Working With Sexual Problems
In Family Practice

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In today’s world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

**Goals**

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

**How to Use the Modules**

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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*Bill Watson*
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Working With Sexual Problems in Family Practice

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SUMMARY

Sexual health and sexual concerns are common in family medicine. Patients want their family physicians to feel comfortable initiating conversations about sexuality and managing related problems. Over 50% of couples will have significant sexual concerns causing distress and the risk of losing the relationship.\(^1\) Many patients wish to discuss sexual concerns with their family doctor but don’t feel comfortable raising the topic themselves. By giving family physicians the tools to initiate conversations about sexuality and manage sexual concerns, we hope to address this gap in care.

OBJECTIVES

After completing this module, you will be able to:
1. initiate conversations about sexuality, including normative sexuality, orientation, and specific sexual concerns.
2. identify common sexual concerns.
3. develop a basic approach to managing sexual concerns related to desire, arousal, orgasm and sexual pain.

Key Features

1. Family physicians require effective knowledge and skills in dealing with common sexual concerns.
2. Many sexual problems have significant biological etiologies, rather than solely psychological or relational ones. Often, all of these factors are involved.

Core Competencies

1. Be able to take a comprehensive sexual history
2. Be able to categorize sexual problems according to desire, arousal, orgasm, and sexual pain
3. Master a basic approach to common sexual problems in family medicine
4. Understand when to refer to a sexual medicine consultant
CASE STUDIES

Case 1: Linda and Brian
Linda, aged 62, and Brian aged 65, have been together for 25 years and have a loving relationship. Although they continue to enjoy physical intimacy, over the past couple of years Linda’s vaginal dryness and Brian’s inability to achieve an erection capable of penetration have made vaginal intercourse difficult. They continue to enjoy oral sex and outer play, but have given up on attempting vaginal penetration and would like to incorporate this into their love-making again. The last time they attempted intercourse was a year ago, when Linda’s discomfort was intolerable despite vaginal moisturizers or water-based lubricants.

- What else would you like to know?
- How would you manage Linda’s vaginal dryness?
- How would you manage Brian’s erectile dysfunction?
- How would you counsel Linda and Brian?

Case 2: Morgan and Carlos
Morgan and Carlos met in their third year of university and having been dating for nine months. They care deeply for each other, but their sexual concerns are creating a rift in the relationship. Morgan has never been able to achieve orgasm with Carlos and feels frustrated about this. She is attracted to Carlos, desires him and becomes aroused with stimulation but feels that she “can’t turn her mind off” when they are being intimate with each other and worries about why she is not achieving orgasm. Carlos has always been self-conscious about his inability to “last as long” as the male actors in pornographic movies. He wants to please Morgan and blames her lack of orgasm on the fact that he typically ejaculates after one minute of penetration. They haven’t discussed the issue with each other because they both feel embarrassed about their respective ‘shortcomings’.

- How is rapid ejaculation defined?
- What options does Carlos have in addressing his concern?
- How would you counsel Morgan on her concerns about pre-orgasmia?

Case 3: Vanessa and Kucy
Vanessa, a chemical engineer aged 58, and Kucy, an accountant aged 55, have been in a relationship for the last 30 years. They are well and take no medications. Their two grown children have moved out on their own. Sex has historically been positive for them, with both having had desire, arousal, and orgasmic responses that were comfortable for them. Vanessa tended to be the initiator, though Kucy would also do so at times. Both of them had had positive intimate relationships before meeting each other. Kucy dated men before realizing that she was gay. Neither of them had ever experienced any abuse. Over the last few years, their sexual frequency has dropped down to less than once a month. This has become concerning for Vanessa who brought up this issue at her last check-up.
- What else do you want to know?
- What other investigations would be appropriate for Vanessa and Kucy?
- How would you manage Vanessa’s concern?
1. Definitions

Sex: Sexual activity can occur alone with self-pleasuring, or with one or more partners. "Sex" includes both penetrative and non-penetrative activities. A useful concept is that of “intercourse” vs. "outercourse". Intercourse refers to either vaginal or anal penetrative sex. Outercourse refers to all of the non-penetrative ways in which individuals and partners can experience pleasure and connection including kissing, caressing, embracing, massaging and any manual or oral genital stimulation. Throughout the lifespan there may be various times when intercourse is less favourable for reasons such as sexual pain, pregnancy, illness, life circumstances or erectile dysfunction. Couples who do not equate lovemaking with sexual intercourse alone are more likely to maintain high sexual satisfaction. ³

Sexual Function and Dysfunction: Sexual experience for men and women of any orientation can be grouped into the categories of desire, arousal and orgasm. There is a spectrum of normal across all of these domains. The definition of dysfunction requires that a symptom causes distress for one or both partners. Dysfunction can occur in any of the three categories. Sexual pain is another important category of dysfunction. Sexual dysfunction can be lifelong or acquired, global or situational (with all or only some partners).

2. Prevalence

Sexual concerns are more prevalent than common diseases like diabetes mellitus or hypertension. In a large American sample, ² the prevalence of sexual dysfunction was 43% for women and 31% for men. Erectile dysfunction increases as men age; 52% of men aged 40-70 have some degree of impotence. ⁴

Sexual concerns are often associated with other medical conditions or their treatment, such as hypertension, diabetes, or vascular disease. A multidisciplinary study found that pathophysiological factors were present for at least 33% of men and 10% of women presenting for sexual counselling. ⁵

3. Sexual History-taking

Patients see physicians as the most appropriate health professionals to aid them in managing sexual dysfunctions. ⁶

Sexual orientation is a core part of each person's sense of self. Family physicians should have an understanding of how their patients see their own sexuality. Being aware of their lesbian, gay, bisexual, transgender, and questioning (LGBTQ) patients can help avoid heterosexist stereotyping and improve overall care as well as sexual health care. ⁷

Identifying sexual concerns changes medical treatment. In a controlled trial, asking patients in a general medicine outpatient clinic "Do you have any sexual concerns?" uncovered new, important medical information for 26% of patients, resulting in changes in medical treatment 16% of the time. ⁸
Most patients are reticent to bring up sexual concerns. For example, only 9% of men with premature ejaculation ask their physician for help. 9 Few physicians routinely ask case-finding questions about their patients’ sexuality. Most leave it to the patient to bring up, which leads to a dance of avoidance in the doctor-patient relationship.

Family physicians can help uncover sexual concerns with case-finding during a complete check-up, or as part of a psychiatric assessment, by asking:

- Have you ever been sexually active?
- Are you sexual with men, women, or both?
- Many people have sexual concerns. What might yours be?

While not directly linked with most people’s sexual concerns, given the high prevalence of abuse, it is worth asking “Have you ever been hurt emotionally, physically, or sexually?” If the patient answers affirmatively to questions about concerns, then ask: “Would you like to talk about these issues?”

In asking patients about being sexual with which gender of partners, one avoids the effect of labelling and the tendency to make heterosexist assumptions. More details about being sensitive to LGBTQ patients’ needs are addressed in the Working With Families module “Providing Health Care for Gay, Lesbian, and Bisexual Patients”.

The PLISSIT model for addressing sexual concerns shows that most sexual problems can be addressed without specialist intervention. 10
Table 1. PLISSIT model for addressing sexual concerns

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<table>
<thead>
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<tbody>
<tr>
<td>P</td>
<td>Permission</td>
<td>Normalize the common nature of sexual problems and invite the patients to discuss sexual concerns. Physicians can also give themselves permission to challenge their own biases and be open to conversations about sexuality.</td>
</tr>
<tr>
<td>LI</td>
<td>Limited Information</td>
<td>Teach the couple about the problem and provide information about interplay of medical, psychological and relational factors contributing to sexual function.</td>
</tr>
<tr>
<td>SS</td>
<td>Specific Suggestions</td>
<td>Offer therapeutic interventions: educational resources, the option to meet with the couple together, and pharmacotherapy.</td>
</tr>
<tr>
<td>IT</td>
<td>Intensive Therapy</td>
<td>Some individuals or couples may benefit from specialist resources, e.g. gynecology, urology, psychotherapy, sex therapy.</td>
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Once a sexual concern is uncovered, appropriate history-taking, physical examination, and laboratory testing needs to be tailored to the individual’s concerns. It is beyond the scope of this module to cover all aspects of managing men and women’s sexual concerns; some of the more common problems are discussed below.

It is important to get a sense of what sex has meant for both partners before the problem arose. Was sex previously a positive experience for both, or has sex always been problematic in this relationship?

The physician must ask what the sex problem is, when did it start, and why. What is the patient’s understanding of their partner’s sexual function? What theories does the patient have about what has caused the problem and what might help?

Family life stages can be important contributors to sexual stress. Problems are common early in a new relationship, after about a year, as the couple starts to work through the power dynamics in the relationship and how they resolve conflict, during pregnancy and after childbirth, with adolescent children, empty nesters, and with the loss of a partner through death or divorce.

A thorough assessment of other potential health issues, surgeries, and medications is important. Is there a history of mental illness that might affect sexual function, either directly, or through antisexual side-effects of psychoactive medications?
A developmental history of how patients grew up in their families of origin can be important to understand how they learned about adult relationships, intimacy, and sex. How were they disciplined as children? Was there any neglect or abuse? How was their parents’ relationship? Did they see their parents being intimate? How was sex talked about (or not)? Did they receive any particular sex education at home, or at school? What were the messages about becoming sexually active, or masturbation?

How and when did the patient transition through puberty? At the same time as others in their class? For women, what was menarche like? Did they have significant pain with their menses?

A dating and sexual history before the current relationship helps in understanding the emotional connection and length of relationships in general, and specifically how sex was with other partners. Was there any abuse in any of these relationships?

Once a diagnosis of sexual dysfunction has been made, discussing therapeutic options with the patient should include consideration of whether to include the partner in this process. Physicians need to be sensitive to boundary and confidentiality issues, especially if the partner is also their patient. If there is active abuse going on in the relationship, including the partner would be relatively contraindicated.

4. Examples Where Seeing Both Partners Can Be Helpful
   - Erectile dysfunction in an older man and postmenopausal atrophy in his sexual partner
   - Dyspareunia due to medical causes such as vaginal atrophy, endometriosis, lichen sclerosis or vaginismus, where the partner can be helped to understand that this is a physical problem and the couple can be taught how to avoid sexual pain by having “outercourse”, rather than only intercourse
   - Rapid ejaculation, where the partner can be invited to explore what the rapid ejaculation means to them and how the couple can explore ways to meet both of their sexual needs

5. Female Sexual Dysfunction
   About 30% of women have concerns about low desire and arousal. Moreover, one in four women feel that they have never had an orgasm.\(^1\)

   Sexuality depends on multiple dimensions that contribute to the Sexual Response Cycle. Althof described the interaction of biological, psychological, relational, and sociocultural factors.\(^12,13\) Historically, the Sexual Response Cycle as developed by Masters and Johnson\(^14\) and later modified by Helen Singer-Kaplan\(^15\) went from desire, through arousal, to orgasm and resolution. There is little evidence distinguishing between women’s desire and arousal. Physiological research suggests that women often become aroused before becoming aware of sexual desire.\(^16\) This has led to a theory of women’s sexual response based on intimacy.\(^17\)
In the DSM-V, Women’s Desire and Arousal problems have been combined into Female Sexual Interest and Arousal Disorder.\textsuperscript{18}

Twenty percent of women have significant sexual pain. The DSM-V has collapsed the historical terms Vaginismus and Vestibulitis/Vestibulodynia into a single category called Female Pelvic Penetrative Pain Disorder because the previous diagnoses could not be reproduced between medical observers. If asked, about 50% of these women would like help in dealing with their sexual concerns.\textsuperscript{18}

6. Male Sexual Dysfunction

Fifteen percent of men report concerns about decreased desire.\textsuperscript{2}

Erectile dysfunction (ED) increases with age: 50% of men aged 40-65 have some degree of erectile dysfunction; 5% of men at age 40 have complete erectile dysfunction and are unable to have intercourse, increasing to 15% by age 65.\textsuperscript{19} Medical risk factors for ED include: vascular disease (smoking, alcohol abuse, obesity, hypertension, coronary artery disease, peripheral vascular disease, etc.); hormonal factors (hypogonadism, hyperprolactinemia, etc.), and neurological (MS, stroke, etc.)

Rapid or premature ejaculation (PE) is the most common male sexual concern, affecting about 30% of men. It is defined as occurring always or nearly always before or within a minute of vaginal penetration.\textsuperscript{9} There is no scientific consensus on a definition of rapid ejaculation for men who have sex with men. Canadian data using stricter DSM-III criteria found that 16% of men had PE and about half of their partners shared this concern.\textsuperscript{20} Historically this was thought to be mainly a psychogenic problem; however, recent advances have shown a significant biological and genetic component. The prevalence of PE stays relatively constant across the adult lifespan, it is not a condition one “grows out of”, nor is it due to youthful enthusiasm. If anything, ejaculatory control may decrease with age.

Rapid ejaculation can be correlated with ED, pelvic pain, prostatitis, and hyperthyroidism. Psychological factors correlating with PE include developmental (negative restrictive sexual scripts growing up, sexual and emotional abuse), individual (anxiety, depression, body image, performance anxiety), and relationship factors (anger, intimacy problems). Correlation does not imply causality. Likely these factors dynamically interact with the PE to maintain the dysfunction.\textsuperscript{9}

Delayed ejaculation occurs for about 5% of men. This often causes significant shame and frequently only comes to medical attention when a couple tries to deal with fertility concerns.
7. Specific Female Sexual Concerns

Desire and Arousal
The prevalence of decreased desire for women is 43%; about 10% of all women are distressed and want help for this. 2, 21

According to the DSM-V, Female Sexual Interest/Arousal Disorder (formerly Female Hypoactive Sexual Desire Disorder) can be due to the interplay of physical, psychological, and relationship factors. Decreased sexual appetite is one of the diagnostic criteria for depression and can be reflective of other psychological trauma. Relationship factors need to be assessed, as most women’s sexual function relates to the sense of connection they feel with their partners. Heterosexual women tend to partner with men about six years older than themselves, who in turn are more vulnerable to having sexual dysfunction as they age. Couple relationship therapy dealing with unresolved tensions, reconnecting, and “rekindling desire” can be helpful. The family physician’s role can be to help the partners understand that they are part of the solution as a referral is made for marital or sexual therapy. 22, 23

The most dramatic change in women’s sexual desire is associated with premenopausal bilateral oophorectomy, more so than natural menopause. Estrogen therapies (see the Working With Families module “Menopause: Time for a Change”) can help with atrophy-related dryness and dyspareunia, but does little for desire. 24 Reducing sexual pain by treating vaginal atrophy, however, can in turn increase desire.

Individual therapies for associated depression, anxiety, body image issues, and post-traumatic stress disorder (PTSD, often from abuse) can be essential to help the woman achieve a sense of safety within which she can then risk being vulnerable and open sexually. While antidepressants and anxiolytics can help sexual function through addressing the underlying mood disorder, they can also aggravate sexual function as noted above. Buproprion (Wellbutrin™) is a relatively sexually sparing antidepressant that can be added to existing antidepressant medication regimes to help counter some of the adverse effects of selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants. 25 Antidepressant-associated sexual dysfunction in women can be helped with the use of Sildenafil. 26 This is one of the few situations where a phosphodiesterase type 5 (PDE-5) inhibitor has been shown to be better than placebo for women.

Medical therapies, including testosterone, have been shown to help with decreased desire in both surgical and natural menopause. 27, 28, 29 Criticisms of the use of androgens for treating women’s decreased desire focus on the often supra-physiological doses required and the lack of long-term safety data. 30 There are no androgen products licensed in Canada for use in women’s sexual dysfunction; however, some use androgen products off-label. Flibanserin, a new class of neurological centrally-acting serotonin receptor agent, has been shown to help both pre- and postmenopausal hypoactive sexual desire disorder (HSDD), increase sexual frequency and reduce distress. It is available in the U.S., but not yet in Canada. 29 As our scientific knowledge about the
neurobiology of women’s sexual desire and arousal deepens, there will likely be further medications available to help these women.

Orgasm
Women who have never had an orgasm have preorgasmia. Most preorgasmic women have it as a global, lifelong pattern. Treatment uses learning theory to teach the woman how to get the right physical and mental sexual stimulation to trigger an orgasm. Masturbation exercises are most likely to be successful, with potential generalization to partner involvement. This involves helping the woman give herself permission to self-pleasure, psycho-education about physical techniques, and use of erotica. Vibrators can be very helpful, but simply prescribing the use of a vibrator without the woman being accepting of this tool and integrating erotic stimuli along with the physical stimulus is unlikely to succeed.

Acquired or secondary anorgasmia is a rarer condition that necessitates a more thorough assessment to decide on a diagnostic cause. Common medical causes include antisexual medications, such as antidepressants, antipsychotics, or prednisone, neurological injuries such as trauma from surgery or accidents, multiple sclerosis, hormonal effects such as hypothyroidism and hyperprolactinemia, and at times menopause.

Sexual Pain
Sexual pain is common for women and merits a thorough physical examination. Congenital anomalies are relatively uncommon in primary care, but imperforate hymens, contracted pelvis, and others do occur. Care must be taken in examining girls and young women to try to mitigate the trauma of such intrusive examinations.

Sexual penetrative pain is categorized as deep or superficial.
- Deep pain can be due to inadequate arousal, resulting in the partner’s penis hitting the cervix. Other deep pain causes include fibroids, endometriosis, pelvic adhesions (such as from previous surgery or pelvic inflammatory disease), and occasionally retroverted uterus. Besides treating the underlying cause of pain, counselling the woman and her partner about alternate sexual positions, and giving her control over intercourse can be helpful.

- Superficial pain can be due to dermatological, vaginal, pelvic floor, or psychological factors. Skin problems such as dermatitis (contact, atopic, and other), vaginal atrophy, and lichen sclerosis can be treated with appropriate topical steroids, or estrogen therapy.

Female penetrative pain disorder, previously known by terms such as vaginismus, or vestibulitis/vestibulodynia, is believed to be a phobic reaction to the perceived (and then real) threat of pain on attempted penetration into the vagina. It is more difficult for these women to control and relax the pubococcygeus muscles to allow penetration. When this is lifelong and global, and other conditions are ruled out, systematic desensitization using graduated vaginal “dilators” can help the woman focus on which pelvic muscles she is
trying to relax (rather than stretching tight muscles), or with pelvic floor physiotherapy.  

Women who have been traumatized are hypervigilant and may not be able to tolerate medical or physiotherapy examinations/therapy until they have worked through these PTSD issues. This therapy can be done individually and in groups for survivors of abuse.

Vulvodynia is a poorly understood chronic pain that is present all the time and not just with attempts at intercourse. It causes severe dyspareunia, often blocking attempts at vaginal penetration. It is believed to be a neuropathic pain that is often refractory to treatment. Vulvodynia has some similarities with interstitial cystitis and can be as debilitating. Therapies including nerve-modulating agents such as amitriptyline, gabapentin, and pregabalin can help. Referral to a pain clinic with an interdisciplinary team is often indicated.

The role of couple counselling is to help the partner understand the causes of the woman’s pain, to acknowledge their own intimacy needs and sense of loss and hurt, and to help the couple strategize about what they can share together sexually, while avoiding pain.

8. Specific Male Sexual Concerns

i. Desire Problems
About 15% of adult men feel they have decreased desire that worsens as they age. 

Evaluation and treatment should address medical, psychological and relationship issues. Medication side-effects commonly cause sexual problems; up to 25% is related to prescribed drugs such as antidepressants, antihypertensives, chemotherapies, steroids, etc. Other problems causing decreased desire include hormonal effects, such as hyperprolactinemia or hypothyroidism, and neurological illnesses such as multiple sclerosis and stroke. Lifelong, generalized decreased desire (usually with associated erectile dysfunction) requires specialized neuro-endocrine evaluation.

A decrease in sexual appetite is part of the definition of depression. Men often self-treat mood disorders with alcohol or other drugs, which further exacerbate sexual and relationship difficulties. Social phobia and avoidant personality traits contribute to decreased desire. Relationship strain often decreases situational desire, but increases the risk of affairs, where desire for another partner may be stronger.

ii. Erectile Dysfunction (ED)
ED is a common male sexual dysfunction; its incidence increases with age and associated deterioration of the neurovascular-endocrine systems. ED can often be the first symptom of underlying cardiovascular disease. Diagnosis and management of ED can be done in family practice. Medical therapies were revolutionized in the 1990s with the introduction of oral PDE-5 inhibitors. Fazio and Brock give a good overview of pathophysiology and medical
management options including intra-urethral medicated urethral system for erections (MUSE) and injection therapies. 38

iii. Premature (Rapid) Ejaculation

Premature or rapid ejaculation is the most common male dysfunction. 9 Therapies traditionally were behavioural, using systematic desensitization (stop-start exercises) and couple sex therapy to reduce performance anxiety. 1 While initially effective, the benefit is often lost over the next one to two years. Psychotherapeutic approaches alone are indicated when a specific life event has precipitated acquired PE, but therapy combined with medications may lead to better outcomes, with the potential to gradually reduce medication as the PE comes under control.

Pharmacological therapy has become a mainstay of treatment of PE, especially for those with lifelong and/or severe PE. Using SSRIs and tricyclic antidepressants can significantly extend the length of intercourse. The doses required are usually lower than for depression, for example:

- Sertraline 25-75 mg daily, or two to six hours as required before intercourse
- Clomipramine 10-50 mg daily
- Combining SSRIs with PDE-5 inhibitors leads to better control than using either drug alone.

Dapoxetine, an on-demand, fast-acting, and short half-life SSRI, can increase the length of time for intercourse by about three-fold, while increasing sexual satisfaction and decreasing distress for both partners. It is available in some European and Asian countries. 39

iv. Delayed Ejaculation (DE)

DE occurs in about 5% of men. 9 Men who have never ejaculated should have a detailed evaluation to rule out neuro-endocrine and possible chromosomal abnormalities. Situational delayed ejaculation is more common, where the man can self-pleasure to orgasm, but is unable to do so with a partner. Neurological and endocrine factors must be assessed, but usually no obvious medical cause is found.

Therapies have been uniformly poor in helping couples move to intra-vaginal ejaculation with intercourse alone. A major goal for most couples presenting for medical care is to achieve pregnancy. Fertility clinics can provide intra-uterine insemination with the man’s semen, obtained either through masturbation or electromechanical stimulation.

Sex therapy focuses on educating the couple about the causes of DE and that the man is not intentionally withholding his orgasm. With this as a basis, further therapy is directed at helping the couple enjoy sex without him ejaculating. It is often helpful to remind couples that 25% of women do not have orgasms with sex and yet can still derive pleasure from the encounter.
v. Sexual Pain

Sexual pain is relatively rare for men in comparison with women, but is not uncommon. Structural problems, such as phimosis from a tight foreskin, or short frenulum, or severe angulation from Peyronie’s disease, can be diagnosed clinically or by having the patient bring in anteroposterior and lateral photographs of the erect penis. Infection due to balanitis is a more common acquired cause and is usually cured by treating both the man and his partner. Psychogenic pain can be diagnosed only after ruling out medical factors and is often related to anxieties about the relationship.
Case 1: Linda and Brian

What else would you like to know?

1. Patients like Linda and Brian can be asked: “Does the lack of intercourse in your relationship bother you?” If a couple is not bothered by the change in scope of intimacy, there is no dysfunction. In this case, however, Linda and Brian are interested in resuming comfortable penetrative intercourse.

2. A full history of Brian’s erectile problem should include inquiring about morning erections, masturbation, strength of erection, bowel or bladder symptoms.

3. A full history of Linda’s vaginal discomfort and dyspareunia should include inquiring about year of final menstrual period, abnormal bleeding, whether the dyspareunia is on insertion or on deep penetration, vasomotor symptoms, and use of systemic hormone therapy.

How would you manage Linda’s vaginal dryness?

Postmenopausal vaginal dryness, also known as vaginal atrophy or urogenital syndrome of menopause, is caused by low estrogen levels in the urogenital area. Vaginal atrophy results in thinning of the vaginal mucosa, narrowing of the vaginal vault, decreased lubrication, decreased elasticity, a change in the vaginal microbiome, and increased urinary tract infections. Dry, friable and/or itchy vaginal mucosa can make penetrative intercourse painful. Dyspareunia secondary to vaginal atrophy is one of the most common reasons why postmenopausal women stop having intercourse. It is important to talk about vaginal health at the menopausal transition, since vulvovaginal atrophy can have a significant impact on quality of life and sexual satisfaction. It is equally important to talk about vaginal atrophy with women who are not sexually active, since it can cause significant discomfort at rest and increases the risk of urinary tract infections.

Nonhormonal local therapies include vaginal moisturizers such as Replens, or water- or silicon-based lubricants with sexual activity. Non-hormonal therapies may provide short-term relief of symptoms but do not treat underlying causes or alter the natural course of the condition.

Local hormonal therapies include local vaginal estrogens:

- Vagifem 10 mcg pv daily for two weeks, then twice weekly
- Estring vaginally every three months
- Premarin cream pv (Premarin can also be applied to the external introitus at the beginning of therapy, but it is variably systemically absorbed and should therefore not be used long-term.)

Systemic hormone therapy (HT) is indicated primarily for vasomotor symptoms and should not be used to treat vaginal atrophy that can be managed with local estrogens alone. Local estrogens used at therapeutic doses should not have systemic effects and are appropriate for long-term use.\textsuperscript{40}
**How would you manage Brian’s erectile dysfunction?**

1. Take a full erection history (outlined in Case 2 commentary). It is important to exclude endocrine, neurological (including spinal pathology or head trauma) and vascular disease as potential etiologies in the workup.
4. Non-pharmacological management: couples counselling or sex therapy (see Information Point 8ii)
5. Pharmacological management: tailor PDE5 inhibitor therapy based on frequency of intercourse. (see Information Point 8ii)

**How would you counsel Linda and Brian?**

Normalize vaginal atrophy and erectile dysfunction as common and manageable conditions. Normalize and support the couple to continue enjoying non-penetrative sex or “outercourse” as a means of maintaining a satisfying sex life even when penetration is painful or difficult.

**Case 2: Morgan and Carlos**

**What is the definition of rapid ejaculation?**

Premature or rapid ejaculation occurs earlier than desired and is distressing to one or both partners (Info Point #9iii). It is a common male sexual disorder, affecting approximately 20-30% of men of all ages. The exact cause of rapid ejaculation is unknown and often multifactorial; however, low serotonin levels may be an important factor. The average duration of intercourse in Canada is five to seven minutes); however, there is no fixed “normal” time to ejaculation. For example, if neither Morgan or Carlos were bothered by the fact that Carlos ejaculated after one minute, then he would not be considered to have rapid ejaculation. When patients present with the concern of rapid ejaculation, it is important to explore why this is problematic for either or both partners and what is their understanding of normal ejaculatory function.

**What options does Carlos have in addressing his concern?**

A basic approach to managing rapid ejaculation involves counselling, behavioural and pharmacological components.

Discuss psychological difficulties that may be causing increased performance anxiety contributing to the problem and or the relationship. Facilitating an open discussion with both partners present may help Carlos be less anxious about his sexual performance.

Certain behavioural manoeuvres to delay ejaculation that Morgan and Carlos could try together include:

**Stop-Start Method:** In this exercise, the partner stimulates the man until he is close to ejaculation and then stops all stimulation until the man’s urge to ejaculate passes.

**Squeeze Method:** In this exercise, developed by Masters and Johnson, the partner stimulates the man until he is close to ejaculation and then squeezes the base of his penis so that he partially loses his erection. This can cause discomfort and is not used as often as the Stop-Start method above. Both these methods can help delay ejaculation.
Pharmacologic management: SSRIs and tricyclic antidepressants have been safely used off-label for many years in the management of rapid ejaculation and are thought to work via serotonergic-dependent pathways. The dosage of SSRI needed to manage rapid ejaculation is lower than the dosages used to treat mood, such as sertraline 25-75 mg daily or clomipramine 10-50 mg daily (Info Point #9iii).

How would you counsel Morgan on her concerns about anorgasmia? Primary anorgasmia, or preorgasmia, in the absence of significant medical illness (MS, spinal cord injury, antisexual medications, etc.) can be effectively treated using a learning model. Explore attitudes about sexuality and self-pleasuring, improve knowledge about women’s sexuality and orgasm triggers, and teach specific behaviours to help the woman learn how to be orgasmic on her own, using books from the reading list (Barbach, Dodson). Once she learns this, she can help her partner give her similar stimulation.

Case 3: Vanessa and Kucy
What else do you want to know?
- Complete the remaining aspects of the sexual history (Info Point #3). While neither Vanessa nor Kucy are taking any medications and sex has historically been positive, more information about their current levels of desire, arousal, ability to orgasm and sexual pain might help shed light on why the frequency of intimacy has plummeted.
- Inquiring about active or recent psychosocial stressors is also an important part of their history.
- Ask case-finding questions about mood disorders.
- Inquire about symptoms of menopause.

What other investigations would be appropriate for Vanessa and Kucy?
- Directed physical examination (general assessment, blood pressure and cardiovascular exam). In the absence of sexual pain, a gynecological examination is not necessarily indicated.
- Bloodwork: thyroid-stimulating hormone, prolactin estradiol level (to exclude perimenopause), free testosterone (for a baseline level should testosterone therapy be considered as a management in the future). A complete blood count, lipid profile and HgA1C are reasonable as means of excluding chronic diseases that can significantly impact sexual function.

How would you manage Kucy’s concern?
- Determining the specific areas of sexual dysfunction (i.e., desire, arousal, orgasm and or sexual pain) is important in tailoring therapy.
- Reassure and normalize Kucy’s concern about the decreased frequency of sexual intimacy. Sexual concerns are more common than diabetes and can often be improved.
- Meeting with the couple together to take a full sexual history would be ideal.
- Recommend individual therapy as needed.
- Refer to either a marriage counsellor or sex therapist if physiologic etiologies have been excluded and relationship issues seem to predominate.
REFERENCES


RESOURCES

WEBSITES FOR PATIENTS AND PROFESSIONALS
- The Sex Information and Education Council of Canada
- SexualityandU.ca
- MiddleSexMD.com
- The North American Menopause Society

BOOKS ABOUT FEMALE SEXUALITY
- Barbach L. For each other. New York: Anchor; 1983
- Friday N. Forbidden flowers; more women’s sexual fantasies. New York: RosettaBooks; 2014.

**BOOKS ABOUT MALE SEXUALITY**

**BOOKS ABOUT SEXUAL COUNSELING**

**BOOKS ABOUT RELATIONSHIPS**

**BOOKS ABOUT AGING AND SEXUALITY**

**BOOKS FOR PROFESSIONALS**
• LaSala MC. Coming out, coming home: helping families adjust to a gay or lesbian child. New York: Columbia University Press; 2010.