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ERECTION DISORDERS

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Abstract

The first physiological response to effective sexual stimulation, produced by a source of physical or mental stimulation, is the erection of the penis. Erection usually occurs within 3-8 seconds of the onset of arousal. When sexual tension and erection reach a certain level in the presence of the partner, the need for interference appears. The intensity of the erection may increase or decrease until it disappears, whether the arousal is prolonged or not. The complicated anatomical apparatus is regulated by a nervous mechanism, just as complex, being dependent to a remarkable extent on psychic influences. By the strong interweaving of these two components - psychological and functional - the sexual function is subject to changes. Erectile dysfunction, when it occurs, is obvious because, although there may be libido, the lack of an erection makes it impossible to perform sexual intercourse. Erectile dysfunction should not be confused with isolated or occasional failures to obtain or maintain a penile erection. They do not constitute a condition or disease that justifies medical attention and should be perceived as absolutely normal. The vast majority of men face such an episode at some point in their lives. One can speak of erectile dysfunction in the case of a recurrent or persistent inability to obtain an erection or to maintain it long enough to complete sexual intercourse, which lasts at least three months. It is especially important because in a normal activity, without erection, intercourse, ejaculation and orgasm cannot take place. (Pathologically, premature ejaculation can occur, without an erection, in the form of pollution!)

Key words: erectile dysfunction, s-on, therapy, testing, evaluation, sexual disorders.

INTRODUCTION

Disorders of sexual dynamics in men are of great importance, they are strongly doubled by a certain "subjective experience" of the patient, with a special character. Always, in the situation of a disorder of sexual dynamics, there is anxiety related to the possible "loss" of the man's manly abilities. This anxiety will be associated with feelings of inferiority, creating the impression of excluding the man from sexual life.

The man attaches to his sexual potency a special importance, necessary for self-affirmation. If they had to choose between giving up sight or sexual potency, they would certainly choose to lose their sight, although everyone knows the implications of this disability.

The problems of sexuality are still an extremely delicate subject, a subject that is still talked about in the ear. Sexual dysfunctions are considered a shameful problem, making a man less manly and recognizing them is almost like

giving up self-esteem. However, denial does not make them less painful or less devastating for the lives of those affected, and the lack of referral to a psychologist or doctor is all the more inappropriate as most of the causes that can cause them can be treated.

According to DSM V, a number of associated disorders can occur. Erectile difficulties in a man's erectile dysfunction are often associated with sexual anxiety, fear of failure, concerns about sexual functioning, and a decrease in subjective feelings of arousal and sexual pleasure. Erectile dysfunction can sever existing marital or sexual relationships and can be the cause of unconsumed marriages and infertility. This sexual disorder may be associated with decreased sexual desire and premature ejaculation.

There are various patterns of erectile dysfunction. Some individuals report an inability to have an erection from the beginning of the sexual experience. Others complain that they have an adequate erection before intercourse, but lose penile turgor when trying to penetrate. Others report that they have a firm enough erection to penetrate, but that they lose penile turgor before or during the intrusion. Some men report being able to get an erection only during masturbation or waking up from sleep. Masturbation erections may also be lost, but this is not common.

Many men who have these erectile difficulties are themselves their greatest enemies assuming the role of their own spectator of their sexual performance and wonder, with great anxiety, if they will be able to have an erection this time. After making various speculations about the situation, they undergo a double effort and the anxiety will increase, which will interfere with the erection process. The pressure they exert on them will defeat the proposed goal. Thus, the man will often avoid sexual encounters to prevent the embarrassment associated with his sexual failure. His partner will also often avoid having sex, so as not to put him in an unpleasant situation, or so as not to feel responsible for his erectile problems.

The symptoms of erectile dysfunction include the following elements:

- the impossibility of obtaining a complete erection;
- inability to maintain an erection throughout sexual intercourse;
- complete inability to obtain an erection.

Regarding the evolution of various forms of male erectile dysfunction, according to DSM V, they follow different evolutions, and the age at onset varies considerably. There are some individuals who have never been able to have an erection of sufficient quality to have sexual contact with a partner, and they usually have a chronic disorder, existing from, and forever. The cases obtained can be remitted in time, in proportion of 15%-30%. Situational cases can be dependent on a type of partner or the intensity or quality of the relationship and are episodic and often recurrent.

Statistics

Statistics show that men between the ages of 16 and 45 have between 100 and 130 sexual intercourses a year. I mean, every two days. Experts estimate that sales of impotence drugs will increase over the next 8 years.

Erectile dysfunction is age-related. Every third man over the age of 40 has erectile dysfunction. It seems that this is the nightmare of many men: to be with the woman of their life in bed and not be able to do anything. And yet, it happens to one in 10 men. Experts say that in 75% of cases, the inability to get an erection has psychological causes. And if it becomes a fixation, impotence can destroy lives. Paradoxically, more and more men have serious problems with potency and even worse is the fact that they are afraid to recognize or ask for help, although it would be much easier for them if they could talk about it. In Australia, for example, there is a hotline, "Impotent Anonymous," which records more than 60,000 calls a year. Therefore, partners do not remain indifferent when they realize that their "manhood" is affected. Often, they resort to all sorts of methods, they will only solve the problem without having to tell anyone or arouse the suspicion of the partner. Asians try to treat themselves with substances extracted from rhino horn, and Africans consume

essence from the bark of the Yohim tree because they noticed, testing it on the mice, that they ejaculate quickly.

As ingenious as these remedies are, so diverse are the opinions of specialists about them. They do not believe in such miracles, but they know for sure that almost half of men over the age of 40 have erection problems, numbering about 400 million. However, it is alarming that 90% of those who suffer from a milder or worse form severe impotence refuses to go to the doctor. It is estimated that approximately 900,000 new cases occur worldwide each year.

The Physiology of Erection

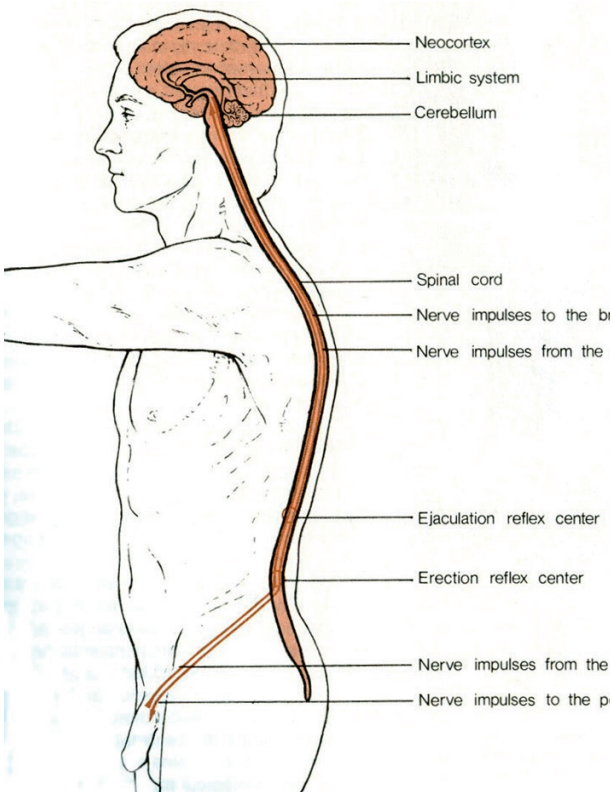
Normally, an erection is a physiological condition that consists of a series of changes in the penis:

- it increases;
- its color tends to pinkish-reddish;
- its temperature rises and the glands is exposed;
- the penis becomes stiffer and moves to an upright position.

The penis consists of two cylinders of sponge-like structure, called cavernous bodies, arranged along its length and parallel to each other and to the urethra. When the man receives the sexual stimulus, the nerve impulses stimulate the blood flow to the corpora cavernosa, causing them to fill with blood, the blood flow increasing up to 7 times normally. This influx of blood leads to the expansion of the structure of the corpora cavernosa and their filling with blood like a sponge. As the blood enters the penis, there is a decrease in the amount that comes out. The arteries that carry the blood dilate, even this leading to an increase in overall volume. The veins that ensure the evacuation of blood from the penis are provided with special valves through which the amount of blood that comes out is gradually reduced. In this way the blood becomes practically "closed" temporarily inside the organ, all these physiological mechanisms finally materializing in obtaining an erection. By maintaining the sexual stimulus, a high blood flow is maintained and an erection is maintained. After ejaculation when the arousal disappears, the excess blood drains through the venous system and leaves the corpora cavernosa, the penis regaining its flaccid shape.

The sympathetic system, through adrenaline, controls the manifestations of defense against any threat, reactions such as fear, and also controls ejaculation and orgasm.

The parasympathetic system is responsible for "recovery": relaxation, blood pressure, heart rate, sleep, and also coordinates erection and orgasm.



Specific steps in obtaining and sustaining an erection:

1. The first stage is represented by the perception of the sexual stimulus: images, touches, words / whispers, smell, imagination, etc.

2. The second stage is represented by the interpretation by the central nervous system of stimulatory signals and the sending of nerve impulses through specific nerve fibers to the sexual organs.

3. The third stage is the vascular response to the sexual nerve stimulus and is represented by the relaxation of vascular structures, with the development of a blood flow that will fill the corpora cavernosa, thus producing an

erection that results in increased volume of the penis and its stiffening.

Erections are not the same and they vary from individual to individual and depending on his psycho-sensory dispositions. In principle, the erection takes place in a purely psychogenic way or under the influence of local stimuli, caresses in accordance with the goal pursued, and involuntary contact with a woman's body. The end of the erection can be sudden or slow, both cases being more or less abnormal and related to psycho-physical influences. The most normal is an average between these two, and the loss of erection at the end of sexual intercourse must be attributed to the changes that take place in the sexual centers at the time of orgasm.

Different types of erections

1) ***Reflex erections due to local stimuli***. In a normal individual, an external local arousal exerted on the male organ or on the glands causes an erection; it occurs at a defined rate and is independent of the cortical centers.

The center of the erection is located in the lower part of the spinal cord. There is a nerve center that controls the nerve impulses sent to the penis. These nerve impulses move to the artery muscles and cause the arterial muscle walls to dilate, resulting in vasocongestion. Erection can occur as a simple reflex action. Thus, the sense organs that detect touch transmit the message of touch to the nerve centers in the spinal cord. The nerve centers receive the message and send a signal to the tissues that produce a physiological response, in this case to the muscles in the arteries in the penis. This process can take place without the intervention of the brain, and the result is that the man will not feel any sensation of pleasure, even if an erection occurs.

2) ***Psychogenetic erections.*** Sensual impressions or mental images represent the starting point of such an erection. Sexual stimulants capable of producing an erection are part of the class of pleasant psychic impressions of medium intensity.

THESE TWO FORMS ARE THE MOST COMMON FORMS OF ERECTION.

3) ***Remote reflex erections.*** These originate from peripheral excitations, which do not come from the skin of the genitals, but from other regions, either neighboring or more distant, or even from regions that from an anatomical point of view, have nothing in common with the genitals. Some sexologists explain the phenomenon by the existence, in men, of erogenous zones, for example: head and nape; armpits; chin; lips; the anus; buttocks; breasts; ears. However, it seems that this would be a psychogenetic erection, as it occurs on the pathways that go from the bark to the periphery.

4) ***Organo-reflex erections.*** These occur under the influence of nerve stimuli from the urethra, bladder, prostate, vas deferens, seminal vesicles. They are found in cases of inflammation of the urethra, which causes painful and persistent reflex erections. They also occur in the case of trauma and degeneration of the spinal cord. Overloading the bladder could also cause an erection.

5) ***Night erections, without dreams.*** In this case, it is stimulants coming from the mucous membrane or from the muscles of the full and swollen bladder.

6) ***Morning erections.*** The heat of the bed maintains the state of peripheral vaso-dilation, increased by the changes that take place in the distribution of blood, due to the increase of psychic stimuli after waking up. The bladder is usually full in the morning, and the pressure of urine on the back wall is quite strong. For this reason, these erections often disappear after urination or from the moment the subject gets up and takes a few steps.

7) ***Erections caused by the fullness of the seminal vesicles.*** Once upon a time it was believed in the existence of this etiology, but today it finds less and less plausible explanations. This condition often occurs after a long period of abstinence, when the blisters are very swollen, to which are added other changes in the condition of the neurosexual centers, internal secretions and their eroticization. The fullness of the blisters should be conceived as an erectogenic stimulant.

8) ***Toxic erections.*** A first group of such toxic substances consists of: yohimbine, picrotoxin, strychnine and cantharidin.

9) ***Autotoxic erections in chronic diseases.*** These erections are found in real leukemia, especially myeloid, in severe uremia and in cases of rabies. In cases of leukemia, there is even priapism, shorter or longer lasting. Erections occur only in severe cases, when the toxic action is felt throughout the striated and smooth muscles.

10) ***Traumatic spinal cord erections***

11) ***Experimental erections caused by the cortex, the midbrain, the diencephalon***

12) ***Sign of erection.*** This phenomenon occurs in acute processes, especially in tuberculous meningitis in children. It is an erection that occurs when we bend the patient's head forward.

13) ***Hanging erection.*** This type of erection is very common, without being constant, and seems to result from a number of physiological agents: arousal of the bulb due to trauma and the rich in carbon dioxide blood, brain ischemia, sympathetic shock.

Types of Erection Disorders

In relation to the etiology of erectile dysfunction, it can be:

- organic
- psychogenic
- mixed

Vascular erectile dysfunction can be arteriogenic (due to deficiency of arterial blood irrigation) or phlebogenic (due to excessive venous drainage deficiency).

Depending on the degree of alteration of the penile erection, there may be:

- ANERECTION
- SEMI-ERECTION
- INTERMITTENT AND CONTINUOUS ERECTION

ANERECTION - *It is the total lack of erection.*

It can be:

- ***total***: when the erection is completely absent from the beginning of sexual intercourse, the vaginal intrusion being impossible and the copulatory act, determining the so-called "sexual impotence through the impossibility of vaginal intrusion". Anerectization can exist from the beginning as such, causing *primary impotence*, after an erectile moment - *secondary impotence* - or even at the time of trying to achieve the intrusion, by losing the erection, necessary for vaginal penetration.

- ***partial (secondary)*** Anerection occurs after a previous erectile condition that allowed vaginal interference, but in the new situation the copulatory act cannot be achieved and therefore not achieve orgasm. The situation mainly targets the elderly who can get a certain erection, sometimes satisfactory, but the lack of tact of the partner compromises the desired copulation.

There may be an erection to achieve a normal intercourse, but an erection obtained through maneuvers of autoeroticism, or spontaneous, during sleep. In general, even if initially there was an incomplete erection that allowed, however, vaginal interference, after the beginning of the copulatory act, by stimulating the state of arousal increases the degree of penile erection, allowing even a satisfactory sexual intercourse.

Clinical types of erectile dysfunction by anerection

- ***Onset erectile dysfunction***: generally occurs as a disorder of the onset of sexual activity. It characterizes the adolescent and a significant number of people who far exceed this age, appearing after a period of autoeroticism, due to the lack of a partner in the heterosexual relationship. It is also present in people who have not had sexual intercourse and are inexperienced. It is characterized by the lack of erection in the presence of the partner, by mental inhibition.

- ***Erectile dysfunction present in the situation of a new partner***: the hypertensive state can paradoxically determine a neuropsychic inhibition with a negative effect on the erection. It is paradoxical because it occurs in an increased libido and which normally should cause an erectile state, but which abnormally inhibits the state of arousal, inducing anerection or premature ejaculation. Of psychogenic etiology, it generally appears

in the inexperienced young man, shy and withdrawn from society, in a new heterosexual relationship, against the background of a normal behavior. The phenomena are transient and in time, through temporary abstinence and the creation of an intimate, exciting climate, removing the incident, a normal sexual behavior is installed.

Psychogenic erectile dysfunction is especially common in young people. It differs from ***organic erectile dysfunction*** in that, in this case, there is a strong nocturnal erection, due to the lack of inhibitory factors such as stress, emotion, anxiety, obsession, present during the day. In the case of organic erectile dysfunction, the nocturnal erection is partial or absent.

Other erectile dysfunctions:

a) The impossibility of performing the sexual act, due to lack of erection, after a period of sexual abuse, over-tensioned states, sexual abstinence, religious imposition, restrained or interrupted intercourse.

b) Impossibility to perform sexual intercourse due to lack of erection, in people with neuropsychiatric diseases, mental lability, excessive shyness, mental trauma, conflict with partner, psychasthenia, self-blame after extramarital affairs in people with a sensitive psyche, fear that he will not be able to perform the act sexual, fatigue.

SEMI-ERECTION *(incomplete erection)*

In relation to the degree of erection and vulvovaginal features (perineal dehiscence, perineal rupture), vaginal interference and copulatory act with ejaculation and orgasm can be achieved. The situation is common after the age of 60, when the intensity of the erection is gradually reduced. At first, the half-erection may alternate with moments of normal erection.

INTERMITTENT AND CONTINUOUS ERECTION

Plastic hardening of the penis (Peyronie's disease)

Described since 1743, the disease is characterized by the presence of insular sclerosis of the corpora cavernosa, with nodules or cartilaginous plaques on the penis. It has an increased frequency between 40-60 years, the causes being still obscure. The disease is associated with diabetes, syphilis, Dupuytren's disease, metabolic diseases, local trauma.

Symptomatology: patients who have a continuous erection of the penis, report penile pain and the presence of nodules or cartilaginous plaques on the dorsal side of the penis. They can develop, causing painful curvature of the penis which sometimes makes it impossible to perform sexual intercourse and causes an incomplete erection (low stiffness).

The treatment is targeted, complex, through radiotherapy, electrotherapy, corticotherapy, anti-inflammatory drugs, vitamin E and others. If the induration is only well circumscribed and stabilized, it is treated surgically.

Priapism. The term comes from gr. "Priapos", the god of fertility in the Greeks, son of Aphrodite and Bachus. Rare disease, with an increased frequency between 20 and 50 years, is characterized by intermittent or continuous erection, painful and irreducible, with hard corpora cavernosa and glands that do not change their consistency, often unrelated to sexual intercourse.

In priapism there is no turgor of the glands. It occurs in the absence of any sexual stimulus. The patient, who has an intermittent erection, does not reach ejaculation or, if there is, it is accompanied by pain. The situation is the result of disturbance of the drainage of venous blood from the corpora cavernosa into the deep dorsal vein of the penis. Stasis blood is viscous at first, then coagulates. This causes fibrosis of the corpora cavernosa followed by impotence. There is a true, primary, irreversible *priapism* and *a pseudopriapism or secondary*, reversible *priapism*.

The treatment is surgical and medicinal. Intervention in the first 36 hours generally leads to the disappearance of symptoms while maintaining erectile function. In parallel with the treatment of the causative disease, sedatives, hormones are administered, and the contents of the corpora cavernosa are surgically drained.

Causes of Erectile Dysfunction

It is known that with age, physical and psychological changes occur in the body, which influence sexual activity. Men find it increasingly difficult to respond to sexual arousal, needing more intense stimulation in order to get an erection. 40% of men over the age of 40 report occasional problems in obtaining and maintaining an erection, compared to 52% of men between the ages of 40 and 70 and 70% of men over the age of 70. It is estimated that up to 80% of cases of erectile dysfunction have somatic causes, and the remaining 20% can be explained by the action of psychological factors. In addition, many lifestyle factors cause erectile dysfunction.

For an effect there is not a single cause, but a multifactorial context in which organic, iatrogenic and psychonic causes can be associated. Maintaining nocturnal and morning erections, as well as spontaneous erections leads more to inorganicity, which does not mean that there can be no neurological or venous causes. Conversely, the disappearance of nocturnal and morning erections does not necessarily mean the presence of organic causes: a psychogenic sexual dysfunction, old and unreserved, old and unresolved, may have such symptoms.

With age, the risk of organic factors increases.

Whatever the organic risk factors, anxiogenic overload, stress and negative ruminant thoughts are always present and must be considered and treated.

There is often a potentiation of etiological factors in the occurrence of sexual dysfunction: the accumulation of several causes leads to the onset of the problem.

The individual factor must often be taken into account, given that the same organic cause does not necessarily have the same effect on sexuality (diabetes or heart disease). In some men, sexual problems are triggered by the fear of the consequences of these diseases on their sexuality. Others, despite these diseases, are optimistic and detached enough not to link their illness to their sexuality. Thus, they will not have problems in the field of sexuality.

1. Somatic causes:

- vascular diseases (atherosclerosis, heart failure, stroke, hypertension, hypercholesterolemia) can affect the blood circulation of the penis. Two-thirds of men with high blood pressure suffer from erectile dysfunction;
- diabetes. Two-thirds of men with diabetes have erectile dysfunction, the risk of diabetics being three times higher than that of men without diabetes;
- neurological diseases include spinal cord injuries, multiple sclerosis, nervous disorders caused by diabetes and alcoholism;
- hormonal dysfunctions. Low testosterone levels can lead to erectile dysfunction;
- prostate disorders, as well as their treatment, especially in men over 40 years of age;
- surgery for colon, rectal or prostate cancer, radiotherapy of the pelvic area can damage nerves and blood vessels, causing erectile dysfunction;
- side effects of medications, such as antihypertensives and antidepressants, hormones, neuroleptics or diuretics;
- alcohol or drug use.

2. Psychological causes:

- man's self-esteem and attitude towards his physical appearance (to like his own appearance);
- performance anxiety (fear that they will not live up to their partner's expectations) very often causes a lack of erection;
- stress of any kind can also affect sexual performance;
- depression can cause erectile dysfunction or, on the contrary, can be caused by it;
- relational problems: conflicts with the sexual partner, regardless of whether or not they are related to sexual issues;
- fatigue or asthenia lead to sexual inhibition as well as intense concern for other life issues such as work;
- the general attitude towards sexuality, which can be generated by education;
- blaming sexual fantasies, fear of self-abandonment or fear of sexual desire of the "active woman";
- trauma of rupture, rejection, abandonment.

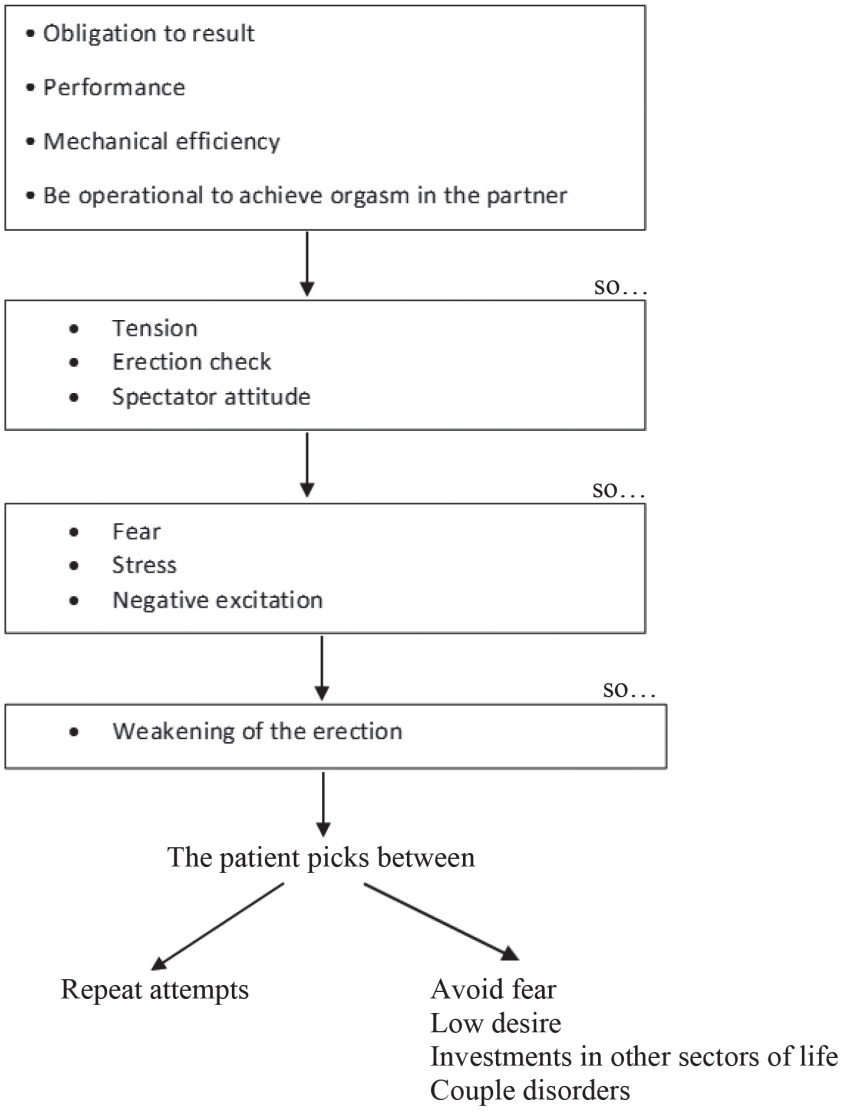
3. Lifestyle factors:

- Excessive alcohol consumption reduces the ability to have an erection. In most cases, drunk men are unable to have and maintain an erection;
- Sedentary lifestyle can lead to erectile dysfunction, both directly and by favoring cardiovascular pathology;
- Smoking increases the risk of erectile dysfunction by 50%, according to studies by Action on Smoking and Health (ASH) and the British Medical Association (BMA). It also causes a reduction in the volume of ejaculation, a decrease in the number of ejaculated sperm, as well as abnormalities in their shape and reduced mobility.

4. Couple factors and relational features:

- Monotony, routine, trivialization of married life;
- Overinvestment of extramarital relations;
- The partner's negative attitude towards sexuality;
- Communication disorders in the couple;
- sexual disorders of the woman (vaginismus, dyspareunia);
- Conjugopathies: settling accounts through sexuality - "as you are ugly and reject me, I show you by my lack of erection that I know how to assault you and punish you".

THE INTERNAL CYCLE OF IMPOTENCE CAUSATION



Diagnosis And Specialty Consultation

It must be understood that it is normal that sometimes there are such problems in the **life** of any normal man, but these should not be the rule. If **the erectile** dysfunction lasts for more than 2 months, this is a problem and you should consult a specialist in such conditions. Your doctor will help you find the cause of this disorder and will make recommendations or prescribe the appropriate treatment.

In most cases, erectile dysfunction is an embarrassing problem for the person concerned and that is why it is important to follow an effective treatment and to treat the generating cause. In many cases this problem can be solved successfully. If the therapy proposed by your doctor does not give the expected results, other forms of treatment will be tried, possibly combinations of treatments recommended by the specialist doctor chosen by you. Any form of self-therapy should be avoided in such situations, the combination of medications made by you can have unwanted side effects and even aggravate the dysfunction.

During the consultation, your doctor will ask you a series of questions about the problem that is bothering you, what symptoms have occurred and under what conditions, what types of medications you use chronically for other conditions and other questions related to your chronic conditions. The doctor will also ask you about the latest changes that have occurred in your life both physically and emotionally.

If during the consultation the doctor suspects an organic cause involved in your disorder, then **blood** samples will be taken to perform a set of tests such as the concentration of male hormones **(androgens)** in the blood or other causes that may underlie the condition, for example **diabetes**, a situation in which we find an increased **blood sugar.** The doctor will also try to eliminate or replace any prescription that may be responsible for the erectile dysfunction. The medication you have that is suspected to cause such problems will be temporarily discontinued or a few doses will be replaced, following the effect.

Kinsey estimates that 85% of causes of impotence are psychological.

There is a questionnaire that can easily and quickly assess the cause of impotence:

1. Do you have morning erections?

2. Do you happen to have dream erections (REM)?

3. Can you produce an erection by masturbation?

4. Does fantasy, erotic readings or shows of this nature cause you to get an erection?

5. If you have ever had sex with a woman other than your wife - have you succeeded?

6. Have you had an erection in various other circumstances?

If the respondent answers positively to at least one question, his impotence can be considered of a psychological nature.

Erection Disorder Therapy

• Individual psychotherapy

- The classical psychodynamic theory, developed by Freud and his successors, argues that sexual inadequacy has its roots in intrapsychic conflicts dating back to childhood and that sexual disorder should be treated as part of a broader emotional development disorder.
- Treatment focuses on exploring unconscious conflicts, motivation, fantasies and various interpersonal difficulties. One of the assumptions of this type of psychotherapy is that the removal of conflicts will allow the sexual impulse to become acceptable to the patient's unconscious and thus he will be able to find appropriate ways of expression in the environment.

• Dual sexual therapy

- The theoretical basis of dual sexual therapy consists in the concept of marital unity as an object of therapy.
- It starts from the assumption that the sexual disorder has a cause related to the relationship between the two partners and not only to the person who suffers from the actual sexual disorder.
- The idea that only one of the partners has a "problem" is not accepted and, since both suffer from the consequences of sexual dysfunction, both must enter therapy.

- The sexual problem often reflects the existence of other areas of imbalance or misunderstanding in the couple's relationship. Therefore, therapy focuses on the whole relationship, taken as a whole, paying more attention to sexual aspects. The psychological and physiological aspects of sexual functioning are discussed, the therapist having an educational attitude. Sometimes the therapist suggests that the couple do certain things, and they should try at home what has been suggested to them.
- Most often, this type of therapy is done by two therapists, a man and a woman, who discuss and clarify various sexual aspects with the two patients.
- The purpose of therapy is to establish or restore communication within the couple. Sex life is considered a natural function that flourishes in the conditions of a proper home life, the improvement of communication contributing significantly to it.
- The treatment is short-lived and is based on a behavioral approach. The therapist tries to reflect the reality within the couple as it is, thus correcting the sometimes distorted image that the two have of their relationship. Sometimes this new perspective is enough to break the vicious circle of a flawed relationship. Specific exercises are also prescribed to help the two with their problem. Sexual inadequacy often involves lack of information or misinformation, as well as fear of performance. Therefore, during therapy, couples are prohibited from any sexual activity other than that prescribed by the therapist.
- The beginning exercises focus on increasing sensitivity and awareness of the sensations of touch, sight, hearing and smell. Initially, intravaginal penetration is forbidden, the two partners must learn to give and receive bodily pleasure without resorting to the pleasure of penetration. At the same time, they learn to communicate non-verbally in a way that satisfies each other, and also very importantly, they learn that foreplay is at least as important as the actual sexual act and orgasm.

• **Hypnotherapy or hypnosis**

- Hypnotherapists focus mainly on the symptom that bothers the two the most.
- Successful use of hypnosis allows the patient to regain control of the symptom that has affected his self-esteem and disturbed his psychological balance.
- It is important to first get the patient's cooperation in a few sessions that do not use hypnosis. These initial sessions are necessary to ensure a good therapist-patient relationship, a certain feeling of physical and mental comfort on the part of the patient, as well as to establish mutually agreed therapeutic goals.
- Therapy focuses on removing the symptom and changing the patient's attitude towards the symptom. The patient is taught several alternative means of coping with situations that might make him anxious, especially those related to the expression of sexuality. Patients are also taught some relaxation techniques to use themselves before engaging in sexual activities. With the help of these methods of reducing anxiety, physiological responses to sexual stimulation can quickly lead to increased sexual pleasure.
- The psychological impediments responsible for the lack of erection are removed by hypnosis therapy. Often, hypnosis is used as an adjunct, as a complementary therapy to individual therapy to accelerate the onset of results.

• **Behavioral psychotherapy**

- Behavioral therapists start from the assumption that sexual dysfunction is a learned maladaptive behavior. The therapist sees the patient's problem as a fear of sexual interaction.
- Using traditional techniques in this method, the therapist builds a list of situations that scare the patient, from the situation that scares him the least to the situation that scares him the most. For example, kissing can generate a fear of medium amplitude, while vaginal penetration can induce a massive fear.
- The therapist then teaches the patient to overcome his fear, through relaxation techniques,

starting from the least stressful situations to the most stressful situation.
- Also in behavioral therapy, the patient learns to openly express, without fear, his sexual needs towards his partner, as well as to refuse his requests when he perceives them as unreasonable. This type of learning often accompanies sexual therapy.

• **Cognitive-behavioral family therapy**
- In the treatment of sexual dysfunctions, and erectile dysfunction in particular, the systemic desensitization technique is used.
- They believe that most sexual problems are the result of conditioned anxiety.
- Normally, the whole complex of realities acts in such a way as to achieve an erection. But if a man goes to bed with fear or a strong desire to succeed and demonstrate his potency, relaxation can no longer occur as an intermediate phase necessary to obtain an erection; Instead, out of fear, adrenaline production increases, a condition that increases tension, preventing erection.
- Fear of failure (which occurs especially in men whose self-affirmation is dependent on sexuality) is the greatest enemy of erection.
- Therapy consists of training couples to engage in a gradual series of more intimate progressive encounters, while avoiding thoughts about erection and orgasm. Relaxation techniques are used (especially between arousal and orgasm) and teaching couples to focus on the physical sensations of touch and caress, rather than what will follow.

1. The exclusion of any possible organic cause.
2. Changing intuition and attitude by explaining to patients the role of conditioned anxiety in sexual problems and telling them how anxiety develops and is maintained in their sexual relationships.
3. Perceived concentration through the senses - couples are taught how to relax and how to enjoy caressing and being caressed. They are given the task of going home and finding the moment when they are both relaxed and free from other problems and then go to bed both naked. Then gently caress each other. The person who has been caressed is simply told to relax and focus on the feeling of being touched. Later, the one who was touched will tell his partner which of the caresses was the most pleasant and which was the least pleasant. At first, couples are told not to caress the sensitive areas of the breasts or genitals to avoid unwanted anxiety.
4. *In vivo* desensitization and progressive exposure to stress - after the previous stage, the couple is given the task to become more and more intimate, but very slowly. They learn to overcome their fears through a gradual and progressive intimate experience of mutual touches. As anxiety decreases and desire increases, they are encouraged to engage in more intimate progressive changes. In the process, they need to communicate what they like and what they don't.
- At the beginning of this stage you can use a list:
- Write down everything the person has not done during sexual intercourse since the onset of the sexual problem.
- write down those things he is still trying to do, but which cause anxiety and confront him with failure.
- is noted for each level of anxiety (0 to 100)
- note on another sheet distressing situations in ascending order, from the least distressing to the most distressing.
- Progressive desensitization will be able to follow this list.

5. It is recommended to increase the variety and duration of preliminary games.
6. Arousal techniques - in which the woman begins and ends alternately stimulating the man, and the beginning of sexual intercourse is done by the fact that the woman guides the flaccid penis in her vagina.

• **Masters and Johnson method:**
- 10 days avoiding sexual intercourse, even when the man feels fit.
- After 10 days, the woman takes the initiative and stimulates the partner's penis
- The woman takes the position above
- It helps to achieve intrusion

- After the intrusion, it is up to the man to make the first movements, then the two to synchronize
- The man withdraws before each sensation of ejaculation, after which the intrusion is performed again
- The final ejaculation is extravaginal
- The partners must have a selfish attitude and do it in such a way as to obtain pleasure on all levels, without thinking too much about the other.

• **Cognitive techniques**

- In parallel with the behavioral therapy exercises, we must also act on parasitic thoughts, mental ruminations, catastrophic scenarios.
- In order for the patient not to close himself in a sterile negative speech, it is important to dedramatize and take some distance.
- In this technique the technique of Beck's columns is used:

1. The situation that poses a problem for me.
2. Emotions arising on this occasion.
3. The ruminant thoughts that were related to that situation and the emotions of that time.
4. What I could say to myself in a positive, more honest, more objective way about my problem.
5. The result I aim for, that is, what I am going to do to progress better *(Table 1)*.

• **Solution-oriented techniques**

- They start from the idea that very often the sexual problem persists because the couple repeats endlessly the same solutions that lead to failure.
- It is based on the following technique of completing the *Tables 2* and *3.*

Table 1 - Examples of congnitive techniques

Beck's five columns				
The situation	The emotion	The negative thought	The positive thought	The result
Weakening of the erection during sexual intercourse	Panic	He will leave me. I got old	I'm currently stressed, it's not the time to want performance, in fact she never reproached me.	By mutual agreement we will leisurely try to find ourselves
Impossibility of penetration during sexual intercourse	Fear, anguish	I'm not a normal woman	I know how to show affection to my husband, he is willing to help me and go to the therapist together	Now I don't think about the child, I regulate my sexual problem, I try to understand my sex better, which I am afraid of.

Table 2 - Solution-oriented techniques

Attempts at solutions	The paradoxical solution	Compromise	Result	Minimal compromise
Avoid	I'm going to another one	We go together elsewhere (to the hotel) to "make love"	Positive for women (climate). Negative for male (erection not maintained)	You find yourself at the hotel, but only for caressing and exploring the body through the five senses.

Table 3 - The steps to the solution are constructed as follows:

What are you doing or not doing now, since the problem	What would you do in the absence of the problem	How do you imagine your wife's reaction to this change	The real reaction of the wife	Compromise solution
I hesitate to approach my wife. I do nothing.	I would approach more often to stroke her head	She wouldn't like it too much, because she wants sex	I like it a lot, but I would want more	Closeness, but asking the other not to touch the erogenous zones immediately

1. What are the solutions already tried
2. What would be the paradoxical solution (the opposite of the one mentioned)
3. What is the acceptable couple compromise between the failure solution and the paradoxical solution
4. What is the result? Did the compromise work?
5. If the answer is no, what is the solution that allows the slightest change and will satisfy you in your sexual play?

WHAT COULD BE THE STEPS FOLLOWED IN AN ERECTION DISORDER THERAPY?

1. For starters
   - Assess the problem on a scale of 1 to 10
2. Basic information
   - The problem has a solution
   - The approach must be progressive
   - Sexual intercourse is not limited to penetration
   - There is a before and an after
3. Progressive exposure to the anticipated penile stress
   - General caresses without focusing on the penis
   - Global caresses and the integration of sexual areas
   - Specific caresses of the sexual areas and penis-vagina contact
   - Disinterested penetrations
   - Resumption of sexual intercourse
4. Systematic desensitization
5. Cognitive therapy
   - Building Beck's 5 columns
6. Reassess the problem on a scale of 1 to 10.

THE CHEMICAL SOLUTION OF IMPOTENCE

- **Prostaglandin injections** (substances synthesized by the body that have very strong effects and hormone-like roles; are involved in the contraction or relaxation of smooth muscles, initiation of abortions, etc.)
- **Caverject** - by injecting directly into the corpora cavernosa of the penis, contains an equivalent of prostaglandin that produces smooth muscle relaxation and erection.

- side effects: penis pain, prolonged erection (priapism), fibrosis of the corpora cavernosa

- **Viagra** - causes the body a strong state of arousal with erection and redness of the face. It causes the release of nitrogen oxide, which increases blood flow to the genitals and blocks the neurotransmitter that would allow the blood to leave the genitals. It takes a longer time to take effect, which lasts less than an hour.
- forbidden for cardiac and hypertensive patients
- does not offer sufficiently satisfying sensations (even after numerous orgasms)
- causes a sudden drop in blood pressure
- changes vision - sees in blue or green
- **Uprima** - dissolves under the tongue and takes effect in 20 minutes.
- **Ciallis (Weekend Pill)** - has an efficiency of over 24 hours.
- **Vacuum devices** - work on the principle of absorbing blood into the penis by suction, creating a vacuum and capturing blood in the penis using a constrictive ring applied to its base. The ring should be removed after a while to allow blood to drain from the penis, which can limit the duration of the erection.
- **Implants** - Penile implants are surgically placed in the main blood vessels of the penis. The devices can be raised or lowered manually, and when raised, the penis has sufficient rigidity for penetration. There are also inflatable implants, which are operated by tightening a small pump located in the scrotum. It releases a fluid that is pumped into two cylinders implanted in the penis.

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