CHAPTER 28
Sexual Problems

Ever wondered if you were allergic to sex? Does it seem to you that every time you do it, you end up with raw, sore bits, and you begin to wonder if it's all worth it? Most of the time it's just wear and tear from a bit of over-enthusiasm. Sometimes, it's infection - not only the traditional sexually transmitted dieases but also normal old skin infections and, quiet often, *Candida*.

But, quite frequently, it is allergy. Both men and women can react to condoms, spermicides, diaphragms, bubble baths, lubricants, feminine hygiene sprays, vibrators and anything else that can come into contact with the vital parts. One interesting case was reported of a guy who developed a severe allergic reaction on his dick from stuff in wrinkle cream his wife had on her face when she gave him a head job.

And intercourse, with its close contact and deep breathing, creates ideal conditions for hayfever or asthma attacks to be triggered by a perfume, after-shave, body lotion or massage oil one happens to be allergic to. Believe me, realising your partner's breathlessness is not due to her ardour or a tribute to your effect on her but to an asthma attack precipitated by the body lotion you've whacked all over yourself is quite a traumatic experience.

If you think that's traumatic, imagine this: The romancing has reached a recent successful conclusion. He's shot his bolt and feeling okay with the world. She's feeling pretty good herself. And then the itching starts in all her most precious parts - her skin and even in her nose and throat. Inside and out, her sexual apparatus itches and swells. She breaks out in hives, particularly over her labia. Her eyes sting and water. Her throat swells. She breathes with increasing difficulty and starts to wheeze.

Believe it or not, this does happen to a few unfortunate women wherever a guy ejaculates inside them - whether in the vagina, mouth or rectum. Some even require hospitalisation and, very rarely, it can be fatal. They are allergic to a substance present in the semen of all males.

More commonly, drugs (penicillin, sulphas, thioridazone, probably many others) and even food ingredients can find their way into a guy's semen and cause allergic reactions in his partner - sometimes even on skin contact.

In mild allergies, antihistamines may minimise reactions. (They also frequently cause vaginal dryness, so a lubricant may be necessary.) True semen allergy may disappear after several years of sexual activity. Attempts at creating a similar tolerance by desensitisation (where a doctor gives the patient injections of the offending substance in gradually increasing doses) have been generally disappointing but there have been some success stories.

The simplest and safest solution is to use a condom - although allergy to the rubber in condoms (and diaphragms) can also occur. Since the protein creating the allergy is not related to the sperm themselves, it is possible for couples wanting children to achieve this by artificial insemination of the woman with her partner's sperm after it has been separated from the semen and resuspended in a suitable fluid.

Allergic reactions to nonoxynol-9, the key ingredient in spermicide sponges, jellies, foams and suppositories, occur in about five percent of people who use them, but are usually very mild and self-limiting. Men experience a mild rash with itching, while women get a burning sensation and vaginal itching.

It is also possible for unexpressed anxiety, fear of intimacy or any number of other powerful emotions invoked by a sexual encounter to precipitate symptoms mimicing an allergic attack.

One the other hand, sex can alleviate allergies. Sex stimulates the flow of adrenalin, which relaxes the bronchial tissue, relieving asthma symptoms, and increases the flow of blood from the head, decongesting the nasal passages and relieving sinus problems

The most common problem in sex, however, is impotence - the inability of the male to

have an erection and/or to ejaculate. Such problems have probably always been with us. Eqyptian papyri from 431 BC gave recipes to cure impotence. At least ten percent of men suffer from chronic impotence, while all men at some time in their lives experience temporary erection problems due to anxiety, depression, stress, fatigue, fear, excessive alcohol abuse, a seasonal effect of cold weather decreasing testosterone production or lack of sunlight affecting mood, and many other factors.

Unfortunately, what should have been a temporary phenomenon sometimes, because of performance anxiety, is allowed to develop into a chronic problem. To prevent this happening, remind yourself that it happens sometimes to every man; focus on what you can do to please your partner; let her know it isn't her fault; and get started on healthy lifestyle changes. She can help by not blaming herself; by being understanding but not fussing; by not using the occasion to analyse him or the relationship; and by continuing to make love without keeping trying to get him erect. Using the sensate focus routines of the previous chapter can also help a lot.

Causes of chronic impotence are about equally divided between physical and non-physical causes. Physical causes include arteriosclerosis (most common cause; about one in eight of all men over 50 have erection problems due to clogged arteries and about a quarter of these will go on to have heart attacks or strokes in the next two or three years), diabetes mellitus (second most common cause), hypertension, venous leak, Parkinson's disease, liver or kidney failure, multiple sclerosis, Peyronie's disease, priapism, congenital problems of sexual organ development, congential hormonal problems, hyperprolactinaemia, sickle cell anaemia, hyperthyroidism and hypothyroidism, amyotrophic lateral sclerosis, prostate disease, Leriche's syndrome, sexually transmitted diseases, fracture or surgery in the pelvic area, neuropathy, spinal cord injuries, aortic aneurysm surgery, heavy metal poisoning, cancer and radiation treatments, direct injury to the penis, alcohol abuse, smoking, drug abuse.

Many prescription and non-prescription drugs can cause impotence. These include:

? hyperacidity, reflux and ulcer drugs - cimetidine (Cimehexal, Cimetimax, Magicul, SBPA Cimetidine, Sigmetadine, Tagamet);

? antispasmodics - dicyclomine hydrochloride (Bentyl, Merbentyl), hyoscine butylbromide (Buscopan), hyoscine hydrobromide (Atrobel, Contact Cold Capsules, Donnagel, Donnalix, Donnatab, Hyoscine Hydrobromide Injection, Kwells, Travacalm), methscopolamine (Pamine), propantheline bromide (Pro-Banthine), tridihexethyl (Pathibamate);

? antihypertensive agents - clonidine (Combipres, Catapres), hydralazine (Alazine, Alphapress, Apresoline), methyldopa (Aldoclor, Aldomet, Aldopren, Aldoril, Hydopa), pargyline (Euronyl, Eutron), prazosin (Minipress, Mipraz, Prasig, Pressin), reserpine (Diupres, Exna-R, Rau-Sed, Regroton, Salutensin, Sandril, Ser-Ap-Es, Serpalan, Serpasil), verapamil (Anpec, Calan, Cordilox, Isoptin, Veracaps, Verahexal);

? beta-blockers - acebutolol hydrochloride (Sectral), metoprolol tartrate (Betaloc, Lopresor, Metohexal, Minax), pindolol (Barbloc, Visken), propranolol (Deralin, Inderal), timolol maleate (Blocadren, Optimol, Tenopt, Timoptol, Timpilo);

? diuretics - bumetanide (Bumex, Burinex), ethacrynic acid (Edecril, Edecrin), frusemide (Frushexal, Frusemide Injection, Lasix, Uremide, Urex), spironolactone (Aldactone, Spiractin);

? antiarrhythmic agents - disopyramide phosphate (Norpace, Rhythmodan) ;

? peripheral vasodilators - guanethidine (Esimil, Ismelin), phenoxybenzamine hydrochloride (Dibenyline);

? antianxiety agents - chlordiazepoxide (Librium, SK-Lygen), diazepam (Antenex, Diazemuls, Diazepam Injection, Ducene, Valium);

? antipsychotic agents - chlorpromazine hydrochloride (Chlorpromazine Injection, Largactil, Thorazine), fluphenazine decanoate (Fluphenazine Decanoate Injection,

Modecate, Prolixin), fluphenazine hydrochloride (Anatensol), haloperidol (Haldo, Haloperidol Decanoate Injection, Serenace), lithium (Eskalith, Lithane, Lithicarb, Lithobid, Lithonate), thioridazine (Aldazine, Mellaril), mesoridazine (Serentil), perphenazine (Trilafon), trifluoperazine hydrochloride (Stelazine);

? antidepressants - amitriptyline (Elavil, Endep, Tryptanol, Trypline), desipramine (Norpramin, Pertofran), imipramine (Imavate, Janimine, Melipramine, Tofranil), isocarboxazid (Marplan), nortriptyline (Allegron, Aventyl, Pamelor), phenelzine (Nardil), protriptyline (Vivactil), tranylcypromine sulphate (Parnate);

? movement disorders - benztropine mesylate (Cogentin);

? anticonvulsants - carbamazepine (Tegretol, Teril);

? antiemetics - metoclopramide hydrochloride (Maxolon, Metoclopramide Injection, Pramin, Reglan), prochlorperazine (Campazine, Stemetil);

? narcotic analgesics - morphine hydrochloride (Morphalgin, Ordine), morphine sulphate (Anamorph, Kapanol, Morphine Sulphate Injection, MS Contin), morphine tartrate (Morphine Tartrate Injection);

? antifungal agents - ketoconazole (Nizoral);

? hormonal antineoplastic agents - chlorotrianisene (Tace), fosfestrol sodium (Honvan, Stilboestrol);

? antihistamines - diphenhydramine (Benadryl, Delixir, Ergodryl, Paedamin Elixir, Panadol Night, Unisom Sleepgels), hydroxyzine embonate (Atarax);

? glaucoma preparations - acetazolamide (Diamox);

? anticholinergic agents - atropine (Atrobel, Atropine Sulphate Injection, Altropt, Contac Cold Capsules, Donnagel, Donnalix, Donnatab, Lofenoxal, Lomotil, Neo-Diophen);

? agents used in drug dependence - disulfiram (Antabuse), methadone (Methadone Syrup, Physeptone);

? appetite suppressants - amphetamine (Biphetamine), chlorphentermine hydrochloride (Pre-Sate), fenfluramine hydrochloride (Pondimin), phenmetrazine (Endurets, Preludin);

? 'recreational' drugs - barbiturates, cocaine, heroin, marijuana.

Given the wide range of drugs that cause impotence, this is probably the first place one should look for a cause. However, one should never stop any prescribed drug without consulting the doctor who prescibed it. The sudden withdrawal of some drugs can produce life-threatening effects - either because of withdrawal effects from the drug itself or because the condition for which it was prescribed may rapidly worsen without it. In some cases, your doctor may be able to prescribe an alternative which will not produce the same undesired effect. In others, you may just have to weigh the drawbacks of the drug versus those of the condition it is being used to treat and decide which is the more important to avoid.

The next step is to determine whether the cause is physical or psychological. If you have no trouble having sex with one partner but you do with another, or if you regularly get roaring erections in your sleep, or if you can masturbate yourself to ejaculation, the problem is all in your head. Read the preceding chapter and put as much of it as you can into practice. If that doesn't work, you need relationship counselling and/or sex therapy. Masters and Johnson, in their series of cases, reported a success rate of about sixty percent.

If, however, your problem is physical and is not corrected by simple lifestyle measures of diet, exercise and avoiding fatigue and stress, you need to consult a doctor to determine the cause. Correcting or controlling the cause may be possible. These days, it is even possible to do a sort of 'penis bypass' to restore blood flow to the erectile tissues.

If none of this helps, there is Viagra. Don't just buy this off the Net at exorbitant prices. See your doctor, have yourself properly checked and have him prescribe it and monitor its effect. And, as pointed out in the previous chapter, don't expect it to increase desire. It is no aphrodisiac; it will only work if you already have the urge. The injection methods are also still around and

have the advantage of being cheaper but have the disadvantages pointed out in the previous chapter. So are vaccum constrictive devices, in which blood is pumped into the penis and trapped therein by a rubber band at the base of the penis constricting the shaft. It is also possible to get a surgical penile implant that enables a man to get an erection whenever he wants simply by pushing a button to activate a pump placed in the abdomen. These are pretty successful: failure rates are down to less than five percent in the first five years, infection rates are about 2-3 percent, and about ninety percent of men with them (and their partners) are happy with the results.

At the other end of the scale is priapism, where a robust and throbbing erection refuses to go down. Sounds like a dream but, in fact, it's a medical emergency that, if not treated within four hours, results in permanent impotence in about half of cases. It results when the veins draining the erectile chambers of the penis fail to open and release the blood therein back into the circulation. Perhaps the most common reason now is self-injection therapy for impotence. Other drugs, such as testosterone, trazodone (Desyrel; an antidepressant), hydralazine (Alphapress, Apresoline, Unipres; an anithypertensive agent), yohimbine and Spanish fly, can cause it. So too can physical injury to the penis or scrotum or rupture of pelvic blood vessels or the urethra; blood disorders, such as sickle cell anaemia or certain types of leukemia; anaesthesia during surgery; damage to the brain or spinal cord caused by such diseases as multiple sclerosis, encephalitis, meningitis or epilepsy. The treatment is bed rest with ice packs applied to the erection and a shot of an erection-deflating drug (steroids, sedatives, female hormones, epinephrine and dopamine have all been used, but the most effective appears to be the asthma drug, terbutaline).

Another common sexual problem is premature ejaculation - which, if defined as ejaculating sooner than you or our partner would like, occurs in about thirty percent of men. Usually, this is a learned behaviour, which simply has to become unlearned. It can be most easily cured by masturbation - by self or partner - in which the aim is to continue stimulation as long as possible before ejaculation. The sensate focus routine developed by Masters and Johnson is also very successful (98 percent response in their series of cases). Better still, try the combination routine suggested in the previous chapter. Whatever you do, don't try dealing with it by focusing your mind on something mundane. This often masks the real reasons why you are ejaculating too soon. It may work for a few occasions but it prevents full enjoyment of lovemaking and could lead to loss of erection as you find it more and more difficult to concentrate on sexual pleasure. If none of the above works, sex therapy offers a range of techniques to deal with the problem.

On the other hand, a man may have difficulty reaching orgasm even during prolonged periods of intercourse. (Fourteen percent of Australian men admit to having faked an orgasm under these circumstances.) This can be simply because of attempting it too soon after a previous ejaculation, or an effect of aging, tiredness, depression, over-indulgence in alcohol, prescribed (especially Prozac and other antidepressants) or non-prescribed drugs, diabetes or other medical condition. If it happens occasionally, there is no problem. If it is chronic, he should get a complete physical and have his doctor check the medications he is taking. He should share the results with his partner. If there is no simple physical reason the correction of which solves the problem, he should see a therapist.

Worse things can happen to a bloke's penis. Believe it or not, it's possible (but difficult) to fracture the erect penis by ramming it into an unyielding surface like a woman's pubic bone. You'll know when it happens. There's an unforgettable snapping sound, incredible pain and swelling up to three or four times normal size. If medical attention is sought immediately, the damage can usually be surgically repaired.

Lack of orgasm is the most common female sexual dysfunction. Some of the drugs that cause impotence in men also create similar problems in women, and women experiencing problems in reaching orgasm that they didn't previously have should check their medications. However, the most common reason is simply lack of adequate arousal before intercourse. Much of this relates to poor male technique but the female can also do much to help herself. She needs to avoid shutting off her erotic potential by locking herself into negative prophecies. She needs to

take stock of her situation, be aware what pleses her and what does not. She should take an active role in changing anything about her, and her partner's, lovemaking that doesn't suit her. She should touch more and think less - except to use fantasies to act as a jump-starter or booster (and also to energise herself sexually outside actual sex - perhaps combined with some form of erotica that appeals to her. She can even act out her fantasies, role-playing an orgasm). She needs to think of sex less as a chore or a mission and just have fun. She needs to experiment with different types of sensual stimulation. Building her awareness of her own body by sensually exploring it, including her genitals, as she looks at herself in a mirror is a good first step. She should experiment with different forms of touching. When she does achieve an orgasm, she should define what triggers the orgasm. If necessary, she can use a vibrator to induce orgasm.

Painful intercourse, or dyspareunia, is the second most common female sexual dysfunction. It can be caused by stress, physical or psychological abuse, guilt about sex, fear of sex or intimacy, anger or deep unresolved conflict with a partner causing involuntary spastic contractions of the vaginal entrance.

At its extreme this can produce vaginismus, the third most common female sexual dysfunction, where the contractions are so strong that penetration cannot occur. Some women with this condition cannot even insert tampons or their own fingers into their vaginas. In such cases, they definitely need to see a therapist. Success rates in treating this condition (usually by teaching her Kegel exercises and then using a gradually enlarging series of vaginal dilators) are almost 100 percent.

In some cases, women can cure themselves by lying down relaxed, inserting one lubricated finger into their vaginas, exploring their vaginas and voluntarily tightening their vaginal muscles around the finger. After a couple of weeks of doing this for five minutes twice a day, they move to doing the same with two fingers. When they are comfortable with this, they can have their partner start with one finger. He merely inserts it; she moves or guides his movements. When ready, she moves on to two of her partner's fingers. At this stage, moving slowly into the ritual suggested in the previous chapter can produce benefits. However, vaginismus is almost inevitable if painful intercourse from whatever cause persists for any length of time and it is important to first find and correct any causal factor that may still be present.

In at least eighty percent of women, however, discomfort or pain during intercourse is due to a physical cause. Pain at the vaginal entrance may be due to infection of any part of the external genitals or vagina, urinary infection, vaginal dryness (due to menopause or otherwise), allergic reactions, episiotomy scars, vulvar vestibulitis, breastfeeding, medications or a clitoris irritated by rough handling. Pain with deep penetration may be due to constipation, battering of the cervix due to insufficient arousal or too long a penis, pelvic inflammatory disease, endometriosis, vaginal cysts, back pain. Since some of these causes can be serious and because persistent painful intercourse can lead to vaginismus, anything more than a once off episode of known cause should be investigatged.

Perhaps even more commonly, painful intercourse is due to poor technique on her partner's part - inadequate foreplay or an excess of vigour. Many cases of supposed frigidity are due to a similar cause. As Alex Comfort says, in *The Joy of Sex*, 'real frigidity is when a woman who loves her man and isn't consciously scared of any part of sex still fails to enjoy it when they've both taken the trouble to see that she should.' In which case, it's time to see a sex therapist.

Sex therapy can help, not just with this kind of problem but with many others related to sex. Any couple that has frequent aarguments about sex, where either or both avoids sex, where there are strong feelings of sexual frustration and disappointment, where there is an inability to talk about sexual problems or desires to each other, or where either or both is having extramarital affairs should consider seeing a sex therapist. If your partner is not keen on the idea, explain to him or her why you think it is a good idea but don't accuse him or her of anything. If he or she still won't be in it, ask for his or her ideas on solving the problems. If he or she doesn't have any, point out that a sex therapist will. If he or she does offer suggestions, point out that a sex therapist

will help in putting these into practice. Without being a complete nag, raise the topic more than once. If all else fails, go alone.

Men can also experience pain during or after intercourse - most often because of prolonged or vigorous thrusting, particularly if the woman's vagina is dry; sometimes due to preparations of one kind or another she may have applied to the genital area.

Peyronie's disease can also make it painful, difficult or even impossible for a man to enter his lover's vagina. In this condition, patches of fibrous tissue on or around the spongy shafts inside the penis stop it erecting normally and make it veer off to the left or the right or up or down or become erect only partway up its length. It tends to appear fairly suddenly when a man is in his fifties or sixties. About half the time, the pain gradually goes a way and, over a period of several years, the bend straightens out all by itself. If it doesn't, medicine has little to offer. Numerous treatments have been tried over the past 200 years but none of them seem to have a significantly higher rate of success than leaving it to nature. Surgery does have a solution if the curvature is not too bad. A small piece of healthy tissue is removed from the normal side of the penis and the opening sutured shut.This straightens things out but does make the penis a little shorter.

The part of a man's sexual apparatus that is most likely to give him trouble is his prostate. Acute infection of the prostate is marked by fever, painful urination, scrotal pain and low back pain and can usually be sucessfully treated with antibiotics. Chronic prostatitis is a harder proposition. Most cases are still due to bacterial infection but, in the absence of acute inflammation, only a few antibiotics are able to get into the prostate. Treatment may still be successful but must be with the right antibiotics and often for a considerable period of time.

Besides this, a condition called benign prostatic hypertrophy tends to occur in most men as they age. The prostate simply gets bigger and bigger, so that it may block off the flow of urine through the urethra, causing problems with urination. Why it occurs is a matter of debate but it is probably a case of nature making up for lack of quality by increasing quantity. A healthy diet including adequate supplies of zinc (the basis of the old pumpkin seed cure), exercise (including of the pelvic muscles) and plenty of sex to ejaculation helps prevent and cure it. If this doesn't work (in about ten percent of cases), the excess tissue can be removed by slipping a tiny tube up the urethra through the penis. This operation, called transurethral resection of the prostate, is one of the most commonly performed on men over 65. It is relatively simple, relatively painless and effective in relieving symptoms in about eighty percent of cases. However, about five percent become impotent, while about four percent have trouble with urinary incontinence. Almost always retrograde ejaculation, where semen is ejaculated back into the bladder instead of out through the penis, occurs. Medical treatment is also available. The drug, Proscar, improves urinary flow in more than half of cases but does cause impotence in about four percent.

Cancer of the prostate is, of course, more serious. Prostate cancer remains something of an enigma. The great majority of cases are, in fact, so slowly developing that something else kills him long before the cancer affects him to any great extent. However, in a small percentage of cases, it is rapidly invasive and kills the patient fairly rapidly. Because of this and because there is no foolproof way to distinguish the two forms in early stages, there is considerable debate on the merits of testing and treatment The usual method of treatment - useful only if the cancer is confined to the prostate - is to remove the prostate. Although methods have improved, this still leaves the patient impotent 25-50 percent of the time. Radiation therapy can also be used but the incidence of impotence is somewhat higher at 25-85 percent. This is not true of one form, in which pellets of radioactive iodine are implanted into the prostate. Here the rate of impotence is only about 2-3 percent. However, it cannot be used in all cases. Since the growth of the cancer is fuelled by testosterone, surgical or chemical castration is often used. This can dramatically slow down the growth of the cancer but can also cause impotence.

Cancer of the testicle is much rarer but is the most common type of cancer among men aged 20 to 40. If detected early, it is one of the easiest cancers to cure. If not, it can be deadly.

Consequently, it is as important for men to do a regular lump check on their testicles as it is for women to do one on their breasts.

Considering their exposed position, it's amazing how relatively rarely the testicles suffer injury. A blow may be excruciating but is rarely damaging. However, any severe swelling, bleeding or bruising should be checked by a doctor immediately. One of the worst things that can happen is for the testicle to twist around on the spermatic cord, blocking off the vein carrying blood back from the testicle. This can happen as a result of a powerful blow or pressure or, sometimes, for no apparent reason. If this happens, it is essential to see a doctor immediately. Sometimes, he can simply manually untwist; sometimes, it will require surgery. If this is not done within 4-8 hours, the testicle will die a slow and agonising death.

Sudden severe pain in the testicles with swelling and tenderness in the scrotum (usually, on one side only) is, however, usually due to an infection of the epididymis, the soft swelling on the back of each testicle. It can be treated with antibiotics, combined with avoiding sex and alcohol and resting in bed with the testicles elevated.

Many sexual problems are really relationship problems and need to be resolved the same way as any other conflict. Sex should not be linked with nonsexual issues. One clearly defined problem should be tackled at a time. If both partners are willing to creatively brainstorm and to compromise, a final agreement suitable to both partners can usually be reached. Make sure the substance and detail of this agreement is clear to both parties.

Traumatic life events - especially those related to sex (like abortion, miscarriage, rape or other sexual abuse) but also such things as drug or alcohol abuse or the death of a family member - can cause sexual difficulties that require careful handling. The first thing the person suffering the trauma must do is to understand the true effects of the experience on their sexuality. They should expect to feel a lot of anxiety about sex for a while and should talk to their partner about what each of them needs and wants sexually. They should take sex as it comes and not set performance standards for themselves. They will probably need to create new patterns in romance and sex as well as in other aspects of their lives. Women who have been raped or sexually abused should seek professional help; this is often necessary to overcome the feeling that the victim is somehow to blame and can also help in other ways. They need to recognise that their partner may also need help to handle his own emotional turmoil. Above all, they must be patient.

Their partner should accept the degree of contact and closeness the person in pain wants. He or she should listen (while making good eye contact) and accept what is said without giving advice or false reassurance or insisting a solution be found but with every attempt to understand what their partner is feeling. Though their own experience may help them understand, they should not use this as a means of comparing situations or competing for sympathy but as a means of connecting with the sufferrer. Let him or her express his or her emotions freely and not feel it necessary to hold back. Don't tell him or her what he or she should be thinking or feeling. The time for making sensitive suggestions to coping with the situation is when the person in pain indicates their readiness.

Believe it or not, if a recent Gallup Poll is to be believed, poor body self-image is not a frequent sexual problem. Only two percent of people described themselves as 'somewhat below average in attractiveness', while less than one percent described themselves as unattractive. Thirty-four percent described themselvs as 'attractive or above average' and eight percent (13 percent of men and three percent of women) said they were 'beautiful or handsome'. On the other hand, 17 percent of men and 29 percent of women wished to look better.