Management of Sexual Dysfunction in Men and Women

An Interdisciplinary Approach

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Preface

Understanding both the physical and psychosocial-behavioral and cultural basis of sexual and reproductive health is essential in instituting effective treatments for men, women, and couples with sexual dysfunctions. The mental and physical aspects of sexual function are intricately interrelated, with established relationships between depression and sexual function in both males and females and links between sexual dysfunction and hormonal dysregulation and fertility in both sexes as well. In addition, a genetic basis for many conditions affecting sexual function is becoming apparent, which will inevitably lead to the rapid expansion of the diagnostic and potentially the therapeutic approaches used to evaluate and treat these patients. The evaluation and management of sexual dysfunction in the male, the female, and the couple is clinically complicated and does not fit into routine conceptualization of gender-specific diseases.

Integrating the individual approaches of urology, gynecology, psychiatry, and psychology, this book is truly transdisciplinary and unique among textbooks addressing sexual dysfunction.

The text provides a comprehensive, state-of-the-art review of the intersection of male and female reproductive and sexual health and will serve as a valuable resource for clinicians and researchers with an interest in abnormalities of sexual function. The book comprehensively discusses the evaluation and management of physical, genetic, and psychological causes of male and female sexual dysfunction. Examined in detail, one finds medical and surgical therapies in both the male and female, specifically focusing on erectile, ejaculatory, and orgasmic disorders in the male, arousal and orgasmic disorders in the female, and an integrated medico-psychosocial approach to the couple. Lifestyle modification through diet and exercise, resulting in optimization of anthropomorphic characteristics, is also reviewed. This approach highlights a holistic view of these disorders that goes beyond the typical focus on obvious pathophysiologic disorders of the genital system.

We believe the text will serve as a resource for physicians, mental health professionals, and researchers interested in sexual medicine, providing a concise and comprehensive overview of the field. Written by experts in their specialties, the text is divided into three sections: sexual dysfunction in the male, in the female, and in the couple. Many of the chapters are complemented by unique commentaries written by mental health professionals, giving an in-depth interdisciplinary approach to the subject of the chapter.

We hope this book will become a unique reference for all healthcare professionals interested in better understanding and treating human sexual dysfunction. Furthermore, it is anticipated that this comprehensive edition will help guide patient management and stimulate novel research efforts to further enhance progress in the field of human sexuality.

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1 Introduction: Advocating for a Transdisciplinary Approach to the Management of Sexual Disorders

Michael A. Perelman

Two concepts were particularly important to me in developing this textbook: (1) a desire to cultivate a transdisciplinary sexual medicine perspective for the reader that emphasized integrating counseling with current and future medical/surgical approaches for the treatment of male and female sexual disorders and (2) emphasizing the need and benefit for the reader to use a biopsychosocial-behavioral and cultural lens when contemplating sexual response and sexual dysfunction.

When asked to coedit this volume, I was concerned about the need for yet another edited text about sexual disorders and their treatments. It was agreed that if we were to write a text for a truly multidisciplinary clinical audience, our editorial and author group would need to be diverse in terms of both gender and professions of origin. Through editorial discussions, a concept emerged of a book whose chapters would be written primarily by sexual medicine physicians and typically with additional commentary from those with a mental health background—often sex therapists. We believed such a dialectic would provide a unique contribution to the literature as well as support the emerging viewpoint that sexual medicine should share a transdisciplinary perspective which has characterized the most recent advances in many areas of medicine [1]. Such an approach goes beyond the multidisciplinary view, previously held by others as well as ourselves. Instead, transdisciplinarity speaks to the need for healthcare practitioners to exchange information in a manner that each contributing discipline and specialty begins to alter its own practices to share an integrated knowledge and achieve common scientific and clinical goals [2].

We hope the reader will develop insights and wisdom that transcends the information explicitly contained in the chapters and commentaries offered within this volume. Why and how? The dialogue between the mental health authors and the medical/surgical authors was often an implicit one. The reason for this was twofold. First, some of the commentaries were written to express the viewpoint of the mental health author in response to their perception of a physician's/surgeon's general approach to sexual problems today. These authors spoke about their view of the generic trends, rather than addressing a specific chapter author's writing. Other commentaries were written to directly complement a specific chapter and commented on the work of a given author. Obtaining a thorough understanding of sexual medicine requires an understanding of the mind/body issues inherent within human experience in general and sex in

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particular. The purpose of this book was to evoke a dialogue within the mind of the reader about a more comprehensive perspective on how to view patient's sexual disorders and concerns. In other words, the book is designed to teach an integrated treatment approach; yet our ultimate goal was to nurture for at least some of you a transdisciplinary perspective for the future of sexual medicine.

Of course, there is no reason to believe a single pathogenetic pathway to sexual disorders exists. Clarity of understanding requires that the clinician and researcher alike maintain a biopsychosocial-behavioral and cultural view of sexual response and dysfunction. Besides the obvious common sense appeal of such models, there is an ever-expanding body of empirically based quantitative and qualitative evidence supporting a multidimensional conceptualization, especially in the areas of treatment optimization, treatment adherence, and continuation of recommended therapies [3–26].

The reader may choose from a number of multidimensional models, but sexual medicine and sex therapy have recently been most influenced by various "dual-control models" [27–36]. Earlier, Helen S. Kaplan brought to sex therapy and to sexual medicine the principles of multideterminism and multilevel causality [32, 37]. However, in her last book *The Sexual Desire Disorders*, published in 1995, Kaplan foreshadowed the important work of Bancroft and colleagues [27] when she both described and illustrated dual-control elements of human sexual motivation and identified sexual "inciters" and "suppressors" to sexual desire dysregulation [31, 38]. She attributed her conceptualization to Kupferman [39] who had noted earlier that "all examples of physiological motivational control seem to involve dual effects—inhibitory and excitatory—which function together to adjust the system" (p. 751). Kaplan felt that control of sexual motivation was no exception and also operated on such a "dual steering" principle (Fig. 1.1).

The seminal works of Bancroft and colleagues are the best known and researched of the various dual-control models [27]. Bancroft's 1999 manuscript [27] and subsequent work with his Kinsey Institute colleagues (Graham, Heiman, Janssen, Sanders, etc.) have provided outstanding, erudite articulation of their dual-control theory, psychometrics, and comprehensive research for over 15 years

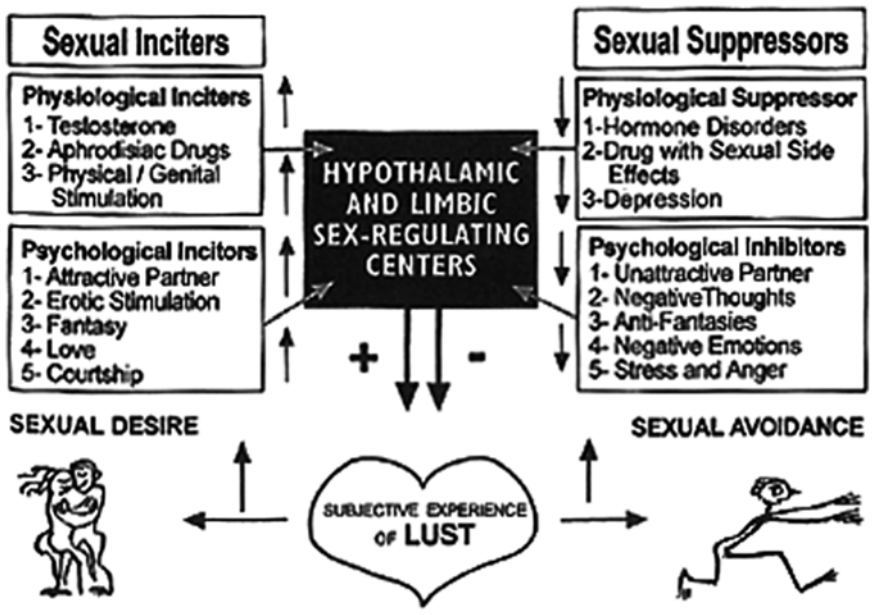

Fig. 1.1 Helen S. Kaplan's (1995) Dual-control elements of human sexual motivation: a psychosomatic model. With permission from Kaplan HS, The Sexual Desire Disorders. Dysfunctional Regulation of Sexual Motivation. Brunner-Routledge (Taylor and Frances, London, 1995: p. 15

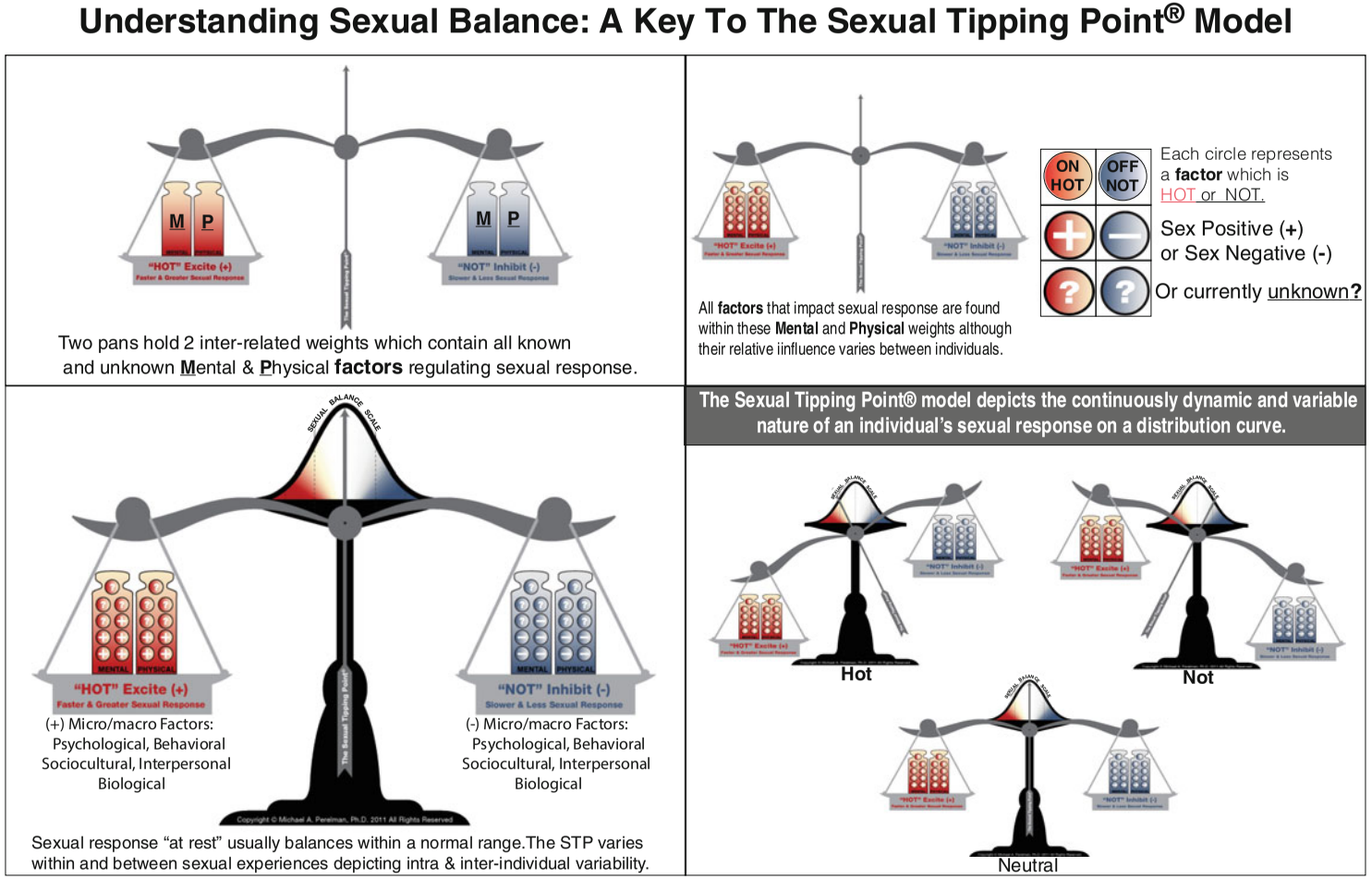

Fig. 1.2 A sequential key to the STP model. mapedfund.org provides a video explanation of the STP model as well as continuously updated images and other resources which are all available for free download by healthcare professionals

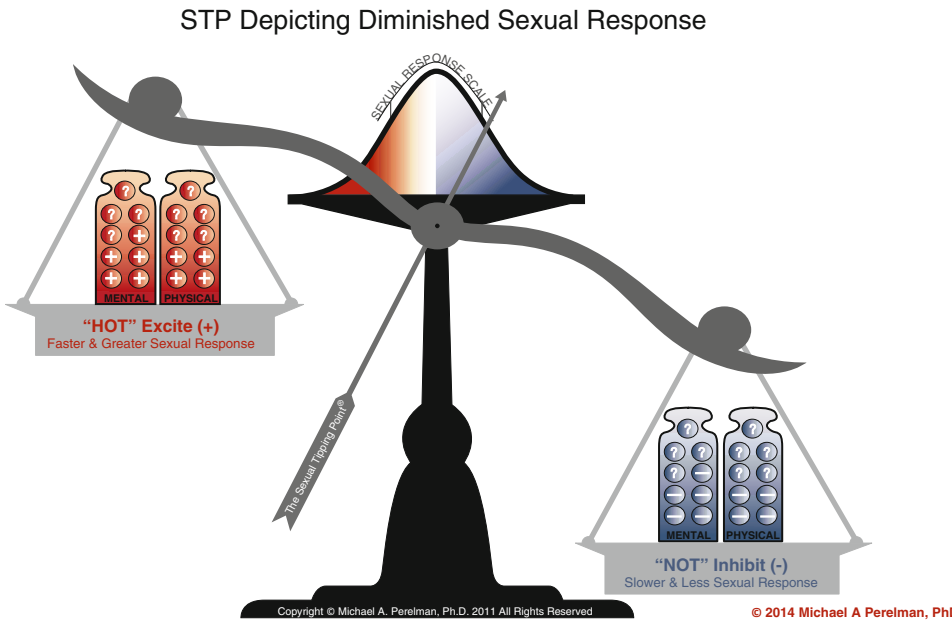

Fig. 1.3 STP illustrates diminished response. mapedfund.org provides a video explanation of the STP model as well as continuously updated images and other resources which are all available for free download by healthcare professionals

[40–42]. In short, they postulate and attempt to demonstrate "that sexual response and associated arousal occurs in a particular individual, in a particular situation, and is ultimately determined by the balance between two systems in that individual's brain, the sexual activation or excitation system and the sexual inhibition system, each of which has a neurobiological substrate" [27, p. 15].

Yet, from our perspective when contemplating the clinical need for understanding etiology, diagnosis, and treatment, we find the Sexual Tipping Point ® (STP) dual-control model particularly useful in its ability to illustrate both intra- and interindividual variability that characterizes sexual response and its disorders for both men and women (Fig. 1.2) [13].[1]

The Sexual Tipping Point® model easily illuminates the mind/body concept that mental factors can "turn you on" as well as "turn you off"; and the same is true of the physical factors. The Sexual Tipping Point® is the characteristic threshold for an expression of a given sexual response. Therefore, an individual's Sexual Tipping Point® represents the cumulative impact of the interaction of their constitutionally established capacity to express a sexual response which is elicited by different types of stimulation as dynamically impacted by various psychosocial-behavioral and cultural factors. An individual's threshold will vary somewhat from one sexual experience to another, based on the proportional effect of all the different factors that determine that tipping point at a particular moment in time. For instance, an individual suffering from a diminished sexual response (desire, arousal, orgasm) is illustrated by the cartoon in Fig. 1.3.

Besides illustrating all etiological permutations, including normal sexual balance, the Sexual Tipping Point® concept is particularly useful for modeling treatment and can easily be used to explain risks and benefits for patients with sexual disorders. The STP model can be used to teach patients where different treatment

[1] The STP model is a registered trademark of the MAP Education and Research Fund, a 501(c)(3) public charity. STP illustrations are available free from mapedfund.org.

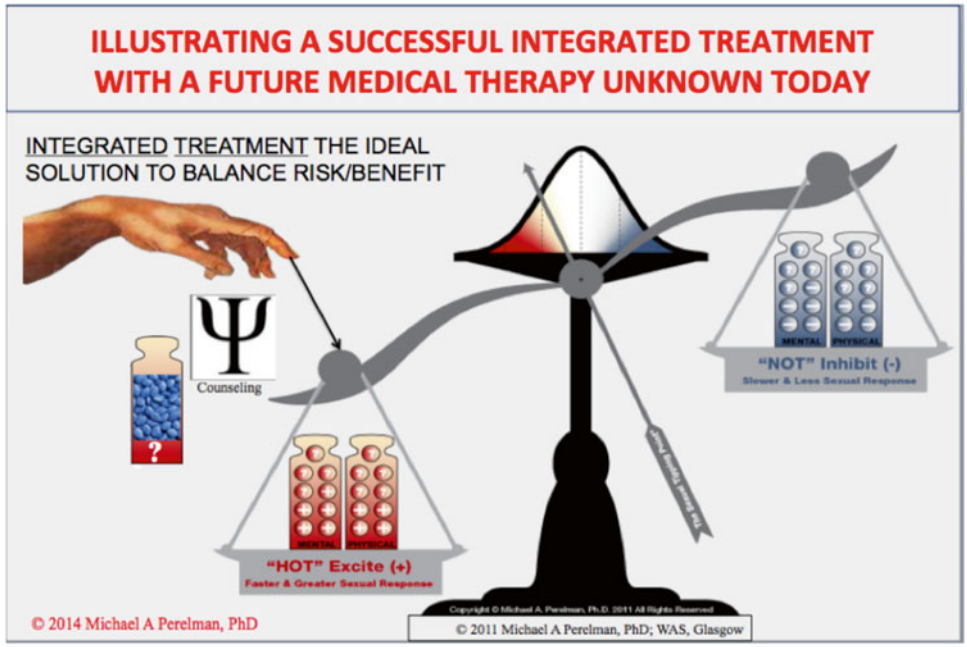

Fig. 1.4 STP depicts integrated treatment with a future medical therapy unknown today. mapedfund.org provides a video explanation of the STP model as well as continuously updated images and other resources which are all available for free download by healthcare professionals

targets should be focused, depending on diagnosis of their etiological determinants. Typically expressed erroneous binary beliefs can be politely disabused, and the patient can be reassured that "no it is not all in your head" nor "all a physical problem." Reciprocally, their partner can be assured it is "not all their fault!" Teaching the STP model to the patient and partner can reduce patient and partner despair and anger, while providing hope through a simple explanation of how the problem's causes can be diagnosed, parsed, and "fixed." In fact, the Sexual Tipping Point® also allows for modeling of a variety of future treatments, including medical or surgical interventions not yet discovered or proven such as novel pharmacotherapy, genetic engineering, or nanotechnology [35] (Perelman, 2011b). This is illustrated in Fig. 1.4.

Indeed, all the biopsychosocial-behavioral and cultural models of sexual dysfunction provide a compelling argument for sexual medicine treatments that integrate sex counseling and medical and/or surgical treatments [43]. Our work is not just to alleviate our patient's sexual symptom but when possible to improve their intimate relational lives. Restoration of lasting and satisfying sexual function requires a multifactorial understanding of all of the forces that created the problem, whether a solo physician or multidisciplinary team approach is applied. The healthcare professional that can accomplish an integrated treatment will offer the most optimized approach and the most elegant solution [43].[2] Treatment formats vary according to the preference and expertise of healthcare providers and tend to incorporate three processes: (a) the clinician's interest, training, and competence; (b) the biopsychosocial-behavioral and cultural severity of the sexual dysfunction; and (c) patient preference as to which healthcare professional

[2] Telemedicine through today's Internet technologies offers the opportunity for inexpensive video conferencing of diverse experts across geographic boundaries, which will perhaps increase the productive interaction between disciplines. Such technology offers the potential of multispecialty referral or consultation being available for the patient or partner when required, independent of geography.

they first choose to consult. Perelman [44] recommended that the degree of medical and psychosocial complexity determines whether a healthcare provider would work alone or as part of a multidisciplinary team. For instance, a physician working alone would assess all needed physical findings (examination, laboratory testing, etc.), as well as diagnose the patient as suffering from mild, moderate, or severe psychosocial obstacles to successful restoration of sexual function and satisfaction. In addition to the physical factors, the physician would attempt to identify the cognitive, behavioral, relational, and contextual cultural factors predisposing, precipitating, and maintaining the patient's sexual dysfunction. The physician would either continue treatment or make a referral(s) on the basis of perceived complexity and the actual progress obtained [5, 43].

Each clinician needs to carefully evaluate his or her own competencies and interests when considering treatments for sexual dysfunction. Having a multidimensional understanding of sexual dysfunction does not mandate a multidisciplinary approach. Solo practitioners may question whether to collaborate with a multidisciplinary team or to provide an integrated treatment themselves. Regardless of which healthcare professional the patient consults first, he or she is entitled to receive optimized care. For many patients, neither sex therapy alone nor medical/surgical interventions alone are sufficient to facilitate lasting improvement and satisfaction for a patient or partner with sexual dysfunction. For those patients who have sexual dysfunction based on deep-seated psychosocial and emotional issues, the use of a simple single-agent pharmacologic therapeutic will not be sufficient. Furthermore, a patient who has physical issues related to age, illness, and so forth is extremely unlikely to be fully restored (versus helped to adapt) by sex counseling exclusively. Indeed, some primary care physicians as well as many specialists will not have the expertise to adequately diagnose psychological obstacles to success, independent of their willingness to treat these factors. Alternatively, most mental health practitioners are neither capable nor licensed to provide medical care to the full extent needed by the patient. And as in all areas of healthcare, professionals should appropriately refer their patients for adjunctive consultation as needed.

We hope medical research will one day bring us more and better treatments to help ameliorate the biological factors that underlie some people's failure to function sexually in ways they would prefer. We believe the multidisciplinary perspective that emerged from an emphasis on the empirical success of combination treatments will be replaced by an integrated approach to sexual issues and dysfunctions by clinicians who will consult to these patients in the future. As that transdisciplinary view becomes more prevalent, we hope it will become the teaching model for all healthcare practitioners early in their training. In other words, we hope our readers will advance sexual medicine with an enlightened appreciation of etiology, diagnosis, and treatment based on a biopsychosocial-behavioral and cultural model. It is our hope that such sophistication will lead to an improved personalized sexual medicine benefitting both patient and practitioner alike. Our aspiration is for all healthcare practitioners to maintain a patient-centered holistic view of healing that integrates a variety of treatment approaches as needed whether for sexual dysfunction or any sexual concern. We hope this book provides a window on how this can be accomplished both now and in the future.

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Why Is Sex Important?

2

Stephen B. Levine

2.1 Introduction

As the reader begins this book devoted to the modern treatment of sexual problems, it is useful to state the obvious. The primary purpose of clinical medicine is to assist patients with their limitations to physical and mental health. To this end, healthcare professionals are continuously educated about disorders and their therapies. Since 1970, this traditional focus on disease has been applied to sexual dysfunction, a term that artfully dodges the idea that many sexual problems are diseases. For several decades the scope of urology and gynecology has expanded to include sexual dysfunctions. A less than obvious benefit of the focus on diseases and their response to treatments is a clearer understanding of the processes that maintain health. For example, as clinical research recognized disease-inducing forms of immunological incompetence, the complex overlapping systems that preserve our health from pathogens were clarified. Similarly, as interventions for sexual dysfunction have evolved, knowledge has accumulated about sexual health. But sexual health, per se, is rarely the subject of sexual medicine articles. These articles assume sexual health equates with arousal or orgasmic functionality and suggest methods for restoring these capacities.

This chapter explores subtle, private aspects of sexual health. In doing so, it will define the lurking sources of disappointment that our patients are likely to feel when they request our assistance. In addition, the examination of sexual health and sexual distress will provide clinicians with some concepts concerning the psychological pathogenesis of many problems.

Sexual problems, theories of their cause, and treatment approaches date back to the earliest of medical writings [1]. Today, the sexual problems that attract clinical attention involve two broad categories: (1) *sexual identity* (transpositions of gender identity, variations in orientation, paraphilic patterns of arousal within and outside of a sexual addiction pattern) and (2) *sexual dysfunction* (symptoms include deficient sexual desire, incapacities in maintaining sexual arousal, anorgasmia, orgasm without pleasure, ejaculatory latency extremes, painful intercourse, and unwanted sexual arousal). Urologists, gynecologists, psychologists, psychiatrists, relationship therapists, sex therapists, and physical therapists each stake out their territories within this expanding array.

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2.2 The First Principle of Clinical Sexuality

All sexual behavior—solitary or partnered, normal or dysfunctional, morally acceptable or socially disapproved of—is ultimately constructed from four general sources: biology, psychology, interpersonal relationships, and culture [2]. This principle is a humbling reminder not to oversimplify the determinants of sexual phenomena in our rush to find solutions to patients' problems. Despite knowledge of this principle, all healthcare professionals are forced by their education, knowledge, and skill set to oversimplify this ordinary complexity in their everyday work. An elegant model that schematically illustrates the interaction of these four major determinants exists [3].

2.3 The Two Systems of Adult Nurturance in Sexual Relationships

Adult sexual relationships are well known to have the potential to stabilize and enrich individuals and make them happy with their interpersonal status. *Psychological intimacy* and *partner sexual behavior* are the two behavioral systems that nurture adults. Partner sexual behavior can exist without psychological intimacy just as psychological intimacy can occur without partner sexual behavior. When they are successfully integrated, however, a positive feedback between them creates a greater degree of mutual nurturance and results in maximization of sexual functional capacities. Psychological intimacy motivates partner sexual behavior, and sexual behaviors create a new degree of psychological intimacy. In sexual health, the two systems function as one.

2.4 Three Paths to the Creation of Psychological Intimacy

2.4.1 Conversation

The usual way to attain psychological intimacy is through conversion [4]. One person speaks; the other person listens. In order to achieve a moment of psychological intimacy, the speaker has to meet three requirements. The speaker must talk about his or her inner subjective psychological self. The speaker must be able to trust in the safety of sharing this with the listener. The speaker must possess the language skills to express in words his or her thoughts, feelings, perceptions, and history. Psychological intimacy will not occur, however, unless the listener is able to evidence the following characteristics: The listener must provide undivided, uninterrupted attention to the speaker. The listener's comments must be noncritical and reflect an accurate comprehension of what is being said and felt by the speaker. The listener needs to construe the opportunity to listen as a privilege to learn about the inner experiences of the speaker. Much conversation, even between established lovers, does not create psychological intimacy.

Psychological intimacy is a transformative moment of connection that occurs simultaneously in both the speaker and the listener. It is a bonding process that creates or reinforces the sense of belonging to one another. There are two basic forms of psychological intimacy. The first is the *two-way psychological intimacy* that ideally recurs in a couple's life. Each member of the couple, of course, takes a turn being a speaker and a listener to potentially re-create moments of connection. In *one-way psychological intimacy*, however, a particular person is almost always the speaker and the other person is predominantly the listener. Physicians and mental health professionals create a one-way psychological intimacy with patients, as do parents with their young children. Psychological intimacies are part of the landscape of numerous kinds of relationships, ranging from friendship to sibling bonds to lawyer-client relationships. Unlike this wide array of psychological intimacies, psychological intimacy within a sexual relationship possesses a special power to repeatedly ease the way to sexual behavior.

These bonding moments of connection have profound consequences for the speaker. The moments strengthen the bond to the listener, causing pleasing thoughts such as "I am accepted." "I feel more stable." "I am happier." "I feel healthier." These moments erase loneliness,

create optimism, and cause the speaker to look forward to the next opportunity for connection. After repeated moments of psychological intimacy, the speaker generates interest in sexual behavior with the listener. Psychological intimacy can be a powerful erotic stimulus. In certain contexts it is the most reliable and safest known aphrodisiac.

Moments of psychological intimacy have positive consequences for the listener as well. The listener gains a deeper understanding of the speaker and experiences pleasure in being of value to the speaker. The listener demonstrates an increased willingness to think about his or her own subjective self and comes to realize how important he or she is to the speaker. These subjective experiences reaffirm the bond to the speaker.

Psychological intimacy is not confined to the adult-adult relationship. Parents ideally maintain it with their children; friendships among any age group exist because of the individuals' capacities to share aspects of themselves. The skill of psychotherapists is their ability to create and maintain psychological intimacy in order to promote psychological growth. Psychological intimacy creates a rarely discussed erotic stimulus in many relationships that are not intended to be sexual. As such, people have to carefully manage themselves so as not to complicate their lives.

2.4.2 Shared Intense Experiences

A second way of creating psychological intimacy, shared intense emotional experiences, does not require much conversation. An intense bond can readily be established or reestablished, for example, by enduring a frightening febrile illness in an infant, caring for a dying friend together, being together in combat, or being on an athletic team.

2.4.3 Sexual Behavior

The third way of attaining psychological intimacy is through sexual behaviors. It, too, is a largely nonverbal shared emotional experience. Many aspects of sex create private emotion. The sight of the partner's naked body is a powerful experience of knowing the person, particularly early in the relationship. To this is added the perception of what the naked person feels about his or her naked body. One learns of the partner's interest in and attitude toward specific sexual behaviors. Each person witnesses the other in arousal, a pleasurable knowledge that is augmented by facilitating, listening to, and watching the partner's orgasm. These intensely private subjective experiences create the sense of knowing the partner in a way that others could not. This is a privilege. In these ways, sex creates a profound degree of connection.

The unmodified word "intimacy" is used to describe shared conversations about private experiences, nonverbal emotional experiences, and sexual pleasure. All avenues of attaining psychological intimacies promote the sense of loving and being loved.

2.5 What Is Learned Over Time Through Sex

Over time, individuals discover their partners' range of sexual comfort. They witness the changing nature of this comfort. They come to discern their own and their partner's variations in desire, arousal, and orgasm. They appreciate some of their partner's motivations for sexual behaviors. Over months, years, or decades, sexual behavior may deepen the couple's bond such that each has a rich, nuanced conviction of the sensual capacities of the other and how best to relate to them [5].

2.6 What Accounts for the Pleasures of Sex?

The pleasures of sex are physical and psychological. Sex can create novel delicious sensations and pleasant emotions before, during, and after orgasm. A person experiences the sense of power in giving the partner pleasure. The ability to give and to receive pleasure increases interest in the other, adds to the knowledge of the other, and

creates the sense of being intertwined with the other. These are the means of creating a sense of oneness. The seamless interplay of physical and psychological pleasure during sex attenuates the sense of time as the individuals transport one another into the realm of sensation. The psychological pleasures of sex also involve personal meanings. These meanings, however, are often either closely held privacies from the partner or indescribable. "I feel it, but I can't describe it. It just is!" "I love you!" is the occasional summary of this complexity.

2.7 Why Is Sex Important?

Sexual behavior stabilizes our sexual identity. Sex allows us to feel that we are confident as a man or woman. It helps us to clarify and stabilize our identity as a heterosexual, homosexual, or bisexual person. It clarifies the nature of our intentions as consisting of peaceable mutuality or varieties of sadomasochism or fetishism.

Sex is the vehicle for early romantic attachment at every stage in life—among the never attached, divorced, widowed, and those having affairs. It can facilitate the vital process of creating an entity from two individuals. Romance conveys the hidden quest for a safe, secure, comforting lasting unity. It is typically accompanied by an intense erotic desire for each other.

In established relationships, sexual behavior reinforces the sense that one is loved and capable of loving. It strengthens the sense of oneness enabling individuals to feel themselves to be an integral part of another. Sex has the capacities to erase the ordinary angers of everyday life, to elevate one's mood, and to increase resiliency for tomorrow. It improves our capacity to withstand extra relationship temptation. And, of course, it is vital to our reproductive ambitions.

Sex remains a vehicle for self-discovery throughout life. It begins in adolescence when eroticism is dominated by fantasy, attraction, and masturbation and continues to reveal private aspects of the self during the many decades of regular or intermittent partner sexual behaviors and into the wistful final alone years.

2.8 The Second Principle of Clinical Sexuality

Sexual experience is a dynamic ever-evolving process. It changes in the short and in the long term in response to numerous biological, psychological, interpersonal, economic, and social factors. Individuals change psychologically, physically, and sexually over time as they mature, take on new responsibilities, and experience loss, personal dilemmas, and illness.

Changes in one person invariably impact on the partner. Therapeutic interventions can be immediately effective because of the responsiveness of the balance of the couple's delicate interactions between sexual identity components and sexual function characteristics.

The second principle illustrates a limitation of medicine's traditional reliance on designing interventions for individuals. For the treatment of coupled individuals, it is useful to expand this paradigm so that the clinician recognizes that forces emanating from the partner can render a therapy that has been scientifically demonstrated to be efficacious ineffective.

2.9 The Sexual Equilibrium

The second principle explains why the sexual fate of an individual entering into a monogamous relationship is not determined by his or her precommitment sexual capacities. Once that person enters into the new sexual equilibrium, what he or she experiences will heavily depend on the interplay between the person's and the partner's component characteristics (Table 2.1).

Table 2.1 The interaction of the sexual components in any sexual equilibrium

Partner A		Partner B
Gender identity	↔	Gender identity
Orientation	↔	Orientation
Intention	↔	Intention
Sexual desire	↔	Sexual desire
Ease of arousal	↔	Ease of arousal
Orgasmic pattern	↔	Orgasmic pattern
Pain-free penetration	↔	Pain-free penetration

The interaction of these components determines the frequency of sexual behavior, what sexual acts they share, how orgasm is attained, and their sexual psychological satisfaction. The sexual equilibrium of each couple has unique features. Some individuals come to know that different levels of satisfaction occur with different partners over their lifetimes. Clinicians have to be alert to the possibility that some patients who request interventions for improving sexual capacity are not planning to use them with the apparent partner. These men and women may have a more satisfying sexual equilibrium with someone who is unknown to the partner, whether or not they have sex with their mate.

2.10 What Is Sensuality?

Satisfying functional sex requires the abandonment of ordinary daily preoccupations and the substitution of a focus on bodily sensations. Sensuality is not how a person looks. It is what a person is capable of doing and feeling during sex. Sensuality has two faces. The readily appreciated face is the capacity to experience the preoccupying sensations of a kiss, lick, a touch, a breast or genital caress, and penetration. The more subtle face of sensuality is the person's interest in transporting the partner to this realm where pleasure predominates.

2.11 An Ideal Life of Sexual Pleasure

High on the list of hoped for personal expectations from life is to have, at least for an extended period of time, a diet of emotionally satisfying sex [6]. It is as though individuals collectively know that sex can be wonderful and that it is a vehicle to feel and express love. In the last analysis, sex may be the easy way to access the much more difficult to describe subject of love [7]. Particularly in clinical medicine, where the topic of love is generally avoided, sex may be a surrogate topic for love.

A satisfying sexual life diminishes the sense that one has been cheated by life. Wonderful sex creates a comforting, stabilizing sense of happiness. People learn from it that in being a part of someone else, they not only do not lose their individuality by loving but their individuality is essential to their blissful sensual excursions. Satisfying sensual sex prevents envy of other people's sexual experiences because people sense that "It could not get better than this."

2.12 Sexual Health Is Only Potential

Recurrently satisfying sensuous interactions—sexual health—is a developmental achievement. It is not guaranteed for men or women by their biological normality, their sex-positive attitudes, or past history of sensuality. While physicians prefer to biologically intervene with sexual dysfunctions, to do so without paying attention to the psychological, interpersonal, and cultural contexts of a patient's life will often disappoint the patient and the doctor. Comprehending the potentials of sex to enhance lives ironically helps clinicians to understand these three contexts.

Sex is important because it has the capacity:

1. To please
2. To stabilize
3. To physically satisfy
4. To emotionally satisfy
5. To improve self-understanding
6. To improve understanding of the partner
7. To heighten the experience of being loved and loving
8. To enhance life through reproduction

Patients with sexual difficulties can be assumed to be currently lacking in the attainment of these potentials. Some have never, even briefly, attained them. Many have attained and lost them.

2.13 Sources of Distress

Modern criteria for sexual diagnoses require that the patient or the couple experience distress about their difficulty. While rating scales can be used to quantify distress [8] and are vital to clinical sexual research, numbers explain the intensity but not the sources of the distress. The right side of Table 2.2 clarifies the subjective contributions to the distress. These are obviously just the inverse of the positive potentials of sex. Understanding the reasons for the distress in these terms, whether or not they are explicitly stated, helps in the establishment of a trusting relationship with the patient.

2.14 Two Subtleties About the Sexual History

2.14.1 The Clinician's Audition

Our contact with the patient begins with our taking a sexual history [9]. There have been many seminal writings published on this important topic since 1970 [10–12]. The clinician should realize, however, that the initial evaluation is a mutual process. The doctor is evaluating the sexual complaint by searching for the correct diagnosis and beginning to ascertain the pathogenesis and factors that may shape the approach to therapy. The individual patient, or the couple, all the while is assessing the clinician's warmth, interest, understanding of their distress, and competence. Some initial evaluations are not followed by treatment. Some treatments are not continued for a reasonable duration. Doctors may be baffled when patients do not return or do not follow their recommendations. One of the possibilities that may be considered is that the clinicians may have flunked the patient's evaluation of them. The goal of the sexual history taking from the patient's perspective is the establishment of a hope-generating trusting alliance with the doctor. There will be no therapy, despite an accurate diagnosis and a state-of-the-art treatment plan, if the clinician fails the audition inconspicuously conducted by the patient.

Table 2.2 Positive and negative potential of sex

Positive potentials	Negative potentials
To please	To displease
To stabilize	To destabilize
To physically satisfy	To physically frustrate
To emotionally satisfy	To emotionally frustrate
To improve self-understanding	To prevent self-understanding
To improve understanding of the partner	To obscure understanding of the partner
To feel loved and loving	To feel empty—unloved and uncaring
To enhance life through reproduction and parenthood	To prevent the pleasures of reproduction and parenthood

2.14.2 There Is No Such Thing as a Complete Sexual History

The specifics of the sexual history vary, of course, with the presenting problem, the specialty of the clinician, the presumptions about the likely sources of the problem, and the patient's capacity to talk about the matter. Despite the inherent pressure clinicians feel to gather a lot of information at the first encounter, there is no such thing as a complete sexual history. For example, a gynecologist and a psychologist may each be thorough in their assessments, but the details that will emerge will be quite different. The sexual history and the doctor's ability to formulate the pathogenesis of the problem are evolving processes. This is more apparent among mental health professionals, but is nonetheless true as well among urologists, gynecologists, and pelvic floor specialists. As a general guideline to attaining a comprehensive sexual history, clinicians can recall the concept of the sexual equilibrium. Eventually, the history should reveal the individual's sexual identity components and sexual functional capacities. It should clarify the partner's capacities and how they interact. It is asking too much of any clinician to obtain a picture of all of this by the end of the first meeting.