Erectile Dysfunction

Georgina Whelan

Psychologist, Sex Therapist & Registered Nurse

Australian Centre for Sexual Health

2-4/1A Berry Rd St Leonards

Overview

Definition of ED

Prevalence of ED

Aetiological

Biological Aetiology

Psychological Aetiology

Treatment: Medications

Treatment: Individual Psychotherapy

Treatment: Couple Therapy

Erectile Dysfunction: ED

- Erectile Dysfunction (ED) (1)
  - Persistent or recurrent inability to attain and/or maintain an erection till completion of sexual activity.

1. *DSM-IV* (1994) . *American Psychiatric Association.*

Impact of ED on Men

- ED reduces overall quality of life: (1)
  - ED is associated with shame; guilt; embarrassment; low mood; & low self-worth (1,2)
  - ED reduces sexual confidence & general confidence (2)
  - Reduces sexual desire and can result in sexual avoidance & relationship avoidance (2)
  - ED is often an early sign of systemic diseases such as vascular, endocrine disease or pathology (3)

1. Rosen (2007). *Principle & Practice of Sex Therapy*
2. Dupress & Morisset (1993). *Sexual & Marital Therapy; 8*: 37-46
3. Porst & Buvat (2007). *Sexual Medicine*. P55-59

Impact of ED on Female Partner

- Decrease in sexual desire, arousal, orgasm frequency, and satisfaction (1, 2)
- Decrease in sexual & general confidence
  - Feel rejected, unattractive, guilty, (3)
- ED causes SD in some women (4)
  - Desire and orgasm disorders

1. Cayan, et al. (2004). *J Sex Marital Ther, 30*:333–41
2. Fischer, et al. (2009). *J Sex Med, 6*(11):3111-24.
3.Carol & Bagley (1990). *J. Sex Marital Ther,16: 70-78.*
4. Specken, et al. (1995). *Arch Sex Behav, 24*:157–72.

Prevalence of Erectile Dysfunction

Prevalence of ED

- 1995, 152 million men were estimated to have ED
  - Predicted increase to 322 million by 2025. (1).
- ED affects 52% of men aged 40-70 years (USA) (2)
  - 17.2% minimal ED
  - 25.2% moderate ED
  - 9.6% sever ED

1. Aytac et al. (1999). *BJU, 84*:50-56.
2. Feldman et al (1994). Massachusettes Male Aging Study; *J Urol; 151*: 54-61.

Prevalence of ED increase with age

Decade of life	Prevalence
30s	2-15%
40s	9-39%
50s	16-67%
60s	27-76%
70s	37-83%

- Only half of the older men are bothered by ED. (2)

1. Table 1. next slide
2. Porst & Sharlip (2007). *Sexual Medicine*, p43-48.

Table 1 references:

- Feldman et al. (1994). *J Urol; 151*:54-61
- Dunn et al.(1998). *Fam Pract; 15*:519-524
- Laummann et al. (1999). *Jama, 282*:537-554
- Braun et al. (2000). *Akt Urol, 31*, 3012-307.
- Chew et al, et al. (2000). *Int J Impotence Res,12*: 41-45
- Meulemann et al. (2000). *Int J Impotence Res, 12*: supp 5, s8:28
- Mahmoud et al. (2000). *Int J Impotence Res, 12:* supp 5, s24:P46
- Koskimaki, et al. (2000). *Int J Impotence Res, 12:* supp 5, s25:P47 .
- Kadiri, et al. (2000). *Int J Impotence Res, 12:* supp 5, s24:P48.
- Martin-Morales et al. (2001). *J Urol, 166*:569-574
- Laumann, et al. (2005). *Int J Impotence Res,17*:39-57.
- de Boer et al. (2004). *Int J Impotence Res,16*:358-364.
- Ponholzer, et al (2005). *Eur Urol, 47*:80-86

Continued Sexual Activity in Older Men

- 71% Germans aged 70-79yrs (1)
- 55-70% Japanese aged 70-79yrs;
- 44% Japanese > 80yrs (2)
- 5.4-6.5 sexual activities per month USA and 6 European countries aged 50-80yrs (3)

1. Braun, eta l.(2000); *Akt Urol, 31*: 302-307.
2. Kamamoto, eta l. (2000). *The Aging Male, 3:* supp 1, 9.
3. Rosen, et al. (2003). *Eur Urol, 44*, 637-649.

Sexual PSYCHOLOGY

Aetiology:

Identify whether primarily organic or psychogenic:

& what psychosocial factors maintain ED

Historical Understanding of ED

- Historically ED was considered either psychogenic or organic
  - Early theorists proposing ED was mostly psychogenic (1,2)
  - We now know that ED is more likely to be due to neurophysiology (3)
  - The increased focus on organic causes & success of PDE-5 inhibitors led us to neglect psychological factors (4)

1. Masters & Jonston (1970). *Human Sexual Inadequacy*.
2. Kaplan (1980). *The New Sex Therapy: Active Treatment of Sexual Dysfunctions.*
3. Porst & Buvat (2007). *Sexual Medicine*. P55
4. McCarthy & McDonald (2009). *Journal of Sex & Marital Therapy, 35:*58–67.

Current Understanding of ED

- High discontinuity rates of PDE-5 inhibitors & high incidence of relapse has broaden our focus from erection to love making & sexual satisfaction and relationship satisfaction.

- Psychosocial factors can be conceived of as additive to primary aetiology (2)

1. Buvat et al (1985). *J Urolo, 133*:34-38

Organic vs. Psychogenic Screening Questions

- Situational vs. generalised
  - No ED when masturbating (psychogenic)
  - Relationship conflict more like in psychogenic ED (1)
- Presence of early morning (EMR) , nocturnal erections likely psychogenic
  - Lack of EMR also occurs in psychogenic ED.
  - Associated with hypoactive sexual desire
- Onset: Sudden (? psychogenic) vs. Gradual
- Duration, Progression & Severity (SHIM)

1. Speckens (1995). *Arch Sex Behav, 24*:157–72.

SHIM: Sexual Health Inventory for Men (IIEF)

1. How do you rate your confidence that you could get an erection?

2. When you had erections with sex sexual stimulation, how often were your erections hard enough for penetration?

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

4. During sexual intercourse how difficult was it to maintain your erection to completion of intercourse?

5. When you attempted sexual intercourse, how often was it satisfactory to you?

- Likert scale. 1= least functional to 5= most functional
- **22-25** Normal; **17-21** Mild ED; **12-16** Mild to Moderate ED
- **8-11** Moderate ED; **<7** Sever ED.

Rosen et al. (1999). *Int J Impot Res; 11*: 319-26. www.njurology.com/_forms/shim.pdf

Co-existing Sexual Dysfunction

- High incidence of co-existing ED & PE, bidirectional (1, 2)
- High incidence of ED and hypoactive sexual desire. (2)
- Female sexual dysfunction can cause ED
  - Pre-existing vaginismus; dyspareunia; urinary incontinence; desire discrepancy (3)

1. Porst, et al. (2007). *Eur Urol, 51*(3): 816-824
2. Hartmann et al. (1998). *Urologe (Ausg. A). 37(5)*:487-94
3. Speckens, et al. (1995). *Arch Sex Behav. 24*(2):157-72,

Biological Aetiology:

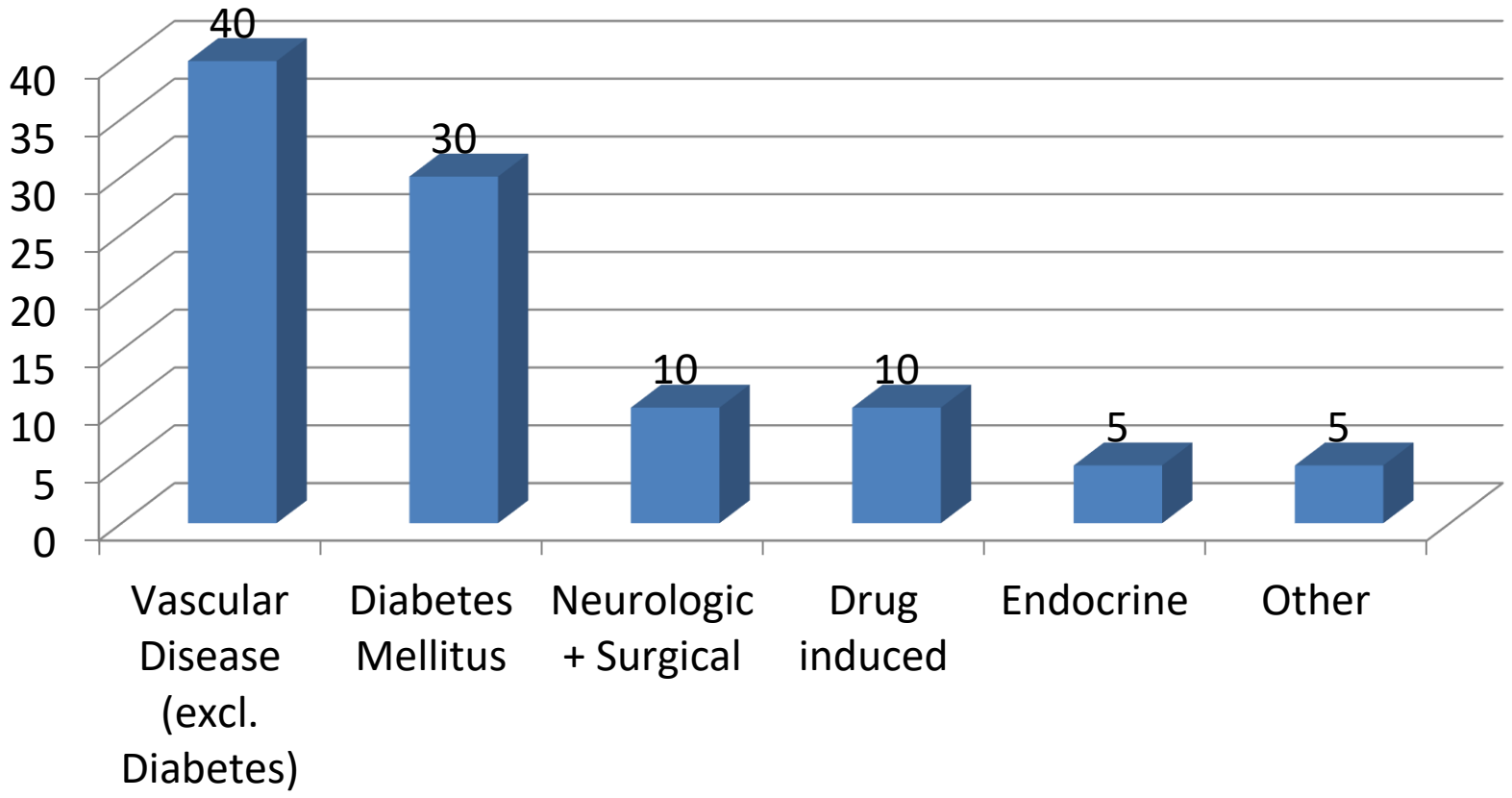
Pathological, Physical, Medical & Medication

ED Is An Early Warning Sign For Sytem Disease

- ED is increasing understood as pathology of endothelial function, vascular flow & autonomic or sensory nerve function (1, 2, 3)
  - Arteriosclerosis most common cause of vasculogenic ED (1)
  - ED signalling early Coronary Artery Disease (2)
  - Between 35-75% of diabetic men will develop ED:
    - x3 more likely to have sever or complete ED than non-diabetic (4, 5)

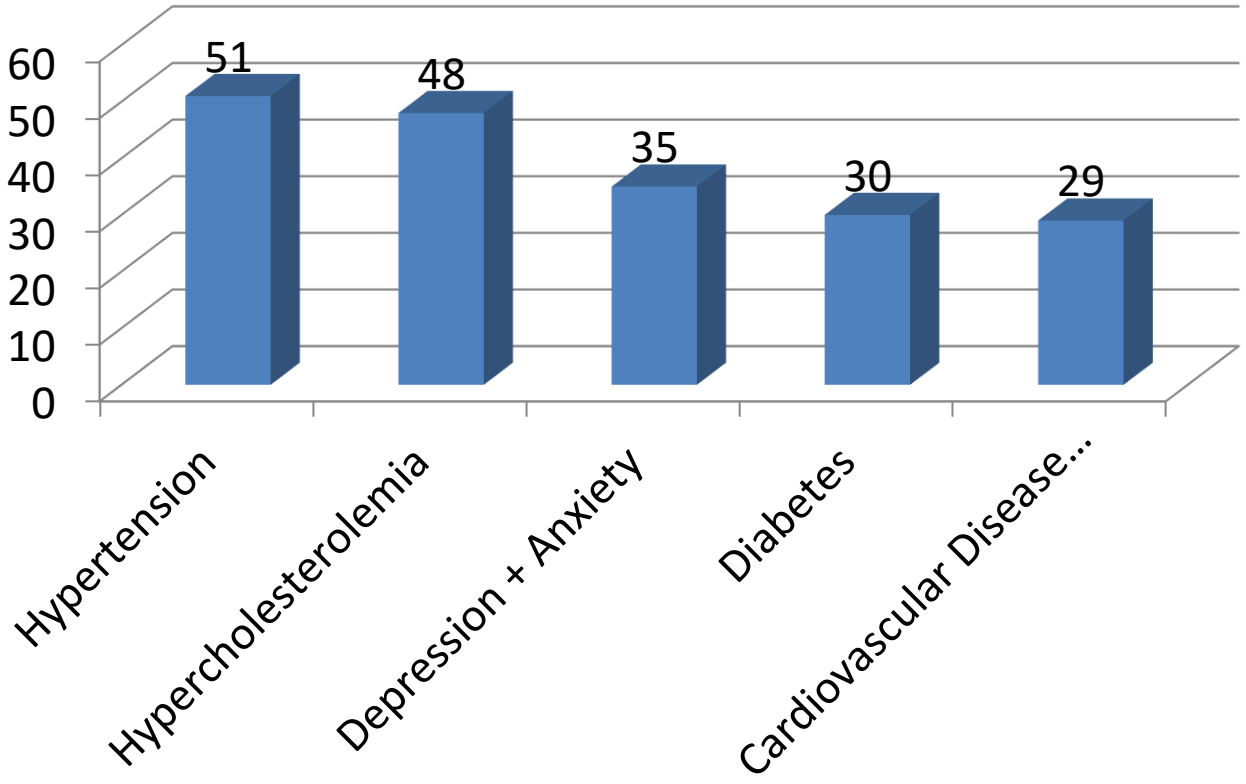
1. Sullivan et al.(2002). *BJU Int, 87*(9):838-45.
2. Billups, et al. (2005). *J Sex Med, 2*: 40-52.
3. Porst & Buvat (2007). *Sexual Medicine*. P55
4. Hatzichristou, et al. (1994). *Sexual Dysfunction.* p 167-198.

Most Common Physiological Aetiologies of ED



1. Porst & Buvat (2007). *Sexual Medicine*. p55

Most Prevalent Co-Morbid Conditions Associated with ED



1. Porst & Buvat (2007). *Sexual Medicine*. p55

Smoking

- Causes premature atherosclerosis in penile arteries (1)
- Damages the penile veno-occusive mechanism (2)
- Causes degenerative changes in the corpus cavernosum (3)
- Reduces erectile response to Papaverine (4)

1. Rosen, et al. (1999*). J Urol, 145*: 759-764.
2. Elhanbly et al. (2004). J Of Andrology, 25(6)
3. Yaman, et al. (1991). *J Urol,* 145: 759 -763.
4. Glina, (1988). J Urol, 140(3): 523-524.

Endocrine Disease, Metabolic Disease & ED

- Hypogonadism (1, 2)
- Hyperprolactinemia (HPRL) (1, 3)
- Liver disease : Up to 50% of men with chronic liver dysfunction report ED (4)
- Obesity & metabolic syndrome (5)

1. Roulet et al. (2006). *Am J Pathol; 169*: 2094-103
2. Buvat, et al. (2003). *Int J Impot Res, 15*: 373-377.
3. Carani, et al. (1995). *The pharm of sex funct & dysfunct*. p145-150.
4. Cornley et al (1984). Hepatology, 4: 1227-30
5. Suwaidi et al (2001). *Am J Coll Card, 37*:1523-27

Neurological Disease & ED (1)

- Multiple sclerosis
- Temporal lobe epilepsy
- Parkinson's disease
- Stroke
- Alzheimer's
- Spinal cord injury
- Lesions of cavernous nerves after pelvic surgery

1. Eardly, (1991). *Diagnosis & Management of erectile dysfunct.* P227-231

HIV Related ED

- High prevalence of ED in HIV + men
  - Combination of HIV pathology & HAART, especially Protease Inhibitors (2,3)

1-9 see next slide
2.Collazos et al. (2007). *AIDS Rev;* 9: 237-45.
3. Colebunders et al. (2001). *Lancet; 353*:1802

Other Medical Conditions

- Sexual Transmitted Infection: Herpes
- Chronic Pulmonary disease.
  - 30% of patients with ED due to hypoxia (1)
  - Sleep apnoea increased incidence of ED (2)
- Real failure.
  - Up to 50% of patients 75-90% on dialysis (3)
- Lower Urinary Tract Symptoms (LUTS)
  - benign prostatic hyperplasia (4)

1. Fletcher, et al. (1982). *Chest, 81*:413-421.
2. Seftel, et al. (2000). *Int J Impotence Res, 12*. supp 3: s73
3. Kaufman et al (1994) *J Urol, 151*: 612-618
4. El Sakka. (2006) *J Sex Med, 3*: 144-149

Physical Trauma

- Radical pelvic surgery: i.e. prostatectomy
- Radiation therapy
  - 20-75% from 1 month to 4 years. Permanent (1)
- Pelvic fracture
- Penile/urethral fracture,
  - Peyronie's-like plaque and or deviation
- Chronic compression syndrome: cyclists (2)
  - Poor blood flow & pudenal nerve compression

1. Goldsein et al. (1984). JAMA, 251: 903-910
2. Mulhall et al (1996). Int J of Impotence Res, 8(3) 130.

Selection of Medications Associated with ED

- Antihypertensives
- Antidepressants (approx 10%) (1)
- Neuroleptics
- Antiarrhythmics
- Antiandrogens
- Recreational substances

1. Segraves (2007). *Urol Clin North America;34*: 575-79.

Aetiology:

Psychological:

Psychiatric Disorder & Psychological Distress

Depression

- High incidence of depression in ED patients (1,2)
  - Approx 30%
- High incidence of ED in depressed patients ED approx 35 % (3)
- Depression is s characterised by loss of pleasure.
- Hard to get an erection if you don't feel pleasure

1. Shabsigh et al. (1998). Urology, 52(5):848—852
2. Hartmann et al. (1998). *Urologe (Ausg. A). 37*(5):487-94
3. Ciesla & Roberts (2001). *Am J Psychiatry; 158:* 725-730.

Anxiety Disorders

- ED common in men with Social Anxiety Disorder; Generalised Anxiety Disorder; Obsessive Compulsive Disorder; Panic Disorder (1)
  - Physiological symptoms of anxiety
  - Fear that they will be seen as anxious
  - Avoidance of sexual activity

1. Corriti, et al., *Journal of Sex and Marital Therapy, (2006) 32,*, 183-1872.

Sexual Performance Anxiety

- Most not anxious but distracted about:
  - Getting and maintaining erection
  - Disappointing partner
  - Partner reaction (1)
    - Feeling rejected, unattractive, doesn't love me, having an affair, his gay
    - Think partner will leave them

1. Carroll and Bagley (1990). *J. Sex Marital Ther, 16*: 70-78.

Condom Anxiety

- No reduction in sexual activity; inconsistent & incomplete use of condoms (1,2,3)
- Reasons given:
  - Decreased sensation with condoms (2,3)
  - Poor fit: condom too tight or too large (2,3)
  - Water based lubes abrasions with RAI: silicone (2)
  - HIV specific concerns: increase HIV ED; disclosure; (4)

1. Klitzman et al. (2004). *Sex Res Soc Policy; 1*:38-57.
2. Adam et al. (2005). *The Journal of Sex Research; 42*(3): 238-248
3. Graham, et al (2006). *Sexual Health, 3(4)*:255-60.
4. Cove & Petrak (2004). *International Journal of STD & AIDS, 15, 732-736.*

Other Psychological Aetiology

- Sex negative attitudes, lack sexual knowledge (1)
- Repetition of sex that is damaging to self confidence or self- esteem
  - Woman acted angrily or belittled him
  - Think that everyone will find out: young men
  - Sexless marriage and or acrimonious divorce
- Poorly processed sexual trauma (2)

1. Heurti, et al. (2005). *Journal of Sexual Medicine, 2(2)*:181-6
2. McCarthy & McDonald (2009). *Journal of Sex & Marital Therapy, 35:58–67*

Other Psychological Aetiology

- Variant arousal pattern (secret/shameful) (1)
- Preference for masturbation vs. partner sex (1)
- Holding onto youthful expectations (1)
- Insertive anal intercourse
- Loss of partner attraction (1)
- Partner conflict: precipitates, exacerbates, maintains ED (2) Resentment/hostility/anger

1. McCarthy & McDonald (2009). *Journal of Sex & Marital Therapy, 35:58–67.*
2. Verhayden et al. (2009). *J Sex Med, 6*(12):3458-68,

Treatment:

Combined Medical, Psychological & Psychosocial

Medications for ED

- All 3 PDE-5 inhibitors are highly effective:89-92% (1)
  - Improve erection rigidity & ability to penetrate (2)
  - Improve orgasm, satisfaction & QOL (2)
  - Improve depression & self-confidence (4)
  - Improve female partner sexual function (5)
  - Reduced relationship problems (6)

1. Steers et al. (2001) *Int J Impot Res;* 13: 261-267.
2. Donatucci et al. (2004) *Journal of Sex Med; 1*:185-192.
3. Hatzichristou (2005). *Journal of Sex Med; 2*: 109-116.
4. Brock et al. (2002) *Journal of Urology; 168*(4pt.2):1332-36.
5. Goldstein, et al. (2005). J Sex Med, 2: 819–32.
6. Verheyden, et al. (2009). *J Sex Med, 6*(12): 3458-68,

PDE-5 Treatment for ED

- High discontinuation rate 40-80%; due to lack knowledge of Rx, resistance to Rx, & psychosocial factors (1)
  - Include partner in dose decision
- Salvage up to 60% with counselling about Rx: (2)
  - Sildenafil and Vardenafil fasting 2 hours prior
  - Tadalafil wait up to 2 hours b4 sex
  - Use highest dose consistently
  - Provide sufficient stimulation

1. Rosen (2007). *Principles & Practice of Sex Therapy*: 277-312
2. Aiemo (2003). *J of Urol; 170*: 2356-58

PDE-5 Treatment for ED

- Change to another PDE-5 after 4 tablets; 4 occasions with optimal stimulation (1)
- Change to daily dosing with on demand PDE-5 or once daily Tadalafil 2.5m, 5mg, 10mg,(2,3)
  - Once daily Tadalafil is preferred (over on demand Tadalafil) by men due to superior & longer efficacy & increased spontaneity (3)

1. Porst & Buvat (2007). *Standard Practices in Sexual Medicine*: p86
2. McMahon (2004). *J Sex Med; 1*: 292-300.
3. Porst (2009). *Urologe (Ausg. A). 48*(11):1318, 1320-9

Daily Dosing of on demand PDE-5 and Tadalafil daily

- Daily dosing is recommended for those with several cardiovascular risk factors (1)
  - Improves endothelium function in cavernous bodies (on demand dose) (2)
- Daily dose Tadalafil, preferred over PRN
  - Superior & longer efficacy & increased spontaneity (4)

1. McMahon (2004). *J Sex Med; 1*: 292-300.
2. Rosano et al. (2005). *Eur Urol; 47*: 214-222. .
3. Porst (1996). *J Urol; 155(3)*: 802-15.
4. Porst (2009). *Urologe (Ausg. A). 48*(11):1318, 1320-9

Daily Dosing of on demand PDE-5 and Tadalafil daily

- Daily dosing is recommended for those with several cardiovascular risk factors (1)
  - Improves endothelium function in cavernous bodies (on demand dose) (2)
- Daily dose Tadalafil, preferred over PRN
  - Superior & longer efficacy & increased spontaneity (4)

1. McMahon (2004). *J Sex Med; 1*: 292-300.
2. Rosano et al. (2005). *Eur Urol; 47*: 214-222. .
3. Porst (1996). *J Urol; 155(3)*: 802-15.
4. Porst (2009). *Urologe (Ausg. A). 48*(11):1318, 1320-9

Aprostadil Injections

- Aprostadil Injection 2nd line therapy highly effective (72%) (1) :
  - 2 sessions on correct injecting technique (2)

1. Rosano et al. (2005). *Eur Urol; 47*: 214-222. .
2. McMahon (2004). *J Sex Med; 1*: 292-300.

PDE-5 Treatment for ED

- PDE-5 efficacy dependent on control of co-morbid diseases:
  - Diabetes; (1)
  - Hypertension (1)
  - Hypercholesterolemia (2)
  - Hypogonadism (3)
  - Depression (4)
  - Excessive anxiety (5)
  - Excessive venous out flow (5)

1. Cartledge et al. (1999). *Eur Urol; 35*(suppl.2); 100, Abstr. 399.
2. Saltzman et al.(2004) J Urol; 172: 255-258.
3. Aversa et al.(2003) *Clin Endocrinol; 58*: 632-638.
4. Brink (2008*). Journal of Neural Transmission; 115*(1):117-25.
5. Virag (2005). *J of Sex Medicine; 2*: 289-290.

Psychological Treatment: Individual

Psycho-Sexual Education on ED

- Debunk sexual stereotypes & myths(1, 2)
  - Sex equals intercourse
  - Male sexuality is natural and simple
  - Men should always be ready for sex and want sex
    - Men should to have erection before sex starts
    - Men's erection stay rigid through out sex
  - Men have higher sex drives than women
  - Anything starting with "I should"
- Male & female sexual response

1. Metz & McCarthy (2004). *Coping with ED*.
2. Zilbergeld (1992). *The New Male Sexuality*.

Education on Age Related Changes to Sexual Function

- Adolescent vs. adult sex
- Age related changes erectile function: (1)
  - Reduced frequency of morning erections
  - >35yrs need direct penile stimulation for erection
  - Delay in erection response is normal
  - Partner intimacy more important for sexual satisfaction
  - Fatigue, stress, conflict, major life change more likely to affect sexual function
  - Reduction in firmness of erection >50yrs

1. Feldman et al. (1994). *Journal of Urology; 151*:54-61.

CBT for ED

- Educate on CBT
- Access & address distracting cognitions
  - I am a sexual failure if lose my erection!
  - I am less of a man if I can't please my partner!
  - There is something wrong with me!
  - I am disappointing my partner!
  - My partner will leave me!
  - I will never be able to have another relationship!
  - I can't feel anything!
  - Why is this happening to me?!

Behavioural Exercises

- Recognise when distracted by thoughts
  - O.K to worry but not while you are having sex
  - Allocate time to think about worries or skill development
- ED is about focusing on the past or future e.g.:
  - " I lost my erection last time, I will lose it again"
  - " better penetrate before I lose my erection"

1. Nichols & Shernof (2007). *Principles & Practice Sex Therapy (4th Ed).*
1. Metz & McCarthy (2004). *Coping with erectile dysfunction*
2. Derogatis and Meyer, (1979). *Am. J. Psychiat. 136: 1545-1549*.

Behavioural Exercises

- Good sex is being in the moment:
  - Mindfulness exercises
  - Refocus on what you like: visual/touch/fantasy hierarchy (1)
  - Practice receiving sexual pleasure; selfish
- Keep going
  - Key to overcoming ED is to lose an erection and get it back

1. Metz & McCarthy (2004). *Coping with erectile dysfunction*

Behavioural Exercises

- Address sexual avoidance
- ED constricts range of sexual activities (1)
  - Expand sexual script: fluid style/ flexible activity
  - Non-demand pleasuring; Stop rushing; avoid I/C
  - Sensuality & eroticism vs. technique
  - Enjoying the sex you have: enthusiasm

1. Derogatis and Meyer, (1979). *Am. J. Psychiat. 136: 1545-1549*.

Good Enough Sex (1)

- Realistic expectations: you are not 20 any more
  - Arousal is impacted upon by fatigue, mental wellbeing & chronic illness
- Don't measure every sexual event as the gold standard
- Playful rather than perfect
- Emphasis on pleasure/intimacy/satisfaction rather than performance, penetration, intercourse
  - Difficult for men for whom sexual performance assumes a large part of their personal identity

1. Metz & McCarthy (2004). *Coping with erectile dysfunction*

Treatment of psychiatric co-morbidities

- Depression: tx first unless ED causing depression
- Anxiety disorder: de-arousal strategies; systematic desensitisation; exposure response prevention; assertiveness training
- Trauma:
  - Men don't conceive sexual trauma as sexual assault
  - Do not disclose to partner due to secrecy, stigma, fear of homosexuality

Sexual Trauma

- Men don't conceive sexual trauma as sexual assault
- "Looking back over your sexual history is there anything that has left you feeling guilt, ashamed or traumatised?"
- Do not disclose sexual assault to partner due to secrecy, stigma, fear of homosexuality (1)
  - May require PTSD treatment

1. Maltz, W. (2001). *The sexual healing journey.*.

Sex Variant Behaviour (1)

- Is often powerful due to combination of shame, eroticism, and secrecy,
- Problematic if narrow, controlling pattern & necessary for arousal
  - Can be a bridge to desire or if man unable to access acts as a barrier to arousal

Sexual Communication training

- Talking about ED improves sexual function, sexual satisfaction, sexual intimacy (1)
  - Impact of illness & disability (2)
  - Open discussions with tolerance of fear & shame (3)
- Talking about sexual preferences during sexual activity improves sexual function (4)

1. Hawton et al. (1992). *Arch. Sex. Behav, 21*: 161-175.
2. Boehmer and Babayan (2004). *Cancer Invest,* 22: 840–848.
3. Rowland, (1994). *J Marital Family Ther,* 20: 327–348.
4. Brenda (1984). Archives of Sexual Behavior. 13(4):321-40.

Sexual Communication training

- Teach couple to:
  - Identify criticism, defensiveness, contempt, & withdrawal (1)
  - Be specific: rather than “You never show me affection”. “I would like it if you could kiss me before you go to bed at night”.
- Reconfirm commitment to relationship whilst working on the problem.

1. Rowland, (1994). *J Marital Family Ther,* 20: 327–348.

Psychological Treatment: Couple Sex Therapy

ED is a couple issue

- Female attitudes contribute to the onset, exacerbation & maintenance of ED (1)
- Female partners influence whether men seek treatment and continuation of therapy (1, 2,3)
  - Men less like to seek TX, if women think aetiology is psychological.
  - Increase discontinuity of Rx if she is dissatisfied (3)

1. Specken, et al. (1995). *Arch Sex Behav, 24*:157–72.
2. Shabsigh, et al. (2004). *BJU Int,94*:1055–65.
3. Montorsi, et al. (2004).*Urology, 63:*762-767.

Relationship Harmony

- Blame & inadequate empathy barriers to treatment (1)
- Team approach:
  - Understand what do you want to be different, take individual responsibility in achieving it
  - Be your partners teacher (2)
- Many couples with ED have good relationship outside sex (2)
  - Foster sexual intimacy

1. Verhayden et al. (2009). *J Sex Med, 6*(12):3458-68,
2. Lamble & Morris (2009). *How to think differently about your relationship*
3. Hawton, et al. (1992). *Arch. Sex. Behav, 2*1: 161-175.1.

Couple Sexual Intimacy

- Prioritise the sexual relationship
  - Make time every day for physical, sensual touch e.g. 10 minute Tantra
- Schedule time for sex
- Enjoy the after glow: hang around after sex.
- Schedule time to talk about sex
  - Sexual communication is a skill that requires practice

Partner Sexual Satisfaction & Female Sexual Dysfunction

- Treat FSD
- Encourage partner responsibility for own orgasm and sexual pleasure:
  - Enjoy her sensuality and eroticism
  - Ask for needs to be met
  - Improves treatment outcomes (1)
  - Continue sex until both satisfied
  - End on a good note

1. Hawton, et al. (1992). *Arch. Sex. Behav, 2*1: 161-175.1.

Life Style Changes

- Weight loss improves erectile function (2)
- Physical activity reduces the risk of ED even if initiated midlife (3)
- Work life balance

1. Eposito, et al (2004). *JAMA, 291*:2978-2984.
2. Deby, et al (2000). *Urology, 56*(2), 302-306.

Client Resources

- Metz, McCarthy (2004). *Coping with Erectile dysfunction*.
- Andrology Australia
  - http://www.andrologyaustralia.org/pageContent.asp?pageCode=ERECTILEPROBLEMS
- Impotence Australia
  - http://www.impotenceaustralia.com.au/site/
- Female sexuality & sexual skills training Betty Dodson
  - http://dodsonandross.com

Conclusion

- ED is common
- ED reduces quality of life in men and their partners
- Effective Rx treatment available
- ED is often a sign of systemic diseases, however psychological factors can cause, exacerbate and maintain ED
- A combined bio-psychosocial approach is advocated