

MALE SEXUAL DYSFUNCTION:
IDENTIFICATION AND MANAGEMENT IN THE PHYSICIAN'S OFFICE

Why should doctors identify their patients' sexual concerns? How to screen for sexual dysfunction? What are the common sexual problems for men? How can physicians manage these problems effectively?

WHY SHOULD DOCTORS IDENTIFY THEIR PATIENTS' SEXUAL CONCERNS?

Sexual problems are common. The prevalence of sexual dysfunction is 43% for women and 31% for men in a large American sample.¹ Erectile dysfunction increases as men age, with 52% of men age 40 - 70 having some degree of impotence.²

Sexual concerns are often associated with other medical illness, or their treatment (such as hypertension, diabetes, and vascular disease (see table 3). A multidisciplinary study found that pathophysiological factors were present for at least 33% of men and 10% of women presenting for sexual counseling.³

Identifying sexual concerns changes medical treatment. In a general medicine outpatient clinic, a controlled trial compared to usual care, asking patients "Do you have any sexual concerns?" uncovered new, important medical information for 26% of patients, resulting in changes in medical treatment 16% of the time.⁴

Patients want their doctor to treat their sexual problems. Patients see physicians as the most appropriate health professionals to aid them in managing sexual dysfunctions.⁵

HOW TO SCREEN FOR SEXUAL DYSFUNCTION?

Patients and physicians both come to the office with the same set of early life experience, attitudes and values about sexuality. Avoidance of discussing sexual concerns for fear of bringing up inappropriate or private concerns leads, for example, to less than one in ten men with erectile dysfunction being identified. However, a soon-to-be released study shows that among recently graduated family physicians, 17.0% of female physicians and 37.2% of male physicians raised the issue of male sexual difficulties/dysfunction with patients at least once a week.

Physicians may feel inadequately trained to deal with sexual problems; that these issues take too much time; or that other health issues are more pressing. Yet 80% of sexual problems can be managed in primary care with only 8% needing referral.⁶

Sexually transmitted disease is a leading killer of young, urban men; and a frequent cause of morbidity for women. Safe sex is sometimes discussed with women, but only rarely with young men. In large measure this is because of men not availing themselves of preventive health care as often as their sisters. Physicians routinely manage contraceptive matters for women and their partners, yet rarely use the opportunity to ask about sexual function of either women or men.

Brief screening questions as part of the social history and/or the genital functional inquiry are high yield for information about the patient that will affect overall health care:

1. Are you in a relationship?
2. Are you, or have you been sexually active?
3. Have you had sex with men, women, or both?
4. What are you and your partner doing about contraception?
5. What are you and your partner doing about safer sex?
6. Many people have sexual concerns, I wonder what yours might be?

WHAT ARE THE COMMON SEXUAL PROBLEMS FOR MEN? HOW CAN PHYSICIANS MANAGE THESE PROBLEMS EFFECTIVELY?

Sexual function for both men and women depends upon the interplay of physical, psychological and relationship factors between each member of the couple. The "10 Minute Sexual History" uses the tradition medical approach to delineate a sexual concern (Table 1). Taking a focused sexual history of *both partners'* functioning once a sexual problem is uncovered can help develop a management plan (Table 2). The six squares of a 2 X 3 grid cover the main areas of a sexual functional inquiry for the couple. About half of partners of the identified patient will also have sexual dysfunction. A common example is dyspareunia due to post-menopausal atrophy and lack of intercourse for the partner of an aging man dealing with erectile dysfunction.

Most patients with a sexual concern will present on their own. Taking a history around emotionally loaded issues such as abuse, sexual orientation, and affairs

may be most easily accomplished individually. But sex is not just a solo sport; usually it is shared with a partner. Treating the couple as the patient generates more diagnostic information from the "consultant" spouse, and allows both partners' concerns to be addressed. Looking at sexual problems as affecting the couple as a system increases chances for successful outcomes.

Couples are often hungry for information about sexuality. The attached readings suggest a number of resources, including "The New Male Sexuality" by Bernie Zilbergeld. Providing sex education is helpful for most couples, and sometimes it is all they need. It can prepare couples for, and is used extensively in more formal sexual therapy. The goal of sexual counselling is to help reduce sexual performance anxiety for both members of the couple, to allow the sexual response to occur without being overwhelmed by stress mediators such as adrenalin.

Many physicians are uncomfortable in talking about sexuality with their patients, being afraid of "opening Pandora's Box". A graduated approach, using the PLISSIT model can aid physicians with their own comfort levels in helping patients' sexual concerns:

**Permission;
Limited
Information;
Specific
Suggestions;
Intensive
Therapy**

Permission giving applies both to doctors as well as patients. Patients need Permission to know that sexual health concerns are appropriate topics of discussion in a medical context. Physicians need to understand their own biases and comfort levels in discussing potentially loaded issues such as premarital sex, abortion and abuse. For some, this will mean identifying patient concerns and making appropriate referrals so that patients can receive help for their problems.

Limited information is immensely helpful for patients. The assumption that since the sexual revolution patients are well informed about sexual issues is false. Brief sex education is often indicated. The reference list at the end of this paper is a possible resource. Normalizing issues such as masturbation, and reminding patients of the risks associated with sexual behaviour is often gratefully received. Partners of men dealing with rapid ejaculation and/or erectile dysfunction often feel that the man is "doing this to hurt me". Helping them understand that the man is not behaving in this way on purpose, but is dealing with a pathophysiological process can be the first step in reducing anxiety for the couple and begin to help them move forward.

Specific suggestions about sexual behaviour are brief interventions that can occur within the context of a regular office visit. For a man with variable erectile dysfunction, suggesting sex earlier in the day, and not after a heavy meal with alcohol; for couples with young children, urging them to put a lock on their bedroom door; or for the man with rapid ejaculation, offering a trial of an SSRI antidepressant on a prn basis are some examples. These suggestions often will be better acted on if the couple, rather than the individual patient, has been present in the office.

Most sexual problems, perhaps as many as 75%, can be successfully solved with the above steps.

Intensive therapy is reserved for those in whom briefer interventions have failed. This may be done by the primary care physician themselves, or involve appropriate referral to urologists, psychiatrists, marital and/or sex therapists as needed. Solution-focused, cognitive-behavioural couple sex therapy can often help couples move forward with their sexual concerns.

Given the multiple causes of sexual difficulties, a thorough history is imperative to determine whether management should be medical, psychological, relational, or a mixture of these (Table 3).

Decreased sexual desire. About 1 in 7 men will admit to feeling decreased desire when asked.¹ This increases gradually with age. Low desire correlates with daily alcohol intake, poor general health, emotional stresses, fatigue, insufficient sleep, being touched sexually before puberty, same sex behaviour ever, or a partner ever having had an abortion. The accelerating pace of life for many leaves little time for relaxed interaction between partners. This is especially prevalent for families with two working parents and young children. The fatigue that many experience in this context leads to sexual shut-down. Permission and encouragement by physicians to take time to nurture the couple as being a core need for a marriage, rather than an extravagant luxury can be a useful intervention. (How many of us would benefit from the same advice?)

Many illnesses and the drugs used to treat them cause lowered desire.⁷ Antihypertensive, antiarrhythmic, antineoplastic, anticonvulsant, and antidepressant drugs are common culprits.

Endocrine disturbances commonly have sexual dysfunction associated with them. Hypothyroidism, hypogonadism, and hyperprolactinemia often cause decreased desire.

As men age their testosterone levels gradually decline over decades starting in the 40's. For some men this becomes clinically significant and is variously called Andropause or Androgen Deficiency of the Aging Male ("ADAM").⁸ Treatment with replacement testosterone is available using pills, injections, patches and

(internationally) sub-cutaneous pellets. Similar to hormone replacement for women, testosterone has positive effects on sexual interest, overall mood and general wellbeing, and reduces the risk of osteoporosis. Long-term trials to assess the potential risks of prostate cancer and cardiac disease have not been reported. Prudent management suggests monitoring the prostate with a digital rectal exam, baseline and initially 3 - 6 month follow-up Prostate Specific Antigen testing. Blood pressure, hematocrit, calcium and cholesterol should also be monitored.⁹

Decreased desire is one of the hallmarks of depression. Antidepressants may help mood, but commonly exacerbate hypoactive desire. Addressing these concerns will help medication compliance. Non-SSRI antidepressants, such as bupropion and nefazodone may be relatively more sparing sexually.

Men at risk for lowered desire resulting from a medical condition or use of medication need physicians to raise these issues since without prompting they are unlikely to do so. Routine questioning about sexual concerns can reveal such problems; patients whose diagnoses and/or medications have an effect on sexual desire offer physicians an opportunity to raise and explore these and related sexual health issues.

Frequency dissatisfaction is common in relationships, with the partner with the lower level of interest often being labeled as the identified patient. While stereotypically the woman is labeled as having lower desire, as indicated above, either partner can have the lowered level of desire. Besides looking at possible treatable causes, such as andropause or menopause, it is important to help the couple understand what this situation means for each partner. Does a lack of sex imply a loss of love or attraction? Does it mean that a partner has to feel sexually frustrated due to lack of sexual contact, or can they pleasure themselves? I use a restaurant analogy with couples around this issue: Both usually agree that they enjoy going out to dinner together, rather than grabbing a bite to eat on their own. I ask them whether each has to eat the same amount of the same food from the menu in order for each of them to feel satisfied and to enjoy the dining encounter. Or can one order steak with all the trimmings, and the other have the pasta? If one partner feels at least neutral about sex, but sees their lover enjoying themselves, can this be enough for them to engage in sex? Can both partners discuss and accept masturbation in the relationship? Helping couples learn to acknowledge each other's levels of sexual desire and frequency as being different and unique to themselves, and aiding them in finding ways to balance these needs is both challenging and helpful. Underlying marital stresses that contribute to decreased desire may need to be addressed.

Erectile Dysfunction. Laumann's study showed that 7% of men in their 20's complained of difficulties in getting or maintaining an erection satisfactory for sex. This nearly tripled to 18 % in the fifth decade. The Massachusetts Male Aging Study showed that while 52% of men age 40 to 70 had some degree of

erectile dysfunction, 5% of all men at 40 have complete erectile dysfunction. With age this increases to 15% for men at age 70.²

Medical treatment for erectile dysfunction has become a primary care skill with the introduction of oral sildenafil proving to be effective in 72% of men and generally well tolerated.¹⁰ Men need to practice with a few doses, and need to be cautioned that onset of action depends on how much food and liquor has been consumed prior to taking the sildenafil. Waiting 1 - 2 hours increases clinical effectiveness, but may increase anxiety. Partners benefit from hearing how sildenafil works, and that it is safe. Many worry that sildenafil could kill their man. This has *not* been born out in clinical practice. Given its mode of action blocks the breakdown of intracellular nitric oxide, it cannot be taken by men using nitrates for coronary artery disease and angina. Otherwise it is quite benign. An algorithm with suggestions for use in cardiac patients has been published in Canadian Family Physician.¹¹

Other treatments include intra-urethral MUSE, and intra-cavernosal injectable Caverject. These prostaglandins work by non-nitric oxide pathway and are safe with nitrates. Patient acceptability remains an issue, but they provide highly effective therapy if sildenafil fails. Penile prostheses are still a fallback treatment if all others fail, however given the effectiveness of newer medications; they are much less often performed currently. Assessment of the couple is imperative before an implant is considered.

Ejaculatory Disorders

Rapid (or premature) ejaculation is the commonest male sexual function concern. One-third of men feel they have rapid ejaculation. Contrary to popular myth, this remains stable across the age spectrum.¹ Defining rapid ejaculation depends on each couple and their sexual interaction. For a heterosexual couple, does she have her orgasm with intercourse only, or is she orgasmic with "outercourse": manual, oral, self, or other non-intercourse stimulation? The length of time that intercourse lasts is between 4 - 7 minutes for the average Canadian couple. Independent of the length of time of intercourse, is she (and he) satisfied with their sexual activity?

Men with rapid ejaculation often ejaculate unintentionally before, or immediately after the moment of penetration. This can be very distressing for both the man, who wishes nothing more than to last longer; and his partner, who in their own frustration might blame him for intentionally not attending to her needs.

Traditional treatment, the "stop-start" technique developed by Masters and Johnson¹², uses graduated masturbation exercises to help the man recognize the stage of ejaculatory inevitability and reduce the amount of stimulation to remain below this threshold. These exercises are detailed in Bernie Zilbergeld's book.

While initially successful in 90% of men, longer term maintenance remains much lower¹³ when traditional sex therapy methods are used alone.

While single men can be taught these exercises alone, they often have difficulties in generalizing gains in ejaculatory delay to their partners. Men who have difficulties in forming intimate relationships because of their anxiety about delayed ejaculation will often benefit more from assertiveness training before starting sex therapy.

Couple sex therapy involves helping the couple understand the physiological basis for rapid ejaculation, and that it is not something the man is doing intentionally to frustrate the partner. Acknowledging the partner's feelings (often of frustration, at times of anger), and dealing with these is a cornerstone of therapy. Expanding the couple's sexual repertoire beyond intercourse ways for both to achieve pleasure allows the negative pressures to abate. Then starting with the man self-pleasuring initially alone, he stimulates himself nearly to orgasm 3 times, before ejaculating the 4th time. Through practice, he gradually gains the ability to pull back from the point of ejaculatory inevitability. Once this is achieved, the partner can be introduced, initially with their dry hand, then with lubricant, and eventually with genital contact. Having the partner on top initially puts the least pressure to ejaculate on the man, but can be frustrating for the woman as she is asked to provide a "silent vagina" and not move to her own rhythms initially. Gradually both members of the couple can start to thrust, and eventually move to the male superior position, in which the man finds it most difficult to control ejaculation.

The SSRI antidepressants cause significant delayed ejaculation, often limiting compliance in depressed patients. Using this side-effect as a therapeutic tool has significantly improved the treatment of rapid ejaculation.^{14,15} Clomipramine is slightly more effective than SSRI's, but causes more side-effects. Paroxetine and sertraline may be more effective than fluoxetine or fluvoxamine. Most clinicians integrate low dose SSRI's with sex therapy. They can be used on a prn basis 2 - 4 hours before anticipated intercourse, or if this fails, then on a daily basis.

Delayed ejaculation is rarer than rapid orgasm, with somewhat less than 1 in 10 men complaining of inability to ejaculate with a partner.¹ A man who has never had an orgasm (through intercourse, masturbation or nocturnal emissions) requires a thorough evaluation for secondary causes. Perhaps the commonest cause of secondary delayed ejaculation is the use of SSRI's as mentioned above. Any new onset of delayed ejaculation necessitates a thorough medical and medication review.⁷

Partners are often more frustrated with delayed ejaculation than the patient in feeling that they are somehow not attractive, or adept enough as lovers to help him ejaculate. Treatment involves helping the couple understand the physiology and psychology of delayed ejaculation. Consideration of medication changes if

possible can be helpful. Cyproheptadine, both an histamine as well as serotonin antagonist, can act as an antidote.

Often couples with delayed ejaculation do not present for therapy until the issue of infertility arises. Many of these men can ejaculate on their own, but not with their partner present. Fertility can be achieved through the use of a 3-cc syringe to allow the couple to insert semen intra-vaginally on their own, or through intra-uterine insemination in the physician's office. Men who have suffered a quad- or paraplegic injury can be stimulated with vibrators, or mild electrical stimulation.¹⁴

Therapy focuses on increasing the pleasure of the process of lovemaking, rather than the anxiety-producing goal of ejaculation. This can then be linked to a behavioural process of stimulus intensification to allow the man to ejaculate initially in any way while in his partner's presence, and then gradually closer to their genitals.

Conclusions

Physicians now have more treatment options than ever before to help their patients better deal with sexual dysfunction. The challenge remains to help physicians and their patients discuss sexual concerns as they do other medical problems, in a direct and forthright manner. This will lead to an integration of sexual health within a patient's overall medical care.

Suggested Readings for Physicians:

Sexual Medicine in Primary Care. Maurice, W.L., Mosby Inc., 1999

The New Male Sexuality. Bernie Zilbergeld.

Holzapfel S. The physician's role in dealing with men's sexual health concerns.

Canadian Journal of Human Sexuality 1998(Fall);7(3):273-286. (This entire issue is devoted to Male Sexual Health.)

Table 1. The "10 Minute Sexual History"

1. CHIEF COMPLAINT

- Is this a problem of: **Desire,**
Arousal (Erection or Lubrication),
Orgasm (Premature, Delayed, or
anorgasmia)
Sexual Pain

2. ONSET

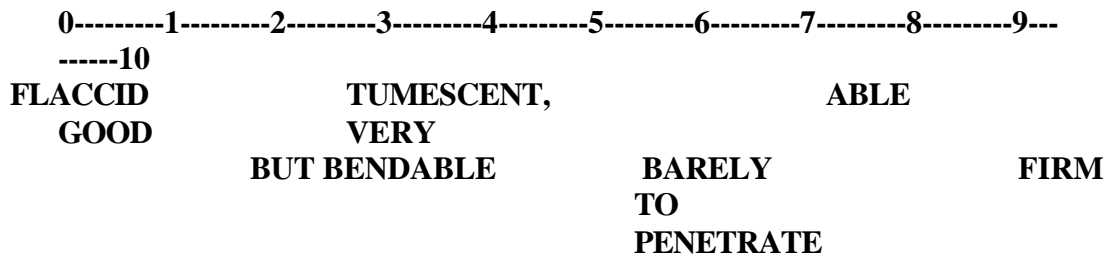
- **Gradual versus sudden (Trigger Red Flags?)**
- **Lifelong or Situational**

3. SITUATIONAL OR GENERALIZED (GLOBAL)

- **Does dysfunction occur with all partners?**
- **How does self-stimulation affect problem?**
- **In Erectile Dysfunction:** **Waking erections**
Masturbatory erections
Partner shared erections

4. RATING OF PROBLEM

- **Rate on a scale of 1 - 10.**
- **Example for erections:**



5. REST OF SEXUAL RESPONSE

- **Review other phases of sexual response cycle**
- **Pain with sex or ejaculation**

6. SEXUAL RESPONSE OF PARTNER

- **If FEMALE: Her desire, arousal and orgasms**
- **If MALE: As above ("Does your partner have any Concerns about his desire, erections, or orgasm?")**

7. REACTION OF BOTH PARTNERS TO THE PROBLEM

- **How do each individually feel about problem?**

- **What are the consequences of the problem?**

8. CURRENT RELATIONSHIP

- **Sexually, what changes in pattern or frequency?**
- **Emotionally, what is the level of intimacy like?**

9. MOTIVATION

- **Is the patient and their partner willing to continue being assessed?**
- **What is the enthusiasm for therapy?**

Table 3. SEXUAL DYSFUNCTION CAN BE DUE TO:

| PHYSICAL FACTORS | PSYCHOLOGICAL FACTORS | RELATIONSHIP FACTORS |
|-------------------------------------|----------------------------------|-----------------------------|
| ENDOCRINE | DEVELOPMENTAL ISSUES | RELATIONSHIP DISCORD |
| AA Diabetes Mellitus | AA Family of Origin Effects | LIFESTAGE STRESS |
| AA Hypothyroidism | Religious & Cultural Effects | AA New couple |
| AA Hypogonadism | ANXIETY DISORDERS | AA Infertility |
| AA Hyperprolactinemia | AA Generalized | AA Pregnancy |
| NEUROLOGICAL | AA Phobias | AA Post-Partum |
| AA Multiple Sclerosis | AA Performance Anxiety | AA Parenthood |
| AA Stroke | POST TRAUMATIC STRESS | AA Adolescent |
| AA Spinal Cord Injury | AA Sexual Assault | Family Stress |
| VASCULAR | AA Sexual, Physical and | AA "Empty Nest" |
| AA Hypertension | Emotional Abuse | AA Loss Of Spouse |
| AA Coronary Artery Disease | | SEXUAL EXPERIENCE |
| AA Vascular Insufficiency | | AA Meaning of Sex |
| SUBSTANCE ABUSE | | to each Partner |
| AA Alcohol | | |
| AA Tobacco | | |
| AA Mood altering drugs: | | |
| AA Narcotics, Cocaine, LSD, etc. | | |
| MEDICATION SIDE-EFFECTS | | AA Different Sex |
| AA Antidepressants | | Drive |
| AA Antihypertensives | | AA Family & Culture |
| AA H ₂ Receptor blockers | PSYCHOSIS | SOCIAL STRESSORS |
| AA Antipsychotics | AA Schizophrenia | AA Financial & Work |
| AA Antineoplastics | | AA Support Systems |
| UROLOGICAL | DEPRESSION | AA Family Needs |
| (Not detailed here) | AA Unipolar | AFFAIRS |
| | AA Bipolar | LIMITED INFORMATION |
| GYNECOLOGICAL | SEXUAL ORIENTATION ISSUES | |
| (Not detailed here) | AA Homosexuality & Bisexuality | |
| | AA Gender Dysphoria | |

HUMAN SEXUALITY SUGGESTED READINGS

BOOKS ABOUT MALE SEXUALITY

The New Male Sexuality. Bernie Zilbergeld
PE: How to Overcome Premature Ejaculation. Helen Singer-Kaplan
Sex for One. Dodson, Betty, Crown Trade Paperbacks, 1996.

BOOKS ABOUT FEMALE SEXUALITY

For Yourself. Lonnie Barbach
For Each Other. Lonnie Barbach
Shared Intimacies. Lonnie Barbach and Linda Levine
Sex for One. Dodson, Betty, Crown Trade Paperbacks, 1996.
Womens' Experience of Sex. Sheila Kitzinger
My Secret Garden. Nancy Friday
Forbidden Flowers. Nancy Friday
When a Women's Body Says No to Sex: Understanding and Overcoming Vaginismus. Linda Vallins, Penguin Books, USA
A Woman's Guide to Overcoming Sexual Fear & Pain. Goodwin, Aurelie Jones and Agronin, Marc E., New Harbinger Pub. Inc., 1997
A Whole Lesbian Sex Book. Newman, Felice, Cleis Press Inc., 1999
Lesbian Sex, Loulan, Jo Ann, Spinsters Ink, 1984

BOOKS ABOUT SEXUAL COUNSELLING

The Magic of Sex. Miriam Stoppard, Random House, 1999
In Touch: Putting Sex Back into Love and Marriage. Beryl and Noam Chernick
Couple Sexual Awareness: Building Sexual Happiness. Barry & Emily McCarthy, Carroll & Graf Publishers, 1998

BOOKS ABOUT RELATIONSHIPS

The Seven Principles for Making Marriage Work. Gottman, J.M., Silver, N, Three Rivers Press, 1999
The Dance of Anger. Harriet Lerner, Harper & Row
Getting the Love You Want. Harville Hendrix, HarperPerennial

AGING AND SEXUALITY

The New Sex Over 40. Saul H. Rosenthal, Penguin Putnam Inc., 1999
Love and Sex After Sixty. Robert N. Butler and Myrna Lewis

Sexual Health in Later Life. Thomas H. Walz and Nancee S. Blum

BOOKS FOR PROFESSIONALS

The New Sex Therapy. Helen Singer-Kaplan

Disorders of Sexual Desire. Helen Singer-Kaplan

Women Discover Orgasm. Lonnie Barbach

Becoming Orgasmic: A Sexual Growth Program for Women. Julia Heiman and Leslie and Joseph Lopiccolo

Textbook of Sexual Medicine. Kolodny and Masters and Johnson

Sexual Medicine in Primary Care. Maurice, W.L., Mosby Inc., 1999

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14. Modified with permission (Ward R) from: Ward R, Basson R, Elliott S. The Sexual History summary sheet in: University of Calgary Mainpro-C Program for Male Sexual Dysfunction 1999.