muscles, increasing the difficulty in reaching orgasmic thresholds or delivering very weak orgasmic contractions.

A good sexual history is necessary to determine issues that need specific attention. The woman's beliefs about female sexuality and her sexual entitlements, her self-sexuality and sexual behaviours need detailed review. The sexual script of the couple needs to be understood. Most reasonably healthy women are 'pre-orgasmic', and will achieve orgasmic status if given permission to be sexual and explore their own bodies, instructed in directed self-masturbation, sexual communication skills, partner communication of self-discoveries, Kegel's pelvic floor exercises, better love-making skills and options. Patience and persistence are critical. The use of vibrators can be very helpful and is not habit-forming or lover-replacing. Lubricant is essential and can be considered most women's best friend. The G-spot area does not seem to exist in every woman, but anecdotally it is a source of pleasure and orgasmic potential in those women who have it. Every woman's orgasms are individual and there is a wide range of experiences from a very mild sense of relief/relaxation to intense whole body and pelvic contractions.

Pain disorders

Dyspareunia

Dyspareunia is defined (APA 2000) as persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse. Pain with intercourse must be treated as a medical situation until all medical causes such as infection, endometriosis, ovarian cyst, painful episiotomy scar, menopausal dryness, and vulvadynia have been excluded.

Important components in therapy include education about adequate sexual arousal, lubricant use and preparation of the vagina for penetration with prior digital stretch, outercourse options and orgasms, depth-limiting sexual positions, especially if the partner has a larger penis, relaxation exercises, positive self-talk and affirmations, and relationship enhancement. Couples are often angry, hurting, and grieving by the time they present, and this needs addressing to enable goodwill to progress to sexual behaviour. The male partner often needs support. There may be feelings of responsibility that in some way they are bad lovers or that they are not desired.

Vaginismus

A reasonable working definition of the debated term 'vaginismus' is that penetration of the vagina is painful or impossible due to reversible spasm of the pelvic floor muscles, which, if severe, may include adductor, abdominal, and buttock spasm. The muscular tightening is in response to fear of intercourse, anxiety about potential, or actual past or present pain. Vaginismus is the most common cause of unconsummated marriages/relationships.

Women suffering from vaginismus often have a distorted idea of their genital anatomy and may worry that their vagina is too small, too dirty, too fragile, or sealed. There may be no problem with desire or orgasm ability, and some of these couples have very successful sexual relationships until something changes, such as pregnancy becomes desired, a Papanicolaou (Pap) smear is wanted, or the partner insists on intercourse.

Some common elements in vaginismus (Crowley *et al.* 2006) are: the desire to maintain virginity till marriage; history of rape, attempted rape, or molestation; childhood punishment for masturbation; fear of pregnancy or labour; fear of sex as painful or traumatic; punitive religious/cultural ideology; poor male relationship role modelling or abusive male relationship; history of recurrent/chronic urinary tract or genital infections; and genital medicalisation. The women may have an anxious personality and low pain threshold.

Partner responses can be varied and will impact on the outcome. If the partner is intolerant or aggressive the relationship will often break down before therapy is sought, but at the other end of the continuum an over-sympathetic partner can lead to collusion in maintaining the situation. Partner sexual function needs reviewing, as there may be erectile difficulties or premature ejaculation issues.

Barring serious psychological or relational pathology, sex therapy can be very successful. The woman needs to feel in control of her body and her safety, and be supported and encouraged to progress in small increments to gain confidence that there is space and sensation, but not pain. The standard desensitisation program includes relaxation exercises, Kegel's exercises, graded penetration with fingers and dilators, woman-on-top penetration, and desired intercourse positioning. Positive self-talk is important. Supporting the partner to be patient and confident of his own

sexuality is critical. Masturbation and outercourse are important elements to discuss and include.

Persistent genital arousal syndrome

Persistent genital arousal syndrome (PGAS), or restless genital syndrome (Lieblum *et al.* 2005), is a relatively uncommon situation where the woman becomes involuntarily aroused and genitally congested for extended periods of time, in the absence of sexual desire and without sexual stimulation. Orgasm brings no or minimal relief and the situation is usually quite distressing. There have been reports of PGAS after withdrawal of selective serotonin re-uptake inhibitor (SSRI) antidepressant treatments. Causation is not understood and there is no specific recommended management.

Female anatomical difficulties

Hymen issues can range from the desire to keep the hymen to prevent shame at not being a virgin to the purely physical problem of excessive thickness being a source of pain and non-consummation. Hymen remnants can cause discomfort with penetration and intercourse.

Although uncommon, congenital anomalies of the female genital tract such as absent vagina, double vagina, and vaginal septum need to be considered, especially with vaginismus and dyspareunia patients.

The external genitals of females vary widely. Changing social mores allowing more obvious visual display of female genitals (especially hair-free) have been associated with increased anxiety about genital appearance and the seeking of 'designer genitals' through surgical intervention. Surgical consequences can be problematic, especially if excessive removal of tissue causes dysfunctional tightness, scarring, and pain on intercourse. However, there is a place for genital surgery, for example the trimming of very long labia in a diabetic woman where irritation and infection are a problem.

Female ejaculation

Some women spurt fluid from the genitals during orgasm (Darling *et al.* 1990). The origin of the ejaculate is variably thought to originate in the vagina, in the bladder, or in the paraurethral (Skene's) glands. A relationship of these expulsions to the stimulation of the vaginal G spot has been reported. Anxiety about this wetting can result in women suppressing having an orgasm. Management includes reassuring the women about their added experience and suggesting using cot liners and pretty towels.

Male sexual difficulties/dysfunctions

Premature ejaculation

Premature ejaculation (PE) is the persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration, and

before the person wishes (APA 2000). Waldinger (2008) added the time limit of 'within one minute or less of penetration'. However, one to two minutes is usually considered undesirable, and it is the absence of ejaculatory control that is most distressing. The mean is 5.4 minutes from penetration to ejaculation. A few men will ejaculate prior to penetration.

PE used to be considered a purely psychogenic condition, but it is now recognised that some men have a genetically influenced very short intravaginal ejaculatory latency time (IELT), which presents as lifelong PE. There is often a family history of PE, and behavioural methods alone will only add to a sense of failure and incompetence (Althof 2012).

As with any skill, love-making needs practice to acquire competence, and in anxious individuals, those with negative early sexual experiences or lacking practice opportunities, PE may become self-perpetuating. Negative sexual, relationship or life events can also derail adequate sexual response. As sexual competence is important to most men's self-esteem, one or two negative experiences can re-set the sexual response pattern. Young men need a period of learning in a dyadic situation after their period of self-masturbation. The sexual scripts (the mental schema of how sex should be) of men are often set young and are relatively inflexible.

In primary life-long PE, pharmacological assistance should be given with SSRI antidepressants (dapoxetine is a specially designed short-acting SSRI for on-demand use) to aid slowing of the ejaculatory response, while also improving education about slowing foreplay, outercourse options for the female to orgasm, and general reformatting of love-making as a recreational activity as opposed to a task that has to be achieved. Men with primary PE usually require lifelong SSRIs to increase IELT. In the secondary acquired situation the specific history will direct focus of management. Some specific therapy items include stop-start and squeeze exercises, desensitisation with vibrators, desensitising creams and condoms, outercourse, and increased frequency of love-making. Relationship dynamics need specific attention as the partner can be quite angry and frustrated, especially if the man has denied the situation for many years.

Inhibited ejaculation

At the other extreme is the man with a threshold for orgasm which requires more than 20 minutes of stimulation/intercourse. Inhibited ejaculation(IE) is defined as a persistent or recurrent delay in orgasm after a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration. There is personal distress and no other causative disorder (APA 2000).

The incidence of IE is unknown, as sexual prowess validates being able to last for long periods before orgasm. However, a regular pattern of not being able to ejaculate when one wants to, needing specific stimulation for an extended time, or not being able to ejaculate with a partner can be troubling. This high threshold for stimulation to ejaculate may be genetically determined.

IE can be primary or secondary. Possible psychosocial factors are fear of causing pregnancy, fear that the vagina is dirty, over-strict religious upbringing, and latent homosexuality. IE can also occur in homosexual men who have a high threshold for stimulation and/or are experiencing psychosocial sexual inhibitors. The primary condition is very difficult to treat and may benefit from medication. Electro-ejaculation may be needed if pregnancy is desired. Secondary IE may be caused by medications, for example antidepressants and recreational drugs, or by neurological and hormonal conditions.

Therapy needs to exclude any negative factors, maximise mental and physical erotic components, explore idiosyncratic masturbation styles, exclude depression, review medications, recreational drugs, and alcohol, and give the man permission to be 'selfish', as some men over-focus on their partner's sexual needs (Althof 2012). Sexual orientation may need to be discussed. Use of vibrators to increase sensory load may be helpful. Intercourse may need to be time-limited to manage partner discomfort caused by prolonged thrusting. The partner's possible beliefs about their sexual unattractiveness or incompetence may need to be addressed so that there is joyful participation in love-making.

Erectile difficulties

Erectile dysfunction (ED) is the persistent inability to achieve and/or maintain an erection sufficient for satisfactory sexual intercourse. ED can be

Box 10.4 Features differentiating organic and psychogenic ED

Organic

- Age over 40 years
- ED developed gradually
- ED becoming worse
- Loss of nocturnal penile tumescence (NPT) and waking erections
- ED is total
- ED with masturbation
- Medical conditions – cardio-vascular disease (CVD), metabolic syndrome, obesity, diabetes, any chronic condition
- Smoking
- Sedentary lifestyle

Psychogenic

- Youngish
- ED came on suddenly after some event
- Severity varies
- NPT and waking erections and masturbation not affected
- ED situational

Box 10.5 Risk factors for ED

- Age
- CVD
  - High LDL cholesterol
  - Low LDL cholesterol
  - Hypertension
- Diabetes
- Smoking
- Obesity
  - Sedentary lifestyle
  - Atherogenic diet
- Insulin resistance
- Metabolic syndrome
- Chronic conditions (for example, multiple sclerosis)
- Prostate disease and lower urinary tract syndrome (LUTS)

psychological, organic, or of mixed causation. It would be unusual for a man with organic ED not to have some psychological component. There is often a high degree of bidirectional comorbidity with ED. For example, a man with PE may lose confidence and develop ED, in which case it is important to address the PE initially or concurrently.

There are many potential psychosocial triggers – personality, relationship factors, life stressors, etc. ED can be a presenting symptom for as-yet undiagnosed medical conditions including cardiovascular disease and diabetes. This is due to the common pathological pathway of endothelial dysfunction. About 80% of ED is due to vascular disease. Lower urinary tract symptoms are also common in older men with ED.

ED has a significant effect on self-esteem, with broad implications for well-being, happiness, and productivity. The relational impact can be significant, although sexual functioning may not be important to some individuals, or not equally important to both individuals in a relationship. Motivation for treatment determines compliance with advice and medication. Older men

Box 10.6 Management options for ED

- Couples therapy with sex education, including conditions for good sex, outercourse, low stress positions, masturbation, vaginal stuffing, erotica, toys
- Phosphodiesterase type 5 inhibitor drugs (PDE5s)
- Vacuum devices
- Intracavernosal injection therapy
- Penis splints
- Implants
- Vascular surgery

with ED are often in a relationship with a menopausal woman, and her issues need to be managed concurrently for a successful outcome.

PDE5s work by increasing blood flow to the penis and have no libidinal effect. They are highly effective with few side-effects. They are thus the first-line therapy for organic ED and are often used short-term for psychogenic ED. These drugs are being used recreationally by gay and young men in their desire to perform supra-physiologically. The major contraindication is concomitant use of nitrites.

Despite the effectiveness of PDE5s, there is a very high rate of stopping usage, perhaps reflecting the need for better supervision by health practitioners to address sexual and interpersonal agendas. Some women will not be happy with the return of erectile functioning in their partners. A non-optimal response to PDE5s requires a review of dosage, patient usage, partner cooperation, and comorbid situations. The issue of low testosterone levels and PDE5 efficacy is being debated, although for some men with low testosterone, supplementation will salvage PDE5 efficacy (Spitzer *et al.* 2012).

Vacuum devices are not so popular, but can be acceptable to older couples where PDE5s or injections are not acceptable. Intracavernosal injection therapy is different from PDE5 therapy in that desire is not a prerequisite. Penile implants are well accepted in men with severe ED that is unresponsive to other treatments or post-prostate surgery, and where the couple has been screened and counselled. The satisfaction rate is over 80%. Venous surgery for ED is having a resurgence but outcomes have not been validated.

Lifestyle counselling is critical, as loss of weight has been shown to restore erectile function in obese men with and without metabolic sydrome. Good management of diabetes, smoking cessation, and cessation of drug and alcohol abuse are all important (Kolotkin *et al.* 2012).

Prostate disease is on the rise with an aging population and earlier diagnosis. Erectile dysfunction and urinary incontinence are common sequelae (Harrington et al.2010). Vacuum devices and PDE5 medication are helpful in the rehabilitation process.

Male anatomical difficulties

Penile size

Penile size is important to men's self-esteem. However, the true micropenis is uncommon and most surgery to increase penile size is cosmetic (Kayes *et al.* 2012). The consequences of failed procedures need to be clearly explained to men. Care needs to be taken with men with body dysmorphic conditions who ask for surgical enhancement of normal genitals.

Peyronie's disease

Peyronie's disease is a deforming connective tissue disorder involving the growth of fibrous plaques in the soft tissue of the penis, and affects 3–9% of men (Pryor *et al.* 2004). Typical deformities include penile curvature, short-

ening, narrowing, hinge effects, and hourglass deformity. ED is common. A variety of treatments have been used, but none has been especially effective. Surgery can be a last-resort option but may result in shortening of the penis.

Key messages

- Good recreational sexual behaviour is learnt behaviour.
- Quality of life, self-esteem, mental and relationship health depend on sexual wellbeing.
- Sexual difficulties can be early warning signals for cardiovascular disease.
- It is the health professional's role to raise sexuality issues proactively.
- There are excellent medical and psychological therapies available.

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