Sexual counselling: A common problem

A woman aged 35 said, 'I have lost all interest in sex. It used to be enjoyable; now I wouldn't care if I never had it again! My husband is constantly annoyed about this, so I suppose I should do something about it.'

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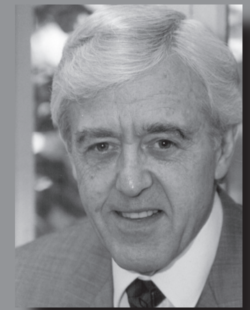

A brief history of the problem revealed that before marriage, they were highly sexually active. She was often the initiator. After marriage, her sexual interest and energy declined and now, four years after their second child was born, she has lost interest in any ongoing sexual activity. She avoids being touched because: 'I know where that is heading and I don't want to go there.' There have been many rows accompanied by threats and punitive moody behaviour.

Several immediate issues require sensitive exploration. Is the loss of sexual interest indicative of a loss of interest in sustaining the marriage and family? Is the loss of interest a symptom of her relationship dysfunction or vice versa? Has she turned her affections and interests to some other person? Her story remains constant: she does not want to disturb the marriage. She loves her children too much, she says – noticeably omitting mention of her husband.

She has a very busy professional life. She is necessarily involved in the activities of their children. Her parents are in need of her support and she is constantly worried about their increasing dependence. By the time each day is over, she feels utterly fatigued and nearly explodes with anger when her husband thinks she should be responsive to his sexual demands. In earlier times, sex was something both looked forwarded to; now it has become a boring chore and like all b oring chores, it is high on the list of things to avoid.

'Partners...tend to act on unspoken assumptions with little in-depth dialogue and with little sympathy for the way the mind, mood and body of each person may operate'

Her sexual disinterest is thus obfuscated by work commitments, family tasks, fatigue, lack of excitement, marital anger and disaffection. Some may feel that by rearranging the items on this level, the problem may be less obtrusive. Others may encourage her to make herself 'available' from time to time and thus appease her husband's wrath-in-waiting. 'Anything for a quite life', but she would reject this as offensive to her individuality.

Some may wonder why a person remains in the marriage when sexual desire is absent and when she feels he is no longer attractive to her. Security needs, family cohesion and social identity concerns may come to play a greater role than a sexual involvement. The 35-year-old woman may be having a premature awareness of what her much older female acquaintances have taken for granted. In time, both she and her husband may acquiesce in what accept as a sexless marriage.

II

It may be appropriate to explore this problem at other levels. We recognise that sexual activity consists of six phases: sexual desire, arousal, excitement, orgasm, satisfaction and the aftermath. Specific problems attend each of these phases.

While the person may speak in general terms of the loss of sexual interest, or of having a sexual problem, the counselling task is to determine where the problem is. A person may be strongly aroused without any desire; or the desire may be present but arousal is absent. A woman may say she becomes aroused but she has lost all interest in her husband: 'I see he is not my kind of person. I feel myself getting tense every time he approaches. I don't know if I am angry with him, with myself, or with my entrapped situation.'

A person may achieve orgasm without difficulty but in her mind she may think, 'I don't like the person I am with.' Another person may pass through the first five phases and feel satisfaction as a result of the sexual engagement but in the aftermath, she may feel very angry or guilty and may destroy a relationship she said she valued.

III

In some instances, the counselling and therapy will need to proceed to a further level: to explore the various aspects of her current avoidant, disinterested and sometimes destructive behaviour.

In the flurry of pre-marital and early marital sexual activity, the heightened sexual pleasure; the discovery of sexual union; and the transcendence of loneliness and parental sanctions may operate apart from, or be dissociated from, the person's individuality, their feminine protections and their intimacy anxieties. Later, these personality aspects may become an unconscious part of the sexual encounter.

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- **Penile injection**

  Prostaglandin E1 (PGE1) also known as alprostadil is the medication with the least risk of fibrosis or priapism. PGE1 is prescribed for men where oral medication does not work or is contra-indicated. It is marketed in Australia as Caverject Impulse™, a neat package where the powder is mixed with water and the dose dialed all within the barrel syringe. Combination mixes available through compounding pharmacies use PGE1 and phentolamine (Bimix) or PGE1, phentolamine and papaverine (Trimix). These mixes may have a higher risk of fibrosis and priapism. The treatment of priapism initially involves taking two 60mg pseudoephedrine tablets if the erection remains after two hours.

- **Vacuum erection devices**

  These devices create an erection by extraction of air from a cylinder placed over the penis. The vacuum created causes increased blood flow into the penis that is held by a rubber constriction ring. The technique requires practice and preferably the assistance of a partner.

- **Penile implants**

  Surgically implantable penile protheses have been in use for 30 years. These days, implants are inserted as the last resort due to the effectiveness of the other ED treatments. A three piece inflatable device (penile rods, scrotal pump and fluid reservoir) gives the best cosmetic and functional result. There are low rates of mechanical failure and infection.

'Treatment should be focused on lifestyle changes and management of current medical conditions'

A note about ED post Radical Prostatectomy

Surgery for prostate cancer is a now a common procedure. If the neuro-vascular bundle on each side of the prostate cannot be saved, then ED will inevitably follow. Treatment with oral PDE5 inhibitors does not work without intact nerves due to the lack of neurotransmitters. Even with intact neurovascular bundles, the return of erectile function may take from six to 36 months to occur (if ever). The quality of erections also depends on the pre-surgery erectile function. Initial treatment is PGE1 injection therapy, however, some men respond early to oral medication. It is important to keep testing with oral medication from time to time because as soon as oral medication becomes effective, injections may stopped. There is some evidence of benefit being on continuous oral medication in the presence of neuropraxia due to the positive effect of PDE5 inhibitors on the endothelium within the cavernosal tissues.

Orgasm/ejaculation

Male ejaculation disorders are premature or rapid ejaculation, inhibited or delayed ejaculation and retrograde ejaculation.

Premature ejaculation (PE) is the commonest disorder, though can be misdiagnosed due to a common male misconception of how long the intra-vaginal ejaculation latency time (IELT) should be. There is some consensus that ejaculation less than 60 seconds after penetration represents true PE. Ejaculation just before or on penetration can be an extremely distressing condition.

PE can be primary or secondary. Primary PE arises in the ejaculation centre in the medial pre-optic nucleus of the hypothalamus and is no longer regarded as a purely psychological problem. However, it can be complicated by a secondary performance anxiety that often complicates the situation. Secondary PE may be caused by stress and anxiety, relationship problems or ED.

Men with PE are often reassured with explanation of normal IELT. The traditional behavioural techniques such as the stop-start and squeeze techniques remain popular treatments. The ejaculation inhibiting effect of some of the SSRI anti-depressant medication can be a successful treatment in severe cases.

Inhibited ejaculation is usually an issue with sexual intercourse rather than with masturbation. It can arise where arousal from penetrative intercourse does not match the arousal obtained from masturbation. This condition may be seen in certain personality types. If a man is unhappy in a relationship, and particularly if his partner wishes to conceive, then he may be unable to ejaculate in that situation.

Retrograde ejaculation often occurs after surgery for a tight bladder neck or benign prostate hypertrophy. Neurological conditions and diabetes may decrease bladder neck tightness where the sensation of orgasm is intact but the semen is directed into the bladder.

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Childhood experiences, developmental attitudes and philosophy, religious training and the concealed fantasies of parental behaviour and marital intimacy may be important ingredients in any one or all of the phases of sexual activity.

IV

Generally, we can assume that if marital partners ever spoke at depth about these issues in the early stages of their relationship, they rarely speak of them later. They tend to act on unspoken assumptions with little in-depth dialogue and with little sympathy for the way the mind, mood and body of each person may operate at different stages of a relationship, in different situations and in the different phases of sexual involvement.

Counsellors and sexual therapists give partners a vital and safe environment free from commentary and direction to explore these important issues, with the added knowledge and perspective that the counsellor/therapist can provide. They are able to designate where the problem is; what meaning and emotion has been loaded on it; what the underlying fantasies and anxieties are; and how the person can appraise her individuality and intimacy needs in the context of her marital relationship.

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