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# Erectile Dysfunction

## Sexual Therapy and Sexual Counseling in the Sexocorporeal Approach

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## Table of contents

<b>Introduction</b> .....	<b>4</b>
Base elements of male sexual health .....	4
Masculinity and erection problems .....	8
<i>Development – men’s journeys</i> .....	8
<i>Development of masculinity in the sexualization process</i> .....	10
<i>Security in the experience of one’s own masculinity</i> .....	11
Insecurity in the feeling of affiliation with the male sex .....	14
<i>The hyper-masculinoid man</i> .....	14
<i>The hypo-masculinoid/hypo-genital man or “fusion type”</i> .....	17
<i>“Shape-shifters” – mixed forms</i> .....	19
The male journey / maleness in the course of life .....	20
Evaluation of the basic elements of male sexual development .....	22
<b>Understanding of erectile dysfunctions with Sexocorporel</b> .....	<b>23</b>
The physiological components .....	25
“Functioning” or “Eroticizing”?.....	26
Individual risk factors for the erection .....	30
<i>Physiological components and ED</i> .....	30
<i>Sexodynamic components and ED</i> .....	32
<i>Cognitive Components and ED</i> .....	33
<i>Relationship components and ED</i> .....	33
“Vicious Cycle“: Reactions to ED with self-reinforcing effect .....	33
<b>Clinical presentation of erectile dysfunction</b> .....	<b>37</b>
Lifelong Erectile Dysfunction .....	37
Acquired Erectile Dysfunction .....	38
<i>Profiles of men with acquired and/or situational ED</i> .....	38
<i>Men with specific problems directly associated with the arousal mode:</i> .....	40
<i>ED in men with problems of narrow or exclusive attraction codes</i> .....	41
Diagnostics and Evaluation of ED .....	44
<i>Cognitive Components</i> .....	44
<i>Physiological components</i> .....	45
<i>Emotional components</i> .....	48
<i>Relationship and partner sexuality</i> .....	50
Diagnostic and logic of the system .....	50
Sexual Counseling and Sex Therapy.....	50
<i>Therapeutic setting</i> .....	50
<i>Conveying knowledge</i> .....	50
<i>Medical treatment options</i> .....	51
<i>Establishing sexual functionality</i> .....	54
<i>Relationship skills</i> .....	58
<b>Special counseling situations</b> .....	<b>60</b>
Men in advanced age.....	60
<i>ED after radical prostate operation</i> .....	63
<i>ED in coronary heart disease, heart attack</i> .....	64

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<i>ED and Diabetes</i> .....	64
<b>Appendix: Arousal Modes</b> .....	<b>65</b>
Archaic Arousal Mode (AM) .....	65
Mechanical Arousal Mode (MM).....	66
Archaic-mechanical Arousal Mode (AMM).....	66
Vibration induced Arousal Mode (VIM).....	67
Undulating Arousal Mode (UM) .....	67
The arousal mode in waves (WM).....	68
<b>References</b> .....	<b>70</b>

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# Erectile dysfunctions

## Introduction

### Base elements of male sexual health

#### Sexuality

Sexuality is a part of being human from the earliest childhood on. It is subject to individual learning steps and cultural developments and therefore to lifelong changes. Primarily based on a biological survival instinct, sexuality depends on learned abilities to allow the integration of all kinds of needs and to serve the regulation of affect and the creation of a relationship to oneself and others. Sexuality enriches our lives from “making love” to “having sex”, or it imposes on us, troubles us. We experience sexuality with animalistic urge, as overpowering, as disturbing, banal, as a cause for suffering, longing, lustful, as self-enriching desire, as a most intensive fusion, as play, etc. Sexuality confronts us with our own limitations and contradictions and, like a well-lived life itself, requires us to take time, to learn from experiences, to search.

Sexuality is a construct, and not the hormones, albeit indispensable, are what drives us.

#### Man and Erection

Sexual functionality of the male, his masculine “potency”, comprises erection (penile engorgement), ejaculation (emission of semen) and the capacity to procreate (fertility).

Sexual failure, the “can’t get it up anymore” is something that threatens men. It throws them into the abyss of no longer “being a man”. Once a lame loin’s misery, the “limp dick” is currently sublimated to *erectile dysfunction* (from lat. *erigo* = erect). To erect the penis and to erect oneself within one’s masculinity remain connected for a long time in a man’s life, and thus erectile dysfunction always affects both of these components.

#### **“I GET IT UP – THEREFORE I AM”: ERECTION AS THE MALE “IDENTITY CARD” (*erigo ergo sum*)**

Jean-Yves Desjardins, who developed the Sexocorporel approach that this paper is based on (Desjardins et al, 2010), described man as a “Giant with Feet of Clay”, referring to the close relationship of masculinity with genital functionality and therefore the dependency on a physiological occurrence not subject to deliberate control. Premature ejaculation, the inability to come (anejaculation), and - even worse - the threatening loss of sexual arousal, becoming limp in the wrong moment (ED) - all these conditions epitomize the out of control penis as narcissistic injury and as derogation of sexual self-assurance. Affected men feel like a loser. They devalue themselves, experience shame, guilt and despair to the point of depression. Fear of failure is breathing down their necks and provokes them to ever increasing desperate “rescue efforts”: They try to establish an erection through harder rubbing, pressing and other physical techniques as well as intensifying all kinds of emotional stimulants and fantasies. In France, this search for increased stimulation is referred to as the “demon of midlife”.

This fight for survival in one’s male identity, carried out at the level of sexuality, is reflected in the efforts to get the penis “to function”. As a male form of “praying”, these efforts are self-pacifying and reduce the existential fear that accompanies ED. For many men, sexuality stops being pleasant. It may take on compulsive traits. Others, less offensively, compensate by burying themselves in their jobs.

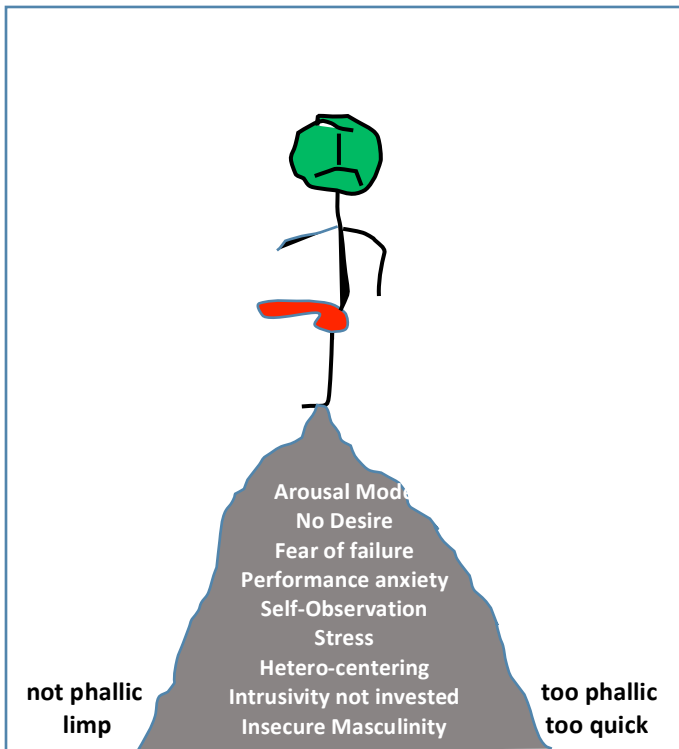


Fig. 1: Man and phallic fears

Feeling insecure or ambivalent about one's affiliation with the male sex inversely also promotes erectile problems. The smaller the bases of masculinity, for whichever reasons, the more desperate is the search for sexual arousal in an effort to once again "erect" masculinity. Some men jeopardize their self-respect developing extreme rituals in their search of sexual stimulation: a compulsive consumption of sexual services, hours of lingering on websites with pornographic content, an escalation to harder porn or the search for sexual arousal in increasingly extreme scenarios in which the partner plays a mere symbolic role and which paradoxically often result in partner ED. This desperate survival struggle of masculinity is often misunderstood as "perverse".

Increasing insecurity leads to an increasingly distorted view of one's own sex. The conviction of having a too small, deformed, flawed or damaged penis mirrors the distress. Erectile dysphoria (Martin 1998) describes this concern with the penis and its function - a vague sentiment of dissatisfaction with the erection. Perception of the partner's genitals is equally impaired. With increasing insecurity, the partner is seen as threatening or idealized as the savior to cling to.

Men find security from early childhood on in the relationship to their genitals. Consider small boys who

comfort themselves talking to their penis, who straighten themselves up and intensify their awareness. Most of them also early in their play develop a symbolism geared towards their genitals' swelling, rising and "pointing-outward" (e.g. fighting, shooting, or playing with weapons). This behavior, which is also fostered by androgenization (impact of the male sex hormones), is supported by social attributions to masculinity and by its medial representation. Play with the increasing and decreasing swelling of the penis, role play, heroic tales, identification with ideals as well as actual experiences condense themselves to the male identity within the feeling of affiliation with one's own physical gender. Later on we will take a closer look at the male sexualization process.

Men with erectile problems often do not cultivate the relationship with their penis. Instead, they regard it with disdain. They do not want to be reminded of its ailing failure and devalue their limp penis as a "ridiculous skin attachment". Along the same lines, in the book of Ben Jellouns (1989), men describe "impotence, this deepest loneliness", as death that begins between the legs. The dying of masculinity means to succumb to the shame of unmanliness.

The most common concern of men in regards to their sexual health is the penis' inability to erect- the older, the stronger the concern.

**The question is not *if* a man will have an erection problem someday. The question is *when* it will appear.**

It is normal to have a fluctuation in the strength of erection during a longer lasting sexual activity. Physiologically, it is even necessary to secure and support the blood and oxygen supply. Young men hardly notice it. With increased age or medical problems erectile variability increases and becomes noticeable. It threatens men, particularly those who perceive their penis only during a blazing erection. The words of a 60 year old: "Earlier I could crack a nut with it, and today it just hangs low." This can start a vicious cycle of performance anxiety and fear of failure mutually reinforcing each other. This vicious cycle is the most common cause of ongoing erection problems.

The loss of the ability to "self-erect" represents a crisis in two senses:

- The relationship to the penis and handling it becomes problematic

- It has an unsettling effect on the self-awareness as a male
- This pivotal experience quite often triggers a relationship crisis in the couple

### Sinful phallus



Fig.2: Phallus

*The “high” song of love and the “low” song of sexuality (Sigusch 2005):*

Our culture’s difficult relationship with sexual pleasure is deeply rooted in the dualistic thinking of the ancient world (body/spirit and nature/culture as oppositions). This tradition continues with the monotheistic concept of a single genderless God who consummated the act of creation through words, in contrast to the sexual intercourse between God and Goddess in polytheistic religions. Genitals beyond the Middle Ages were always represented as symbols of evil and sin, in the form of monsters. In order to protect their values from the “above”, the monotheistic religions created standards that lead to a separation of genitality (“below”, animalistic) and love, compassion, spirituality etc. (“above”). It is difficult to this day to think of or verbally express the fundamental unit of the body and the brain, of the person as a whole.

The “below” was seen as source of all crimes and reprehensions, e.g. described in the bible in Sodom and

Gomorrah. This disapproval of genitality, this mutilation through prohibition of all that does not serve procreation is experiencing a renaissance today. For example, a growing number of North Americans are committing to premarital sexual temperance or abstinence outside of procreation (Herzog 2008).

Thanks to de-mystification, to the reduction of sexual prohibitions and to gender equality, sexuality became more natural and mundane in the second half of last century. Sex is now no longer a heated and “difficult to control” impulse driven by prohibitions. It is generally accepted that young people, children and older people are sexually active. That is the positive side (Schmidt et al 2006). Yet we are all still subtly permeated with negative assessments of sexuality. Genitality is still being curtailed, is still under suspicion, genital learning is rarely promoted, and there is a dearth of erotic culture. Many subtle prejudices penetrate our thinking without us being aware of it. The World Association of Sexology’s definition of sexual rights stands for an ideal which still awaits realization.

This ongoing ambivalence is reflected in the attitudes towards erotic displays devoted to the explicit representation of genitals and sexual actions, a.k.a. pornography. Here, the anti-sex discourse subtly hides behind criticism of the alleged misogyny of pornographic representations and behind moral outrage and media excitement over the depravity of the adolescent porn consumer (see Schmidt: “Fantasies of the Young, Phantasms of the Old”, 2009).

Sex remains a “problem generator” of social anxiety over changing popular themes. Sometimes, emotional themes are causing outrage: rape, porn, prostitution, child abuse. Or sexuality becomes the bone of contention in “scandals” of celebrities. Good topics for media processing are sex addiction, children as sexual perpetrators, sex in public - but also casual sex with random partners, early sex in adolescence, and even “cheating” sell well (Levine 2002). Our intent is not to belittle real existing problems but to question their misuse to demonize sexuality.

There has never been such an imbalance between the public flaunting of sexuality (ranging from the internet to reality shows and the platitudes of “sexperts”) and the resistance and inhibition to talk about one’s own sexuality in a private setting. The erect penis must furthermore be publicly obscured because it becomes a projection field for negative aspects of masculinity, as we will explain later on.

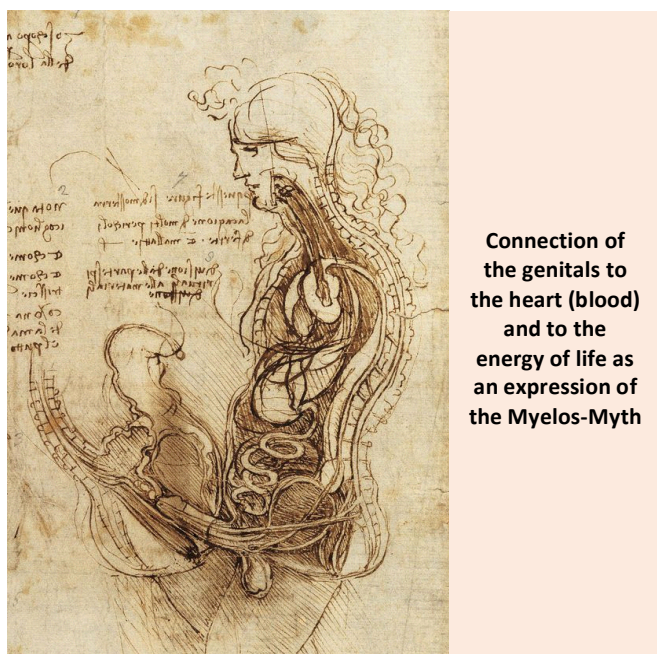


**In reality, male and female genitals are the basis of gender affiliation. They serve the creation of life, are areas of lustful self-talk and are at the center of passionate to banal encounters with other people.**

### Medicine and Penis

Science has been interested in the penis, this “weak point” of man, for centuries.

Already the Pharaohs’ Egypt knew means of treatment for impotence (prescription 663 Papyrus of Ebers). In *De aere aquis et locis*, Hippocrates mentions the Scythians’ high incidence of impotence and infertility as a result of perineal trauma due to excessive horse-back riding. In the 2<sup>nd</sup> century, Galen describes the muscoli erectors penis (M.bulbospongiosus, Mm. ischiocavernosi).



**Connection of the genitals to the heart (blood) and to the energy of life as an expression of the Myelos-Myth**

Fig. 3: Coitus of man and woman in sagittal section by Leonardo da Vinci.

From Hippocrates to Galen to Arab doctors all the way to Leonardo da Vinci it was assumed that *pneuma* (Greek for “the spirit”, “the breath”, “the air”) was responsible for the swelling of the penis. At the beginning of the 16<sup>th</sup> century, Leonardo discovered intensified blood flow as the trigger of erection. In his drawings he also confirmed the Myelos-myth, which can be found in many cultures (lat. *medulla spinalis*, Greek *myelos*): the equation of brain, spinal cord and sperm with the energy of life, and, in consequence, the ideology of frugal management of ejaculation (Benz

1989). Furthermore Leonardo da Vinci postulated another passage next to the urethra through which the soul of the child was passed during procreation.

Da Vinci observed the incongruence of the male “wanting to” and factual “being able to” and explained it by an autonomous function of the penis. According to da Vinci, the penis was equipped with an own will. He writes in “*Della Verga*”: “...it appears as if this creature commands a life independent of the male, possesses its own intelligence.”

Just like in the book “Me and Him” by Moravia (1988), the penis becomes the alter ego, represented and named as miniature-man. A kind of parasitic homunculus, attached to the male body, it has its own brain and a special carnal intelligence. This penis brain is usually conceived in opposition to the rational conscious control of the head brain. It follows its own goals, which gives rise to the battle of both wills between the man and his penis pursuing different intentions.

The discovery of the effect of NO (*nitric oxide*) as neurotransmitter on smooth muscle fibers of the cavernous bodies brought the 1998 Nobel prize to Furchgott, Ignarro und Murad. It lead to the development of **Sildenafil** and other *phosphodiesterase-5-inhibitors* that could be applied orally. Unlike injectable prostaglandins, they demand sexual stimulation and arousal sources. For many men with erectile dysfunction they represent effective aid.

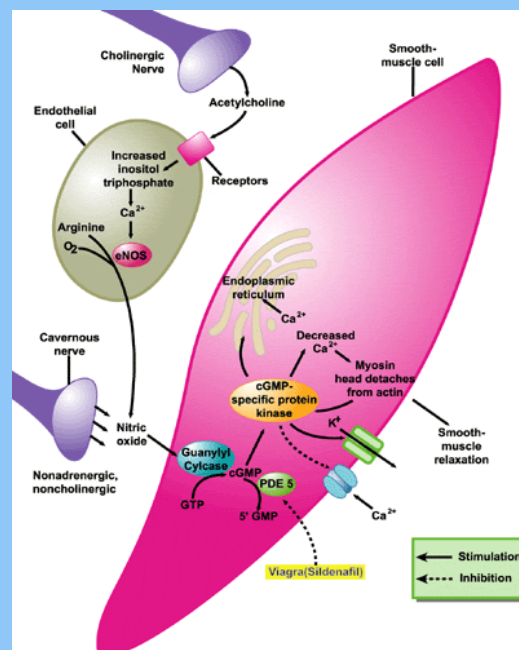


Fig. 4: Nitric Oxide as a neurotransmitter

Medical contributions and efforts to breathe life into the failing penis and into the procumbent masculinity were varied and, for a long time, mostly unsuccessful. For example, in 1889, Brown-Séquard experimented with androgen therapy by injecting blood from testicular veins and testicular extract from young and strong dogs and guinea pigs. The testosterone level was then found to be so low in his extract that the effect was deemed placebo. In 1981 in Paris, the urologist Virag (1984) succeeded for the first time in triggering a “pharmacological” erection through the injection of papaverine or prostaglandin E into the cavernous bodies. It was now possible to produce an erection that was independent of sexual desire, fantasies and other arousal sources.

On the one hand, the scientific look at the molecular biological processes within the erectile tissue allowed for the development of new and helpful treatments that enriched sexual medicine (Lue 2004). On the other hand, Sexocorporel researched new sexual learning steps, aiming at understanding the integration of the arousal reflex into physical, cognitive and emotional relationship skills.

### **Masculinity as a social problem**

Christoph Kucklick (2008) in his German book “The immoral sex. On the origin of negative andrology” impressively describes the discomfort about masculinity that arises in modern times. From antiquity up to the 18<sup>th</sup> century, certain forms of masculinity were presumed to be guarantors of social order. In fact, the Latin word *virtus* (virtue) is derived from *vir* (man). But since the 18<sup>th</sup> century, pressing social problems such as violence, profit, greed, insensibility, objectification and inability to love were increasingly attributed to men. Nowadays, men lead wars, disturb the social order and misbehave.

The sociologist Anthony Giddens (1991) expressed the opinion that society is not threatened by crime and violence, but by masculinity. Man deteriorates society and woman heals it. Periodically a demand for the new man emerges, rooted in the resentment against the old one. Man as a species is being questioned and with it the idea of masculinity in itself.

The current discourse about violence and abuse puts men as fathers or teachers under general suspicion and reinforces a negative perception of masculinity in public. While this may also be a shameful reality, the latent misandry threatens to become a societal problem (Hollstein: “What’s Left from the Male”, 2008). The

downside of traditional masculinity is its unattainable ideal of the always active, potent and self-assured man (Bönisch 1993). Bernie Zilbergeld (1999) also addressed such myths about men in *The New Male Sexuality*.

## **Masculinity and erection problems**

### **Development – men’s journeys**

The polarity of the two sexes is internalized in every culture. Each child is urged to develop characteristics that are ascribed to its own gender and to suppress or deny those that typically apply to the opposite sex. Growing into manhood therefore means relinquishing a part of human characteristics, behavioral patterns and experiences as they are ascribed to the female. Even if this contradicts real life, in general *masculinity* is culturally associated with characteristics like rational, protective, aggressive, and dominant, while *femininity* is associated with emotional, caring, receptive, and adaptive. In reality, within Western industrial society, men express their masculinity on this stereotypical level in increasingly different ways.

#### *Some differences between boys’ and girls’ socialization*

Boys much more than girls are consistently hindered at displaying gender inappropriate behavior. Especially cross-gender behavior is a quite rigorous taboo. Homoerotic relationships and homosexuality are still sanctioned frequently for their imagined threat of emasculation. Boys growing up and adult men continually have to prove their masculinity.

The normative male socialization leans on the feeling of shame: Becoming independent of the mother is professed as a development objective, instead of hanging on her apron as “mama’s boy, sissy, wuss”. This socially required separation from the mother acts as a cultural coercion to negate the longing for the security experienced in early childhood.

With the image of a bridge I would like to symbolically represent both the development of a male identity within a particular society as well as the psychological development. The internalized path over the bridge – from mother’s (women’s) land to father’s (men’s) land – will decide if and how sexuality will be



available to this man as a resource for experiencing himself and for his forming of relationships, as well as how flexible he can manage his masculinity in an intimate relationship.

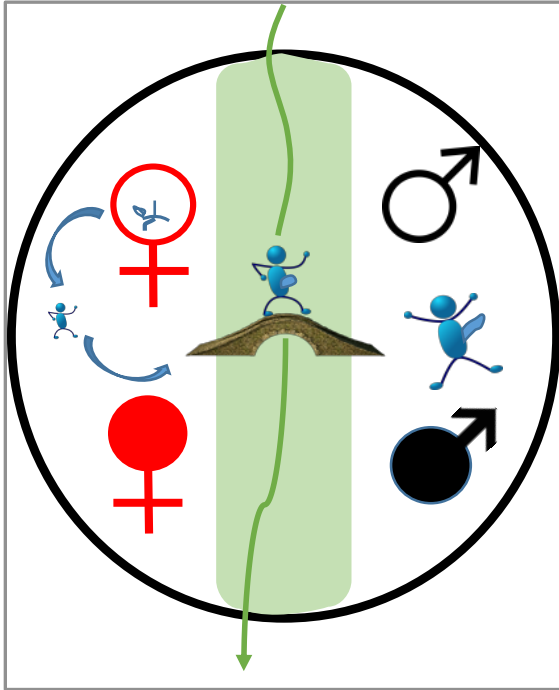


Fig. 5 Sexualization process of the male

Earlier ideas like the dis-identification theory (Greenson 1968) reflect a patriarchal point of view: It is crucial to men not to identify as women. A gender identity that is based on rejection of the feminine, however, remains unsure.

We assume that biological, androgen-dependent gender-specific characteristics already influence the very first perceptions of the male fetus (unity of body and brain). Furthermore, to be born in a male body also generates gender-specific reactions of the environment. Both factors influence the developing feeling of affiliation with one's own physical sex. Early formative influences consist of the boy's interaction with his bonding figures, his relationship to his genitals, his capabilities to regulate emotions, but also cultural norms. His own individual reactions, predetermined through his psychodynamics, to all these factors and their interaction with his biological development are also of importance.

The feeling of manhood does not develop linearly. Men and boys experience it in various phases of critical development. The boy's journey from a male body to a masculine identity requires the integration of being different than his mother. In order to evolve within his masculinity he must maintain and transform the relationship to his mother. This requires a partial and often painful parting of the idea of being able to be the mother or to belong to her gender. The more accessible the father or other important male figures, the more successful this endeavor will be. Through the relationship to a father whom he admires, who deals with him and guides him with care, the boy can absorb impressions that unite both active, "penetrating", and "receptive", caring characteristics as a basis of a healthy and flexible masculinity.

To assume gender identity is more difficult for the boy than for the girl. Masculinization remains tainted with the risk of contamination by the female, through the boy's feminine identifications, his longing to be like his mother and longing for the earlier feeling of security with her. Later, this is reflected in the fear of many men not to be enough of a man, not to live up to their ideal of masculinity. The fear of loss and its opposite, the fear of being monopolized again by the mother, is only lessened after multiple attempts of withdrawal and reconnection. The resolution of this "fusion complex" (Crépault 1997) allows the boy to individualize from the mother without fear of loss - and it allows the man to engage in an affective relationship with a woman without the fear of losing his identity and freedom.

When the adolescent, in search of his own identity, differentiates from his family, it is helpful if the parents are able to bear this detachment and to deal with the resulting emotions and pain. Having his masculinity accepted by the peer group is also important. For this, his sexual skills play a pivotal role. When the young man begins his "heroic journey" into the world and enters into intimate relationships outside the family, it is important that fatherly mentors accompany him. M. Diamond (2007) describes the lifelong significance of the father-son relationship in his book *My Father Before Me*.

***Anatomy is not only fate:******What the boy and man make of it is decisive for the fate of his masculinity.***

The sexualization process plays a central role on the journey over the bridge. It comprises the integration of the arousal reflex into physical, emotional, intellectual and social learning steps. If this development is successful, it will contribute to the development of personality and enrich relationships. Sexual learning begins with birth and lasts lifelong.



**Fig. 6: Ultrasound in 18<sup>th</sup> weeks of pregnancy with recognizable erection**

## Development of masculinity in the sexualization process

The genitals and foremost the penis, with its sensations and the reactions it triggers in others, play a central role on the journey over the bridge into the men's land, towards a male identity. Touching and playing with it conveys support, consolation and helps to endure loneliness. Presenting the erect penis fills its owner with pride, even exhilaration, sometimes bordering on feelings of omnipotence and invulnerability. Yet experiencing that this fascinating swelling and detumescence is not subject to the boy's deliberate access causes insecurity. The feeling of belonging to his physical gender is the end of a long journey paved with

the boy's fear of losing this penis through running or swimming, since it has a life of its own. Or some evil power could take possession of it. We encounter these fears around their penis with most men. They are reflected in jokes and myths. E.g. in the Far East a goddess collects penises at night; or the penis that retracts into the belly (Koro = "shriveling penis", described as "genital retraction anxiety") or the penis that will be bewitched, etc.

### Definitions:

**Sexual identity = biologically predetermined, i.e. genetically defined as xy, xx, or intersexual variations. The sexual arousal reflex is part of it. Feeling of affiliation to one's physical gender = subjective perception of sexual identity, i.e. the ability to feel one belongs to one's own sex. It is essentially based on the sexual archetype and its eroticization, the sexual stereotypes, and sexual self-assurance.**

**Sexual stereotype = Assignment to a gender from a respective societal point of view: A "masculinoid" man shows "typically" male characteristics in regards to physique, interests and behavior, where as a "feminoid" man is distinguished by characteristic traits which are ascribed more to the female gender. Today there is a much broader spectrum of possible ways to live being a man.**

The process of sexualizing – becoming sexualized – takes a spiral course just like the development of socialization or intelligence. Sexual functionality on a personal and relationship level is mastered through learning, discovering, verifying, repeating and consolidating. Age specific sexual games support this development. They allow the integration of the different interacting components of sexuality.

Paying attention time and again to one's genitals and their excitability strengthens the feeling of masculinity. Likewise, regulating emotional tensions with this genital play, sexual play alone or in sexual engagement with other boys or girls all support the feeling of gender affiliation, individualization and

development of autonomy. To recognize and accept gender difference, e.g. while “playing doctor”, helps to embed one’s own gender in reality. Sexual behavior, lustful emotions, curiosity, fascination and the ability to talk about “it” are learned this way.

The journey from “having genitals” to “having a feeling of affiliation to one’s own gender” consists of a long chain of experiences with an erect penis alone and in relationships with both genders. Following are links of such a chain:

*How was it called? How welcome was it? What did I call it? Memories of the swelling and detumescence, of games with it, memories of warm feelings, first discharge, dialogues with it, reactions of the surroundings. And the balls? Comparisons with others, peeing games alone, with the father, games with others, boys, girls. Experiencing the changes of puberty. First ejaculation: how, where, when? The construction of masturbation, physical techniques to increase arousal, accompanying fantasies. Types and frequencies of touching, erections in everyday life. Comparisons with others. Its significance for being a man. Sexual games alone, with others. To hand over the penis, allowing it to be touched. The “first time”. Experiencing the penis, too big, too small, crooked, beautiful, stinking, dripping, ejaculating too rapidly or not at all, not hard enough. Experiencing the female genitals, the genitals of another man, the penis inside of a vagina, in the mouth, in the anus. Expressing one’s sex through posture, look and language. To be a father of a boy, procreate, use contraceptives. Awareness of penis in different conditions, soft, hard, warm, swelling, firm, explosive, squirting, pulsating. Talking with other men. Fear that it might fail. Shame with first experience of ED. Changes in the handling of the penis, in the relationship to it in getting older.*

On the journey over the bridge, the majority of boys engage in games and behaviors in which intrusivity and penetrating are practiced. Movement patterns outwards and away from the body – like fighting, kicking, or shooting – figuratively thrust and penetrate in accordance with the direction of the erect penis. They are expressions of the developing archetype. The

**sexual archetype** allows for a “reproductive sexuality”. It is based on the physical sex, on physiologically programmed erections and hormonally controlled functions like ejaculation and libido<sup>1</sup>. Through sexual learning and eroticization of male “**intrusivity**” (=the ability to penetrate), the archetype evolves into the supporting pillar of male identity. It is symbolized in posture, attitude, language, and gaze as an expression of male “phallicity” (=proud ownership of a phallus, a potentially erect and eroticized penis). It enables the eroticization of others and the development of coital sexual desire.

These phallic tendencies, which are established in the symbolic play of the little boy, will be redesigned, adjusted, integrated and changed throughout the entire development of the male. They are decisively involved in the subjective perception of manhood.



Fig 8

## Security in the experience of one’s own masculinity

A secure feeling of masculinity can show itself in many ways: in how the man advocates for his wishes, ideas and goals, in his joy about bodily pleasures, in his enthusiasm, in the flexible handling of hierarchical relationships, in his rivaling in the sense of competing and competence. Also in his capacity to create relationships and intimacy with others and to allocate equal importance to his own satisfaction and the satisfaction of his partner. Added to this are age related

<sup>1</sup> We define libido not as sexual desire, but as the biological drive to ejaculate. Sexual desire is much more complex in that it encompasses biological, emotional, cognitive and relational elements.

characteristics like the desire for a lasting relationship, a higher appreciation for self-awareness, as well as a reduction of the fears associated with psychological sensitivity and vulnerability.

***Phallic eroticization is an important element of male sexuality***

Arousal habits play a pivotal role in the experience of sexuality (Chatton et al. 2005, Bischof 2012). An integrating ***arousal mode*** (*arousal mode in waves*) is a requirement for phallic eroticization. Thanks to flowing movements, the man can sensually experience his whole body. With pelvic movements (the pelvic swing), the man can modulate the intensity of his thrusting according to his needs. Thus, he can perceive himself as strong in his masculine intrusivity and symbolize it in internal images (eroticization of the archetype of penetration). He can experience his sexual arousal with pleasure, enrich it with multiple fantasies and connect his genital and emotional needs. A further element of phallic eroticization in autoerotism as well as in relationships is ***sexual self-assurance***, which comprises feeling comfortable in one's own body, enjoying to present oneself to one's partner as an aroused man (***sexual exhibitionism***), and experiencing oneself as lovable and sexually desirable (***sexual narcissism***).

This phallic eroticization of his own masculinity also opens the man's eyes for others, supports the eroticization of others, of their bodies, genitals, character traits and sexual and emotional expressions. Thus, he can eroticize closeness and distance on the basis of his own autonomy. It opens a broad spectrum of erotic relationship skills and diverse sexual games that also include body orifices and inner sensations, in order to ultimately have the choice between fucking, love-making and other own creations.

**Introduction to the Sexual Arousal Modes** (for a comprehensive description see end of this article)

Jean-Yves Desjardins observed that humans from childhood on tend to employ their bodies in preferred and repetitive patterns during sexual arousal that influence the perception and the emotional experience of this arousal (Bischof 2012, Chatton et al. 2005). There are essentially 6 different arousal modes, with different consequences for the sexual experience. Some persons use more than one mode, and the described patterns may be more or less rigid.

**Pressure or Archaic Arousal Mode:** Pressure on penis / perineum / groin, squeezing parts or all of the penis with hands or objects, lying down on it, bending it down and squeezing it between the thighs, or rubbing it using great pressure with fingers or fist. High muscular tension, body often stiff and immobile. Orgastic discharge is often brief and focused, and the ensuing release of muscle tension is perceived as relaxing and pleasurable. With very strong pressure or pelvic floor tension, ejaculation may occur with a soft or partially erect penis, the sperm flow may be slow. In partner sex men may find the pressure exerted by a vagina or mouth on the penis to be insufficient and prefer anal intercourse, or use a hand to press on the base of the penis. Coital erectile dysfunction may begin at a young age. Stimulation through fantasies, role plays and other mental sources of arousal may help if physical stimulation is not intense enough to suit the pattern. (See Perelman 2001 for a description of men with this arousal mode and ensuing anejaculation.)

**Mechanical Arousal Mode:** Stimulation of superficial nerve receptors through rapid friction of the penis or parts of the penis. The stereotypical rubbing motion can be done with little conscious investment, automatically – hence “mechanical”. Stimulation may start out more slowly and varied, and increase as arousal mounts, to show its typical rapid uniform pattern during the last minutes of the arousal curve. Mounting muscle tension. Stiffening of pelvis, legs and abdomen, with interrupted, short breathing.

Typically, during masturbation the body is immobile while the hand does all the work. Usually, rapid and efficient increase of arousal to an orgastic discharge. In intercourse increasingly rapid thrusting motions of the whole torso “en bloc”, possibly requiring a vagina that supplies sufficient friction, i.e. is sufficiently tight, not too moist. Some men may prefer anal intercourse for its greater friction.

**Archaic-Mechanic Arousal Mode:** Archaic mode with additional mechanical friction of the penis.

**Vibration induced arousal mode:** Stimulation with high frequency, by vibrator or water jet, usually in a body with high muscle tension similar to the archaic arousal mode. May be limiting in partner sex, if the stimulation ritual follows an exclusive pattern.

**Undulating arousal mode:** Comes with a high degree of pleasurable sensations. Respiration flows freely. Movements of whole body, often slow and deliberate, to obtain maximum pleasure from motion and contact. Not geared toward orgasm, as the state of arousal itself, even if not particularly high, is so pleasurable that it can be fully satisfying. Typically rather lower muscle tone, so we find this mode more in women than in men, whose muscle tone physiologically is higher.

**Arousal Mode in Waves:** movement *in* vertical axis (“double swing”): pelvis tilts so the penis moves forward during expiration and backward during inspiration in a swinging motion (“pelvic swing”). Neck and jaws relax and the sternum collapses during expiration (“upper swing”). The double swing includes the spine arching backward during exhaling and inward while inhaling, with the neck doing the respective opposite. Movements of the mode in waves are of varying intensity, amplitude and rhythm. They solicit superficial and deep sensitive nerve receptors in all of the body, with a focus on the genital and pelvic region, enabling high degrees of sexual pleasure and allowing to steer the increase of sexual arousal both during self-stimulation and during partner sex to a powerful orgasm.



## Insecurity in the feeling of affiliation with the male sex

Schematically, two poles can be distinguished within the spectrum of “normal” masculinity:

- Men with an indication of “too much” masculinity: *Hyper-masculinoid<sup>2</sup> men*
- Men with an indication of “too little” masculinity: *Hypo-masculinoid men*

As always, let’s keep in mind that, in reality, we will find *mixed forms*, as human diversity lies beyond typology.

One thing these men have in common is the limited relationship with their sex – a limited relationship with their penis due to their arousal mode, and insecurity in their feeling of gender affiliation. While they may be able to stabilize their masculinity with the help of other pillars like their profession, their role as partner or father and their social activities, this will only compensate for their restricted sexual self-confidence, but it will not change it.

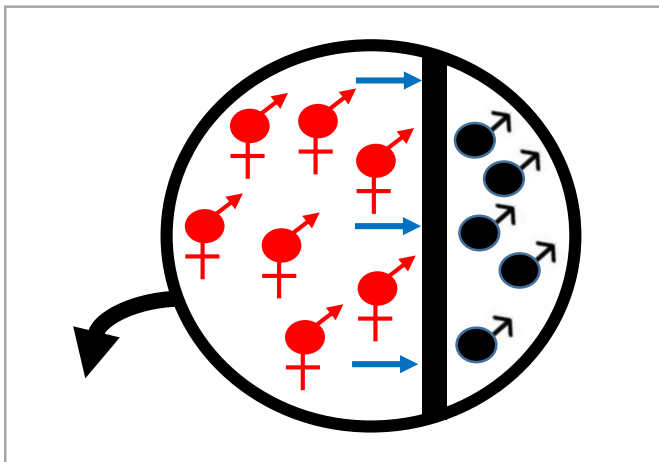


Fig. 9a: Hypo-masculinoid man

### The hyper-masculinoid man

This includes a wide range of men, from the “intimacy-fugitive” to the man with good bonding and loving

<sup>2</sup> We use the terms *masculinoid* („man-like“) and *feminoid* („woman-like“) in reference to characteristics that can occur in both sexes but are culturally attributed only to men or to women respectively.

ability. His fear of being unmanly is reflected in his strongly emphasized masculine attributes.

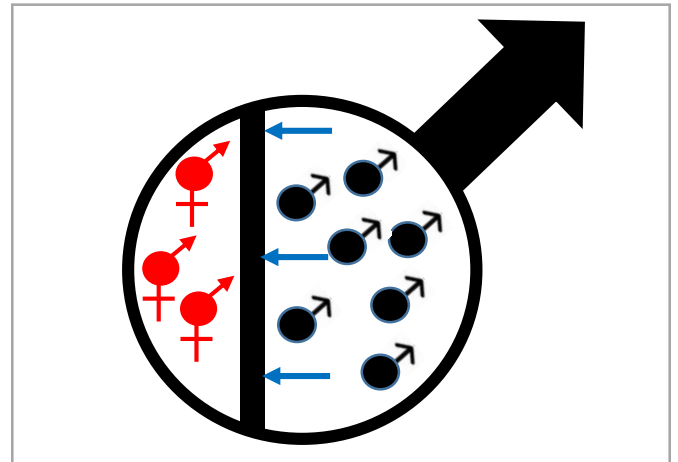


Fig. 9b: Hyper-masculinoid man

The lacking eroticization of the archetype (missing “inner erecting” of masculinity) is compensated by the accentuation of the stereotype (enhancement of outer aspects of masculinity). He goes by the principles of the cowboy, the rebel, who subordinates and attaches to no one. He is a conqueror, a nomad who looks for the adventure. Bodybuilding, for example, can serve to compensate for the insecurity in the experience of his masculinity. A common worry concerns the allegedly insufficient penis size. He is insecure in the *feeling of gender affiliation*, his *archetype* is intrusive, but not eroticized. He believes not to suffice as a man, fears “feminoid” attributes like emotionality, and especially fears to move fluently (i.e. giving up muscular tension). His concerns circle around such “fears of emasculation”.

Other men are perceived as potential rivals. Relations are characterized by competition, domination and rivalry. The demonstration of phallic aggressiveness serves as proof of masculinity.

With women he seeks sex for superiority and activity, not for fusion. He avoids intimacy, emotions, has a difficult time trusting, and often shows a strong need to control. In his innermost self he feels unable to love, fears dependency and believes that he is not lovable. He desires sexually attractive, feminoid women (to demarcate a clear gender difference), but is insecure because of their sexual potency and fears they might prefer a stronger rival.



While the woman he sexually desires increases his fear of “emasculated”, he fears to be too “masculine” (aggressive) for the woman he loves. It is also difficult for him to sexualize his longing for love. He often finds women who attract him emotionally to be out of reach.

*His sexuality is all about genital needs and his enjoyment of “functioning”.* In this “physiological” version of sexuality, the focus is on experiencing the relaxation that comes with ejaculation. In contrast, the journey to increase arousal is often considered “work”. Both in autoerotic and in partner sex, this is in connection with the **archaic arousal mode** (AM), the **archaic-mechanic arousal mode** (AMM) and also the **mechanic arousal mode** (MM). Because of their high muscle tension, these arousal modes leave little room for pleasurable enjoyment (Bischof 2012). To let go of muscular tension, to move fluently and to allow emotions – all this is equated with unmanliness. While this man may retain a good sexual function for a long time, he runs an elevated risk of erection problems with aging due to the limitations of his arousal mode, the performance orientation and lack of eroticization.

In case of heterosexuality, his *fantasies* frequently depict his superior masculinity, penetration and ejaculation on the breasts or in the mouth of a depersonalized woman – all this confirms his sexual potency. This potency is staged with attributes of strength, domination, big penis, penetration from behind etc. Femininity is represented as “sex-bomb”, horny woman, prostitute, multiple women, or then dominated women, tied-up women etc. Other men may be present as “re-enforcement” of his masculinity or, less often, as sexual partners. The fantasies are geared to models of porn movies. Other fantasies revolving around becoming the object of desire of a woman of high social status are less genitalized and serve narcissistic confirmation.

His *sexual desire* encompasses the search for sexual arousal and discharge, with predominantly genitally polarized needs. With his “inferior” partner he is looking for a strong ejaculation, for “shooting his load”, for getting rid of tension. His partner’s pleasure, which is brought about by him, is an important arousal source to him and is combined with the need to control his or her sexuality and to ensure her availability. The more the partner corresponds to his image of seductive feminine

attractiveness, the more intense his need for control and possession. Increasing jealousy can become a problem. He perceives the woman as a seductress who could betray him at any time. The feeling of inadequacy can, over time, produce *performance pressure and fear of loss of erection*.

*Autoerotism:* For the hyper-masculinoid man, self-stimulation is an important means to get rid of tension and frustration. It therefore can take up a great deal of space, for example by following the urge to remain in a state of sexual arousal for as long as possible. The goal here is not a sexual discharge but the experience of one’s own potency. In other cases, frequency substitutes for emotional satisfaction. Some men for hours screen erotic contents on the internet, in a compulsive and addictive search for intensity, kicks or the experience of power. Not infrequently, homosexual behaviors are also found in men with heterosexual attraction codes. Such behavior is usually selective, time limited and without the presence of true homosexual attraction codes. It serves to live out such fantasies that are harder to realize in the context of heterosexuality. It is also done to replenish masculinity or out of loneliness.

*Experiencing the penis:* The penis is symbolized as a tool, weapon, gun, drill, control stick. It is attached to the outside of the body. Penetrating equals hard plunging, jabbing, nailing and hammering, and ejaculation becomes a powerful shot.

*Experiencing the body orifices of the partner:* Symbolized as “hole” or receptacle. Inside the vagina or anus, the man experiences himself as hard and differentiated. The hard penis symbolizes intrusivity and male pride. During penetration, the man may not be aware of his penis, which is rationalized as too wide of a vagina. In reality, this penis requires sensory rehabilitation – as does his owner.

### **Several factors increase the risk of erectile dysfunction:**

- Arousal mode limits pleasurable enjoyment of sexual arousal
- No sexual desire of eroticized penetration
- Limitations within arousal sources and attraction codes

- Missing eroticization of the archetype increases insecurity in the feeling of gender affiliation
- Fear of sexual inadequacy, jealousy etc., pressure to perform

## Hyper-masculinoid man: Summary

### Stereotype

- Hyper-masculinoid façade, armored, rigid
- Cowboy, rebel who does not subordinate or bond
- Conqueror, nomad on the search for adventure, Superman
- Bodybuilder and other “masculine uniforms”

### Feeling of gender affiliation

- Insecure
- Intrusive but no eroticization of sexual archetype

### Genitality

- Narrow arousal mode (AM, AMM, MM)
- Important, but with little qualitative investment
- Orgastic discharge
- Invested in coitus, oral and anal penetration
- Action oriented

### Experiencing the penis

- As means to an end, focus on functioning

### Partner sexuality

- Confirmation of his own potency through the partner’s pleasure, avoidance of intimacy, focus on functioning
- Illusion of superiority

### Pleasure

- Tension release
- “Giving” the partner pleasure confirms his masculinity

### Attraction codes

- Feminine women, to maintain gender diversity; in case of homosexual attraction codes: often effeminate men
- Possible homophobia (“unmanly, threat of emasculation”)

### Sexual desire

Sexual arousal, discharge, functioning as confirmation of own masculinity

### Fantasies

- Penetrating (oral, anal, vaginal), ejaculating onto the face, many forms of domination, being superior (partner tied-up, enslaved) “porn-flick” on the mind constantly

### Needs

- Confirmation of own masculinity and potency
- Genital polarization

### Relationship with women

- Incompatibility of emotional and sexual attraction
- Labors to establish affective relationships

### Relationship to men

- Rivaling, competing, showing superiority

### Fears

- Of unmanliness
- Of closeness and intimacy
- Of losing identity through letting go of rigidity
- Of loss of erection
- Of rivals

### Reasons for therapy

- Anejaculation or erection problems
- Unsure about sexual orientation
- “Sex-addiction”, meaning compulsive to obsessive experience of sexuality

### Therapy project

Enhancing masculinity through qualitative development of genitality and sensuality, phallic eroticization

## The hypo-masculinoid/hypo-genital man or “fusion type”

This includes a broad range of men, many of whom are good partners and fathers, are capable of bonding and creating relationships, while others have massive attachment anxieties.

The hypo-masculinoid man is inhibited in his phallic aggressiveness, his self-confidence and his ability to assert himself, to compete and to rival. He does not want to be macho and overinvests in the role of the “shepherd”, the protector who bonds and searches for security. He avoids male “aggressiveness” as he judges it negatively, and “designs” his masculinity and eroticism under a feminoid aspect. This is reflected in his posture, his gait and the way he carries his pelvis. He is not the proud bearer of a male sex but hides it by retracting his pelvis, walking with short paces. The upper body leans forward, reflecting his appeal to others. Sometimes this is reinforced by muscular hypotension.



He experiences other men as dominating, rivaling and as potential aggressors. He tends to submit to male authority. Situations of intimacy with other men are stressful for him. He often struggles to adapt to a male working environment.

As a gay man he is looking for a phallic partner who provides security.

He prefers a female environment, feeling more secure around women. There he is looking for safety and security in a “strong” woman, the “nurturing mother”. He tends to bond quickly and to cling. He has the desire to possess this mother and fears to lose her. He may, infrequently, have the desire to save a vulnerable woman. He will focus on her needs and wants to be her prince and protector. He strives to remain fused and fears to be rejected. After a time of initial passion, the partner distances herself and the man feels neglected. He doesn’t understand his partner’s attitude because he experiences himself as

loving, attentive and adaptive (hetero-centered<sup>3</sup>). He will get feelings of abandonment up to the impression of being used and exploited. In interpersonal relations he remains in the position of the object of the other and has trouble seeing himself as a subject.

Sexualizing a woman without loving her causes guilt feelings and fear of punishment. His sexual desires allow him only to be infatuated, to fall in love with an eroticism where “fusion” predominates. He fears to be perceived as macho by the woman he loves. He is afraid to hurt her feelings, to be disrespectful and to be rejected for that.

A sexually attractive woman activates his fear of being insufficient with his sexual performance and potency. The occurrence of erection problems will trigger separation anxiety all the more.

The central anxiety of the hypo-genital man concerns his negative representation of masculinity, especially phallic aggressiveness. He does not want to be a macho-man who uses women for sex, etc. He often sits between a rock and a hard place with his fear of (evil) manliness and a sneaking worry of not being a real man, of becoming feminized.

His genitality is underdeveloped. The arousal modes are narrow: AM, AMM, MM. The hypo-masculinoid man devalues autoeroticism, fearing that it could alienate him from his partner and would foster cheating. He may only use it as an emergency solution when he is without a relationship.

Intense feelings can cause arousal in this “emotional” variation of male sexuality: Being in love, the desire to be close, but also a fear of loss as reflected in clinging to the partner by insisting on sexual activities. All the while, physiological arousal may be minimal. The focus is completely on the “above”, the emotions. There may also be feelings of shame causing him to avoid sexuality.

His *sexual desire* aims at intercourse as search for fusion rather than search for sexual arousal and discharge. He loves sensual pleasure and tenderness, as his needs are polarized towards the affective. He doesn’t want to “degrade” or “dominate” his partner and therefore prefers coital positions that allow for

<sup>3</sup> „hetero-centered“ as opposed to auto-centered: centered or focused on the *other’s* real or imagined needs, as opposed to on *one’s own*

closeness. Because of his high emotional excitability he may tend to ejaculate prematurely and also experiences stress and fear of loss. The lack of sexual desire for eroticized penetration nourishes the fear of losing his erection at the moment of penetration. Initially the man justifies his loss of sensations during coitus with the perception of the vagina being “too wide”. Thus, he has a paradoxical experience of too much arousal and too little sensations in the penis.

Not inhabiting his genitality keeps him from being aware of his pelvis and his genitals; he hardly has the desire to touch himself. As a young man he functions in autopilot and experiences rapid ejaculations. He symbolizes his penis as a connector, as an antenna for his partner, as a spiritual “vacuum cleaner” that absorbs the energy of the partner. He often uses belittling names, like “my peepee”.

The orifices of the partner are places of fusion, to unite, to flow into each other, meaning they are symbolized as “crucible”. He describes the experience of penis in vagina as comforting, warm and beautiful.

The *sexual archetype* is neutral to receptive. He often views masculine intrusivity negatively, and doesn’t associate being erect with it. Penetration serves to reinforce closeness and the feeling of shelter within each other. Ejaculation reinforces the impression of flowing into each other. It may be experienced as leakage.

With heterosexual attraction codes, in his *sexual fantasies* there is often little or no action. They consist of beautiful women with vague body forms, big breasts, while the female genitals often are not in focus or eroticized. Scenarios revolve around the prospect of being the object of a woman’s desire and lust: An active and strong woman seduces him, directs him, takes him, sits on him and guides his penis into her vagina. He is orally “serviced” by women and surrenders. Other men penetrate his partner while he remains spectator or is in the company of a proxy who takes over the penetration. There are first signs of “phallic” desires, as long as he remains in a passive position, for instance when a woman orally pleases him or another man. The more receptive the archetype, the more the fantasies revolve around scenes of him being passive, tied-up and dominated (phallic symbols are now in possession of a dominatrix). Scenarios may include fetishes like the

wearing of diapers or, frequently, female clothing – all the way to fantasies of being a woman and being taken by men.

Men with homosexual attraction codes fantasize about succumbing in a fight with a strong man, being beaten by him and tied up, or having their hair chopped off, etc.

His *sexual attraction codes* reflect his emotional polarization. The hypo-genital man eroticizes the “above” and fusion to the point of fantasies of his own receptivity, as described above. Due to declining erectile functioning as he grows older, the scenarios often become narrower and more extreme, to the point of compulsive experiences and spending hours in specialized scenarios with a partner, in autoeroticism - often with the aid of porn in the internet - or in professional settings with paid partners.

### **Several factors increase the risk of erectile difficulties:**

- *Limiting arousal mode*
- *Little interest for autoeroticism*
- *Emotional polarization of needs*
- *Insecurity in own masculinity with negative representation of phallic intrusivity*
- *Sexual archetype neutral to the point of receptive*
- *No sexual desire for eroticized penetration*
- *Partner and her/his genitals are not eroticized*
- *Attraction codes tend to become ever narrower (fetish/submission)*
- *Refusal of the partner to participate*
- *Fear of loss causes stress and a vicious cycle*

## Hypo-masculinoid man: Summary

### Genitality

- Narrow arousal mode (AM, AMM, MM)
- Genitality hardly invested
- Devaluation of masturbation, sex for bonding is priority

### Experiencing the penis

- A link to the partner

### Partner sexuality

- Fulfillment of desires for closeness and fusion

### Appraisal of sexuality

- Does not want to be like other men (rough, aggressive, “only wanting sex”)
- Sex experienced as animalistic, must be ennobled by love, emotions and closeness

### Hetero-centering

- Struggles to accept being given pleasure
- His pleasure consists of giving his partner pleasure, wants to do it right for her/him

### Stereotype

- Image of shepherd, savior, protector: settled man who bonds and searches for fusion
- Hypo-masculinoid to the point of feminoid
- “Teddy bear”, leaning forward, affectionate, kind, shy

### Feeling of gender affiliation

- Insecure
- Archetype neutral to the point of receptive, phallic intensity/aggression are viewed as negative
- Missing sexual self-assurance
- Finds he lacks masculinity, fears losing what little masculinity he possesses
- Fear of emasculation during sex with women

### Sexual desire

- Search for emotional fusion is at the center; love desire activates sexuality

### Needs

- Safety, closeness, love
- Emotional polarization

### Attraction codes

- Attracted to eyes, hair, face, smile; lower part of the body is not eroticized
- Is looking for a woman/man who provides safety

### Fantasies

- Romantic scenarios, beautiful woman
- Passivity, initiative comes from the partner
- Sex between two women, he is spectator, possible penetration of the woman by another man

### Fears

- Fear of loss of relationship, separation
- Fear of being too masculine, of inflicting pain, of being too little of a man
- Fear of autonomy (inhibited Autoeroticism)

### Relationships

- Struggle with distance, unable to eroticize it
- Struggle eroticizing gender and character differences, is looking for closeness; differences are threatening

### Reasons for therapy

- Frequent coital erectile problems
- Lacking sexual desire
- Compulsive experiences of sexual activities within narrow scenarios (attraction codes)
- Fear of losing his maleness during sex with women

**Therapeutic project: Fortify masculinity through development of genitality, phallic eroticization**

## “Shape-shifters” – mixed forms

This man functions in “both-and-also”: In a context without affective attachment, he embodies the cowboy, in an affective context, he tends towards the protector, i.e. “fusion-eroticism”.

He shows a certain ease in dealing with other men and tends to perceive himself as the better man. In

situations of vulnerability he hides behind a façade of mistrust or pseudo indifference. To be like other men will cause women to disapprove, that is why he must be better.

Dealing with women is easy for him. He carries himself as the man who respects women and as the lover who cares about the erotic pleasure of his partner. With the “madonna” he acts like a shepherd and with



the “anti-madonna” like a cowboy. At first impression he seems to function just as well in a “fusing” as in a “distance” context. However, this functionality is based on a split. Both in his fantasies and in his reality, he is not able to behave erotically with the woman he loves as he can with his lover. He fears that he will injure his partner, not respect her enough and give her the impression of being a sex object. He invests in the “madonna” as a source of affective security and in the “anti-madonna” as an object of lust. Just like with the other two types, the “madonna” activates the fear of being too masculine and the “anti-madonna” the fear of unmanliness.

*His erotic functionality is based on* limiting arousal modes, often the MM. In an emotionally important relationship, sexuality after the conquering phase becomes boring and routine. Sexual desire dwindles and fear of loss of erection occurs. Sex becomes more and more mechanical. He doesn't surrender to the experience, but focuses on the pleasure of the partner. He is focused on “doing” and takes on the role of a spectator. This is how he keeps his distance and doesn't search for fusion like the Hypo-man. Like the Hyper-man he cannot eroticize pleasurable enjoyment because sensuality threatens him in his manliness by awakening fears of feminization. With increasing frustration, hostile interests outweigh the desiring ones. Due to the narrow arousal mode, there is often an inability to ejaculate in the presence of the partner. After he has satisfied her, he masturbates outside of her range of vision to fantasies of sexually attractive women. With a lover he allows himself more masculine desires and therefore is able to develop more phallic aggressiveness and intrusivity. In case of a very narrow arousal mode, even with the lover he may tend to coital anejaculation. In order to ejaculate he must pull out of the vagina and either masturbate in front of her or allow himself to be orally or manually stimulated by her. We also find this dynamic in hyper-masculoid men as an expression of coital fears, reinforced by an archaic-mechanic or mechanic arousal mode with a narrow stimulation pattern or high muscle tension inhibiting an orgasmic release.

### Therapeutic project

- Reinforcement of masculinity through qualitative development of genitality, sensuality and phallic eroticization

***Insecurity in experiencing one's own masculinity + lack of eroticization of the sexual archetype of penetration = higher risk of erection problems***

## The male journey / maleness in the course of life



Fig. 10: *To erect and to flag, to become and to die*

### Challenges for the man in different phases of life

(after M. J. Diamond, 2007)

#### *Midlife/Midlife crisis*

During midlife, developments in the job, in relationships and through fatherhood can give new impulses. The pleasure of experiencing the present moment, the joy of being and of understanding becomes more important than the excitement of seeking and finding. Insights, connection and thoughtfulness are given priority. It is a time when the feeling of affiliation to one's own gender, a deepening of eroticism and attachment, and an overall appreciation of life receive a central meaning.



Many men go through a “depressive” slump during the *midlife crisis*. This may be an expression of their pain about the psychological restrictions they imposed on themselves in order to build and maintain a culturally approved sense of masculinity. They experience a growing need to recover the lost parts of their self. Thus, the concept of masculinity becomes more flexible and balanced and must no longer rigidly differentiate between masculine and feminine aspects. C. G. Jung has noted: In middle age the man has to make room for his “female” side, so it can revive his diminishing biological fire.

#### *Masculinity in middle and advanced age:*

In order to maintain a stable feeling of identity, the aging man must integrate parts of his personality that he had given up or needed to reject during his socialization. The need for a clearly defined and sharply demarcated masculinity diminishes. In earlier phases of his life it fulfilled important adaptation tasks, but the mature man is no longer dependent on it. Ideals that were held high while growing up to be a man yield to ideals supporting the development of personality. They drive him to an in-depth and inner search for meaning beyond the facts of his physical existence. Many men experience this phase as a time when their nourishing side is integrated into their concept of mature masculinity.

Figuratively speaking, this period is about the transition from holding up external attributes of masculinity to erecting the inside.

#### *Challenges in advanced age, late life crisis:*

Confrontation with death and the associated anguish at best leads to a further transformation of the “ego-ideal”.

If this fails, the aging man will define his feelings of masculinity by the means of rivalry and aggression in hierarchical relationships. He may ruin his life and his family in order to conquer a “trophy-wife”. He maltreats himself recklessly until his body goes on strike. Instead of relying on his overall personality and accepting his desire for relationships, he feels compelled to prove his masculinity.

At that age, there is an increasing amount of losses in the form of psychological and physical changes.

Potential injuries and narcissistic crises are to be expected. They are characterized by shame, humiliation and mortification and result from the difficulty to accept physical deterioration, separation, loss, and dependency as inevitable products of passing time. All thoughts of omnipotence will have to seriously be questioned. Reality of old age forces the man to drop the fantasy that his objects are immortal. He must say goodbye to the hunt for the ideal object and replace his manic search for the ideal with growing acceptance.

**Example:** a 79 yr. old man, owner of his own firm, professionally active, had everything “under control” until a rupture of an aneurysm of the aorta, which was accompanied with fear of death and total helplessness. After a successful operation with no lasting medical consequences, he daily withdraws to his office for many hours. There he arouses himself with erotic pictures and erotic literature. In order to regain his self-esteem, he is looking for support from his penis and searches to erect his manpower. He fights against the loss of dignity, his shame and mourning, in which he isolates himself. He can’t envision a recovery of the previously active and well “functioning” sexuality with his partner or his girlfriend. This traumatization has offended and unsettled him in his masculinity too much.

Men who are trapped in a rigid form of masculinity do not give up the illusion of phallic conquest of the world until the end of their lives. They deny any feelings of helplessness, neediness and despair. Ideas of their own power and inviolability and corresponding actions support the illusion they can control age and death.

It is easier for the aging man to acknowledge physical frailty, dependence and the inevitability of death if he can integrate his need for assistance into his identity. He finds consolation in inner images, which originally came from the loving care of parents. If an aging man loses his outside relations, this inner connection can help him. Many men only in old age stop denying the dependency of human existence, to

overcome the illusory Western attitude of individual autonomy and finally recognize our fundamentally relational nature.

The aging man is forced to become small, to say farewell to grandiosity and omnipotence – so that he can become whole.

W. Whitman: *Leaves of Grass*

I am of old and young, of the foolish as much  
as the wise,

Regardless of others, ever regardful of others

Maternal as well as paternal, a child as well as  
a man

## Evaluation of the basic elements of male sexual development

### 1. Sexual Functionality

How did the man develop his genitality? How did he integrate his arousal reflex into learning steps, how did he erect his penis? How does the man function in his sexuality taking into account his age and his physical and mental health? Does he have adequate stimuli in order to trigger and maintain sexual arousal? Did he learn an arousal mode that allows him to enjoy the sensations associated with sexual excitement and thus gain access to sexual pleasure? Is he able to increase his arousal, to modulate and to let it spread throughout his whole body (*diffusion*)? Can he indulge in the physical reactions and sensations caused by his orgasm?

### 2. Feeling of gender affiliation and phallic eroticization

Is the man proud of his masculinity, his genitals? Does he experience his body and his erect sex as pleasurable? Does he experience sexuality with himself and with others as a resource for self-confirmation? Can he experience himself in physical and emotional fluency? Is he able to strengthen his feeling of masculinity through

the enjoyment of sexual arousal? Can he embody it, express it in internal images and sexual fantasies, in language and behavior – thus can he erect himself in his masculinity on a real and a symbolic level? *This eroticization of the archetype – i.e. having the notion of penetrating with pleasure (phallic eroticization) – is the most important developmental step in the sexual life of a man and is the prerequisite for being able to eroticize another person and for coital sexual desire.*

### 3. Eroticization of another person

Can the man direct his desiring gaze outwards? Is he able to experience the other persons' "otherness", their body, experience their genitals as sexually arousing, and can he desire them sexually? Does he have sufficiently evolved attraction codes that allow him to eroticize a man or a woman even as they are growing older? Is he actively enjoying penetration and his sexual aggressiveness as part of his sexuality, as an enrichment of his fantasies and as a force that intensifies the relationship? Can he modify with his body the emotional intensities that accompany his sexual arousal; can he experience himself as fluent and abandon himself to his orgasm, can he let go?

### 4. Autonomy and individuation, sharing with another person

Can he share joy, lust, arousal and his sexual passion with another person, can he eroticize intimacy? Can he find ways to reconcile attachment and solitude, closeness and distance? Can he position himself as a subject and can he express his desire and his sexual and affective needs in the interaction with a partner? Can he respect and accept the desires of the other? Does he enjoy the activity, sexual aggressiveness and emotional intensity of his partner? Does he allow the other to enter him, discover his orifices and open up to inner sensations of his sex?

### 5. Adaption to the reality of everyday life and changing life situations

Is the man able to adapt his erotic needs to his own limits? Does he adapt to getting older and to illnesses and to changes on the part of the partner?

## 6. Erotic relationship skills

Can he maintain a certain fascination and idealization of another person in the everyday life of love? Does he enjoy experiencing and showing himself as a lovable and sexually desirable man? Is he able to anticipate a sexual encounter, erotize distance and win the other person over with his seduction skills? Is it possible for him to communicate his own erotic needs and actively shape the sexual relationship? Does he possess erotic skills to please the partner? Can he see his own sexuality in relation to the cultural environment and its values?

# Erectile Dysfunctions

## Understanding of erectile dysfunctions with Sexocorporel

In recent years, the ideological controversy of schools as to whether its causes are of a psychological or organic nature has given way to a more differentiated view of erectile problems. The former either/or perspective risked a unilateral medicalization of the problem on one hand, and a psychopathological view of many mentally healthy men on the other hand. Psychological, physical, social and sexual health are connected to each other and influence each other. The one-sided search for emotional conflicts or organic causes emerged from the “genitophobia” deeply rooted in our society. It prevented taking a look at the real relationship of men to their genitals, at their genital and erotic learning steps.

Comparable to models of psychological and physical health, Sexocorporel employs a model of sexual health beyond dualistic ideas. It examines the most important

components that interact with our sexuality (Desjardins et al, 2010).

It is based on the person being a unity of brain and body. Body and psyche are therefore two aspects of the same. Each cognitive and emotional impulse causes a physical change and each physical change influences what we feel and what we think. For practical purposes, we divide this unity into components, which in reality remain inseparably connected.

Erectile dysfunction is not a random event affecting just any man. It is a consequence of causes. Sexocorporel distinguishes between *direct and indirect causes*. Direct causes can be found in limitations within the components that constitute the affected man’s sexuality, while indirect causes are stressful life events, social and relationship conflicts, psychological and health issues that he may encounter in the course of life. Indirect irritants may or may not actually cause ED, depending on how well the man has appropriated his sexuality and how much stability its direct components provide, how susceptible it therefore is for interference.

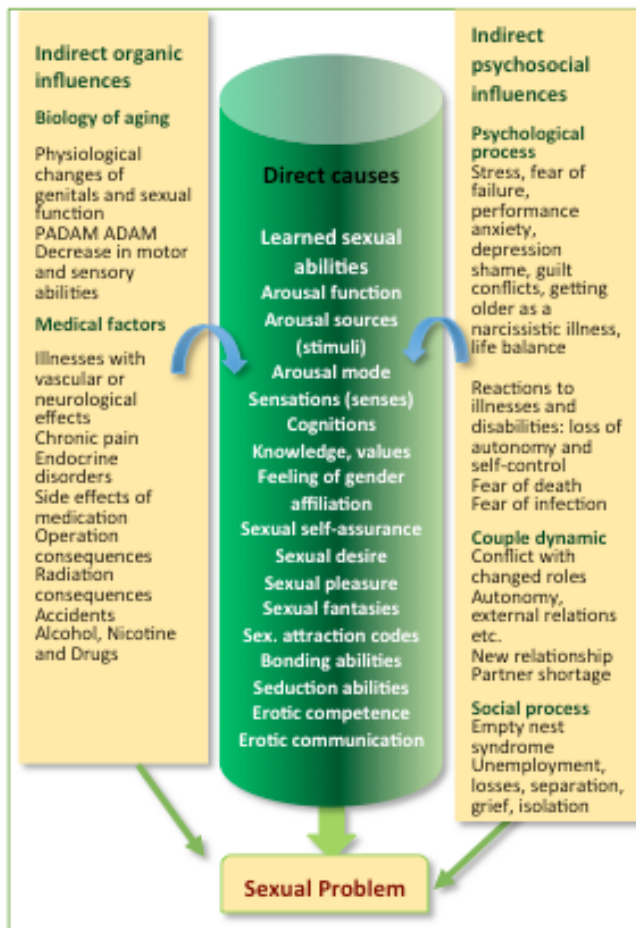


Fig. 11: Direct and indirect causes of sexual problems

Limitations within the components of sexual functionality, particularly the sexual arousal function and its arousal modes (archaic or mechanical arousal mode), inhibit the development of sexuality on a qualitative level. They prevent a pleasurable experience of masculinity and directly increase the risk of ED, particularly if aggravating indirect causes for ED are present. It is important to note that men with so-called “organic” ED (i.e. associated with illnesses such as cardiovascular problems or diabetes, as will be discussed later on) often regain a good functionality through sexual learning steps reinforcing the components of sexuality, with or even without the help of PDE-5-inhibitors.

*The arousal function* is the basis of sexuality. If we don’t evaluate it, we cannot understand a sexual problem. Learning steps enable the perception of

physiological sexual arousal and its resulting sensations. Sexual learning is also required to symbolize this experience in pictures and in fantasy. It allows us to experience ourselves consciously in our feeling of gender affiliation, to abandon ourselves to our arousing emotions in the encounter with others. It means to develop a desire to re-live these experiences, as well as social skills to allure others for it; all this within the limits given by age, disease, and the life situation.

Example: A 48 yr. old man, suffering from diabetes, has received a daily insulin shot from his wife (she is a nurse) for the last two years. Since then he has been experiencing difficulty with his role as a partner and lover. He also suffers because, as a “chronic patient”, he feels devalued in his manhood in his performance-oriented work environment. Since his son also suffers from diabetes, he feels guilty and reacts with depressive moods. His physician inquired about his sexuality and asked if he still had good erections. A week later he experiences a first “failure”; with time he gets into a vicious cycle of negative expectations and ED becomes chronic. The urologist can’t find any evidence of organic causes, he prescribes a PDE-5-inhibitor, however without an effect. The sexological evaluation shows that from adolescence on, the man has been functioning in an archaic arousal mode, and that with it he has been experiencing difficulties to ejaculate during intercourse for quite some time.

*Quiz question: How many direct and indirect causes are present here? Why is the PDE-5-inhibitor not working?*

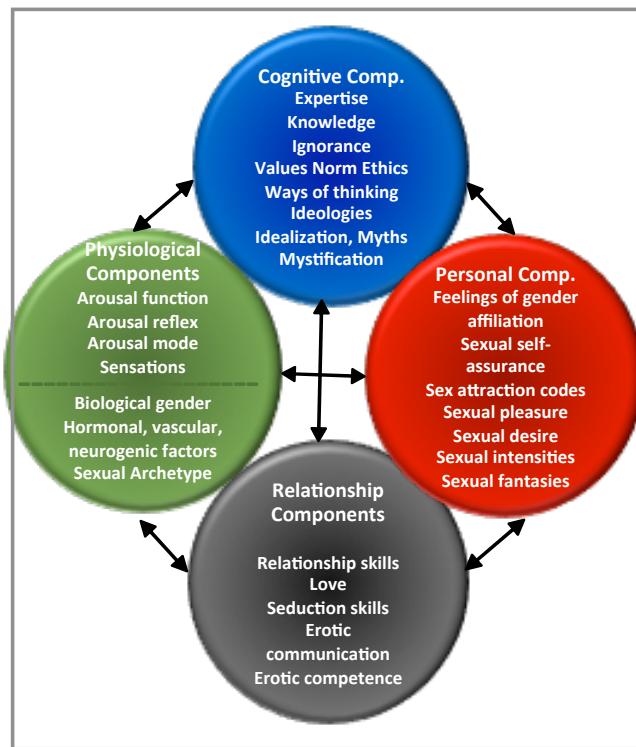


Fig. 12 The components of sexuality in Sexocorporel

These four circles comprise the most important components interacting in sexuality; they change, develop and adapt in the course of life.

The components listed in the four circles can also be represented as a chain. Their evaluation allows us to identify strong or weak links, i.e. break points in the chain. The aim of sex therapy is to develop the weak links and harmonize the way all components interact.

## The physiological components

Men and women wish to enjoy sexuality and to realize it within a love relationship. This requires connecting genitality with pleasure and intimacy. The starting point for this is sexual arousal, a reflex-like event. If it can be increased successfully, then the journey ends with a second reflexive event (orgastic discharge/orgasm). Through learning processes we can make the “space” between the two reflexes “habitable”. Learning means activating overriding cortical centers and enabling awareness.

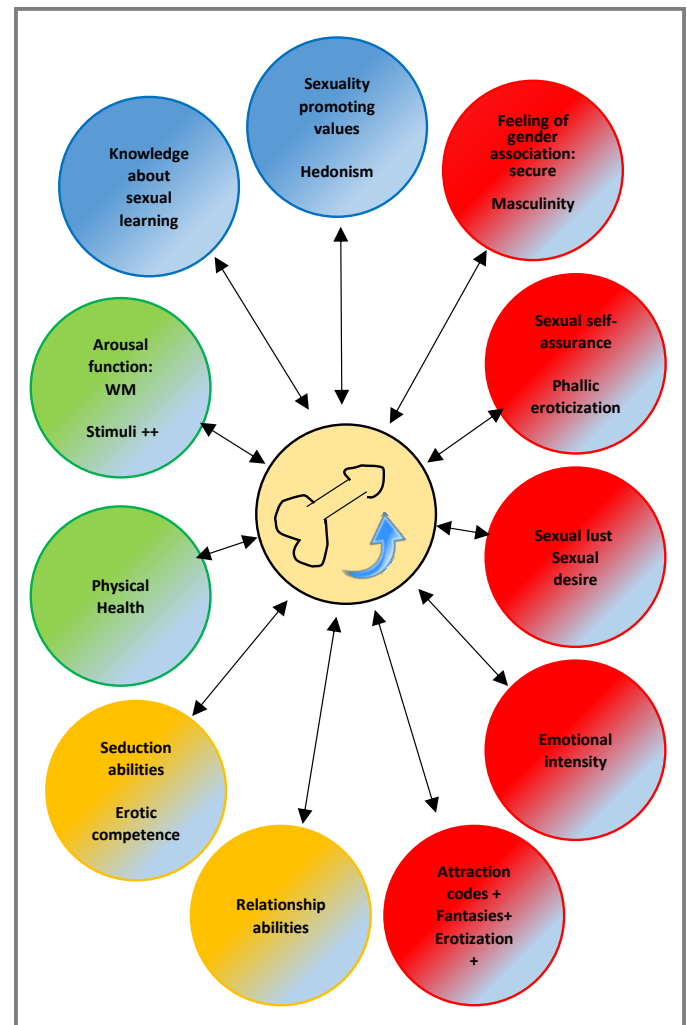


Fig. 13: Influence of the individual components on the erection ability

The arousal function is directly related to the quality of erotic action and experience. It includes genital vasocongestion (blood flow into erectile tissue), as well as the neuro-vegetative influences of the arousal reflex<sup>4</sup> on respiration and musculature. Since breathing and musculature, as opposed to vasocongestion, can be modified at will, it is possible to influence sexual arousal and its accompanying emotional intensity through conscious learning steps. Variations of muscle tension, movement, movement rhythms and breathing can maintain, modulate, intensify and increase arousal arbitrarily. The particular way these *three laws of the body* (muscle tone, rhythm and amplitude of

<sup>4</sup> Genital sexual arousal, in the strict physiological sense, is not a simple reflex. We employ the term „arousal reflex“ for didactic reasons as a simplified model.



movement) are employed to physically design the arousal curve is called the *arousal mode*. The arousal modes decisively influence the experience of sexual arousal, the associated sensuality and the emotional "tint" (Bischof 2012). Every woman and every man can have access to this deliberate control and influence on vasocongestion and perception of their arousal through physical learning processes. These, like all learning processes in various human forms of expression (walking, talking, playing, dancing, etc.), are based primarily on the handling of the basic laws of the body.

The way in which the body is used in the process of arousal shapes perception and experience and creates the prerequisites for more or less pleasurable enjoyment. Changing the arousal mode signifies a change in the relationship with yourself (at a physical level), a change of self-perception, of the internal symbolization (fantasies, verbal expression), and of relationships with others.

The arousal function is the red thread of sexuality, the foundation of the concept of sexual health in Sexocorporel. The emotional components, i.e., the qualitative dimension of sexuality, are based on it. The goal is to connect sexual arousal with pleasure and with intensive self-awareness within one's gender identity, with eroticization of oneself, one's arousal and genitals. This way the partners can also be eroticized in many aspects of their physical body and personality. This eventually allows for the development of a sexual desire beyond being in love.

Using the example of the archaic and mechanical arousal modes, we can understand that the development of the qualitative dimension of sexuality can be narrowly limited by the modes and has an effect on all components.

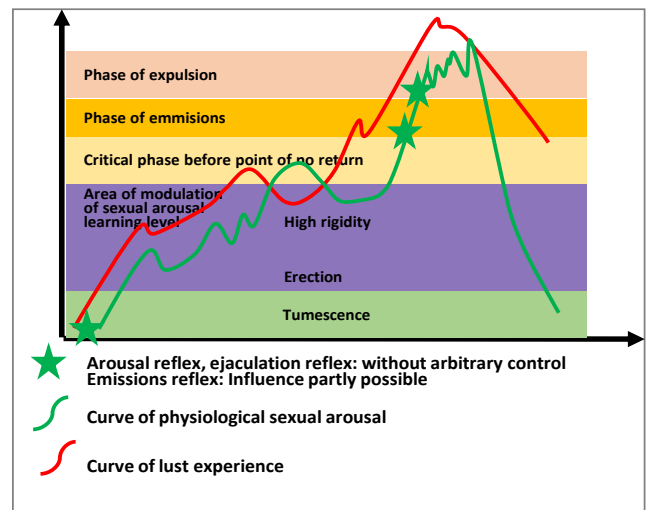


Fig. 14: Areas of perception of the arousal curve

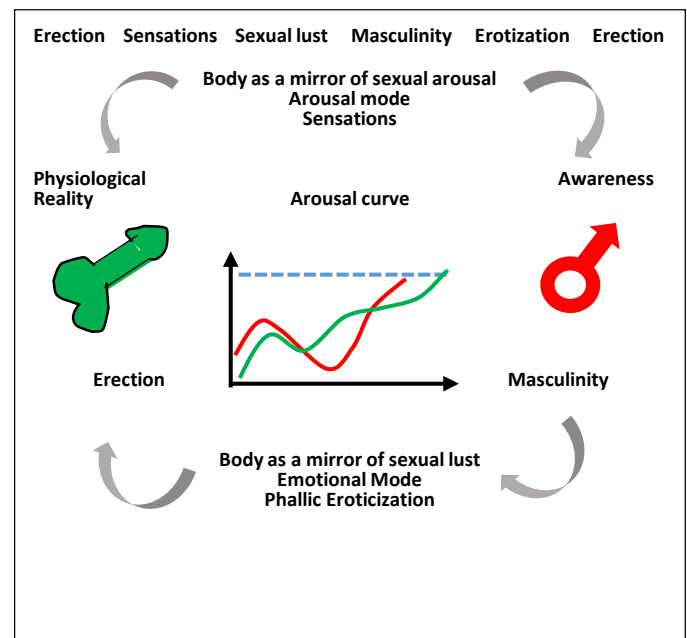


Fig. 15: Concurrence of erection and sensations (after Claude Roux-Deslandes)

## “Functioning” or “Eroticizing”?

A central factor in the genesis of male sexual problems is *the inability to develop an erotic dimension in sexuality*. Men experience and enjoy their sexuality in various ways. Here are the three most common forms:

In the *“physiological”* form, the man focuses his awareness on the pleasure of the relaxation that accompanies ejaculation. He often looks at the process of increasing arousal as “work”. We find this situation in



the archaic mode (AM), the archaic-mechanic mode (AMM) and also the mechanic mode (MM). Motivation for sex is a *sexual desire* for arousal and discharge. His needs are genitally polarized.

In the “*emotional*” form, sexual arousal is triggered through intense emotions such as affection, desire for closeness, but also fear of loss. The focus is completely in the “above”. Genitality is poorly developed. The arousal modes are the same as in the physiological form: AM, AMM, MM. Motivation for sex is a *coital desire*, where coitus is sought not for its genitally arousing quality but as a means to fusion. The needs are emotionally polarized.

The “*integrating*” form requires an undulating (UM) or wave-like (WM) arousal mode. This form combines emotional intensity and the other emotional components with the increase of arousal and enables intensive physiological and emotional arousal and release. It creates the basis for the development of many erotic abilities, especially phallic eroticization and a *coital sexual desire*, where coitus or penetration is desired both for its genitally arousing and emotionally enriching qualities.

We find erection problems predominantly with men of the first two groups. In most cases, impeded functionality is the reason for consultation. Lately, we have also been hearing increasing complaints about missing sexual desire and libido problems, sometimes even with good erectile function, whereas men rarely consult about problems related to sexual pleasure.

### **The auto-pilot: “Functioning” as a forerunner of ED**

MM as the most frequent male arousal mode (estimated over 50%) is an important risk factor for erectile dysfunction, particularly in combination with aging or other factors, such as illness, social or psychological problems. But even without extensive sexual learning steps, men with a MM may function well for many years. They experience sex as “natural” and are happy when “it” works. They hardly think about their sexuality, they function.

Incentives for masturbation or partner sex:

- Physical desires (“I need to get off”)
- Interactions with other people, visual stimuli, erotic pictures, movies, erotic reading

- Sexual fantasies
- Being in the same bed with the partner in the evenings

The sight of the partner’s body, its warmth, its scent and the closeness lead to a reflexive erection. This erection is not so much a result of sexual desire, of anticipation, memories, fantasies and wishes, but occurs automatically and thus leads to a functioning on “*autopilot*”. As useful as the autopilot proves to be in certain situations, the lack of genital learning and of a qualitative development of sexuality is the crucial risk factor for erectile dysfunction. These men, usually psychologically healthy, are often simply ignorant of the way in which they can consciously influence their arousal curve through their body (play with muscle tension, movement, rhythms) and breathing. They persist in their system of rubbing and “wanking”. They will “whack off”, “beat off” and “shoot their load”. They “hump” or “bang” their partners. Typically, in this functioning on autopilot, men derive little pleasure from the build-up of their arousal. Not the journey there, but “cumming” is enjoyable, ejaculation and the subsequent relief and relaxation.

### **Experiencing one’s own genitals and the genitals of the partner**

These men don’t feel their penis unless it is fully engorged or in maximum rigidity right before ejaculation. They complain about a lack of penile sensitivity when the erection is “weaker”. This unsettles them and they may lose it. They best function at the top of the arousal curve with a firm erection, produced through erotic films or fantasies. The fundamental lack of sensory perception of their penis and their bodies demands an increase in stimuli and leads to the search for the ultimate kick through ever harder images and fantasies. Because of the high muscle tension and restricted movement in the mechanical mode, there is only limited diffusion of sexual excitement throughout the whole body. If men cannot experience their sensations in the middle range of the arousal curve as erotic, they can’t use them as arousal sources. This limits their ability to become a “midfielder”, i.e. to enjoy different erection strengths without fear of “crashing”.

Some try to maintain sexual arousal and their masculinity during sexual intercourse with the help of

ever tougher fantasies. In addition, they may help themselves with PDE-5-inhibitors. Sexual interactions become work, even a struggle for erection. All the attention is directed to the function of the penis. Performance anxiety increases, and the only thing “alive” are the cries of lust of the partner, her movements and her orgasms. These fascinate and prompt the men to become increasingly aroused by the female experience and no longer by their own sensuality. Others are desperate for friction during intercourse, because they perceive their penis only with the rapid back-and-forth movements of “banging”. Over the years, they may lose their erection if the woman lubricates well and friction is reduced. This entails the complaint that the vagina is too wide, as they feel small and lost in the alleged vastness of the female sex and develop fantasies of being “devoured” and of “drowning in it”.

**Example: Nighttime dream of a 48 yr. old man who, after decades of good function, because of his AMM no longer perceives his penis during coitus and loses his erection. He sees himself as a dwarf in front of a large voluptuous woman who shows him her vulva with her legs spread and beckons him with her finger. He experiences fear and feels unable to cope but is also fascinated by this great gaping sex.**

Typically, such men experience their penis as externally attached to their bodies like a post or a “rod”. Some use a warlike rhetoric and others experience their genitals as a foreign object. Since they are not aware of the area where the cavernous bodies originate, there is no feeling of inner connection to the penis - they do not “inhabit” their penis. They are astonished as they begin to perceive this part of the penis via the activation of the pelvic floor, and this discovery is often accompanied by the impression that the penis has grown longer.

**Example: In this sense, a differentiated, affectionate, compassionate, sensitive young man handled his sexuality very mechanically and eroticized neither himself nor the women. He described that at the moment of sexual activity his partners to him only consisted of three holes. After having penetrated all three holes, he’d wonder what he was doing, he’d lose desire and eventually his erection. The vagina here serves just as a hole to produce friction. One is inclined to think of the proverb: “If your hand is a hammer, then everything looks like a nail.”**

Some men function on autopilot until they are 80 years old and are satisfied with it. More frequently, however, a first “crash-landing”, a breakdown or a creeping deterioration of the ability to erect turns into a self-reinforcing negative spiral of increased self-observation and the anticipation of failure and collapse. The sheer visibility of the male genitals fosters performance anxiety. The failing penis is a nakedness that cannot be hidden and entails strong feelings of shame. The more threatening the failure, the more complicated and dysfunctional the strategies will be to remedy the problem. The one-time breakdown turns into a chronic erection problem. Search for pleasure is no longer in the foreground as the sexual encounter becomes a performance test that he must pass in order to remain a man. Performance pressure and fear of failure turn into fixed ideas that dominate his thinking, occupy more and more space and impair his sense of self.

## “Eroticization” – a process of developing sexual pleasure

### Definition:

**Eroticizing something = experiencing it as erotic, arousing. Learnable ability based on being able to combine sexual arousal with perceptions, feelings, emotions and fantasies via a wide range of arousal sources and physical activities (undulating and wave-like arousal mode) and to enrich oneself with the perception of one’s gender identity during sex alone or with partners.**

Eroticizing oneself means experiencing oneself as sexually attractive and desirable. This enables eroticizing and sexually desiring another person, their diverse physical characteristics and their genitals. Eroticizing allows expression and satisfaction of diverse needs in sexuality with ourselves and others. Sexuality thus becomes a resource for every-day life that can enrich us and our sexual relations, particularly during difficult times, i.e. during health problems. A central component for men is the eroticization of their intrusivity, the pleasure of real and fantasized penetration of another body. The discourse of male violence and the general depreciation of masculinity can unsettle more sensitive men. The high muscle tension of their sexual arousal and rapid “humping” movements may then lead them to associate sexual intercourse with a violence they do not want to inflict onto their partners. An erected penis allows penetration into the body of another person. It goes “under the skin”! This can fuel fears of injuring the partner, particularly if the arousal mode demands very tonic, rapid movements with little means of conscious awareness and control.

Inversely, the arousal mode in waves facilitates a positive experience of sexual aggressiveness and sexual surrender. Rhythms can be varied as muscle tension comes and goes in the movement of the double swing. It allows for powerful and pleasurable penetration with high intensity, but also with subtle control and perception of the partner.

### Summary

1. Erection is a reflex-like event. It cannot be triggered just at will but requires effective stimulation. Sexual excitement maintains the erection and can be influenced by physical activities and different sources of arousal. It can be represented by the arousal curve. Most men learn to increase their sexual arousal through a certain body technique, the arousal mode. Arousal modes are: archaic, archaic-mechanic, mechanic, undulating, arousal mode in waves.

2. The erection is closely related to the experience of one's own male identity. It is the prerequisite for sexual self-assurance. Erectile dysfunction affects many men in their quality of life and experience of their masculinity. ED is experienced as a narcissistic injury. It affects the self-image and the maintenance of a feeling of phallic masculinity. ED directly causes anxieties which can assume an existential dimension.

3. Conversely, identity problems and an insecurity about one's own masculinity increase the risk of erectile dysfunction for various reasons. E.g. The emotional intensity accompanying the penetration into another body can be experienced as destructive aggression. Ensuing fear of injury can hinder the physical function.

4. The journey from erection to coital-sexual desire via phallic eroticization stabilizes sexual functioning and the feeling of gender affiliation. Despite its associated difficulties, in getting older, it enables a high quality in autoerotic and partner-oriented sexuality. This way sexual aggressiveness is experienced as sexually arousing and as a force that deepens the relationship and strengthens self-assurance.

## Individual risk factors for the erection

Factors that favor an ED are usually also factors that prevent eroticization.

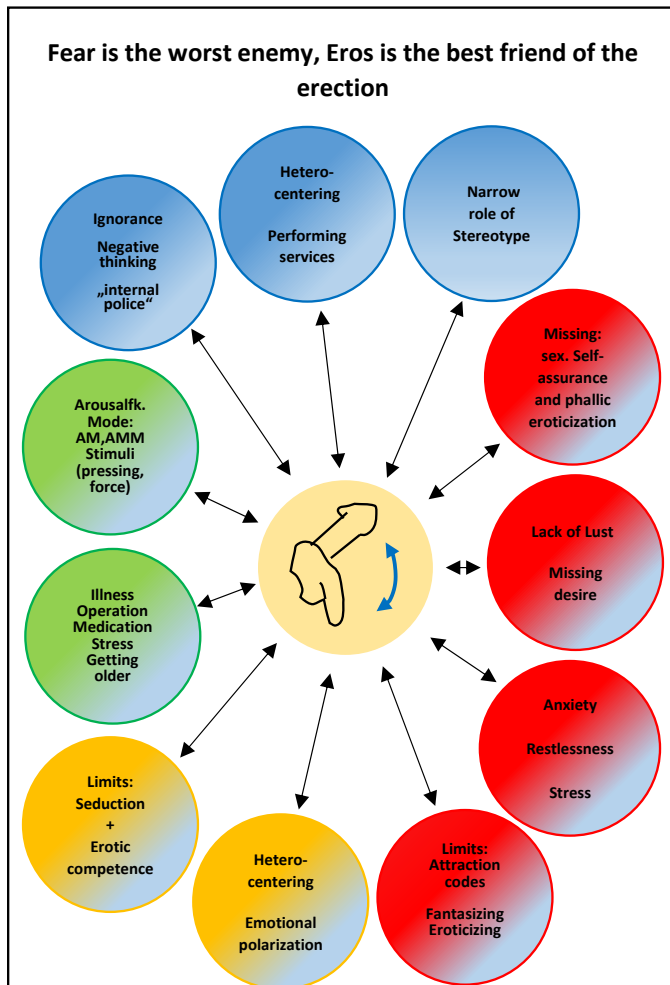


Fig. 16: Enemies of the erection

## Physiological components and ED

### 1. Arousal function

The majority of sexual problems are caused, aggravated or triggered by the arousal mode. The *archaic mode*, the *archaic-mechanical mode*, and the *mechanical mode* are associated with a significantly higher risk of ED since they influence the arousal function directly by means of the following processes:

- High muscular tension to rigidity in the area of the pelvis, especially the pelvic floor, often spreading

over the whole body, limits perception and blood flow to the penis.

- Flat and constricted breathing can only be accelerated but not deepened with high arousal and limits the emotional experience.
- Focus of awareness is aimed on the penis, as the sole area to increase arousal.
- Penis sensitivity is often poorly developed due to the mechanical or pressuring handling.
- Muscle tension restricts blood flow, so arousal cannot diffuse within the body, i.e. no pleasurable whole-body experience.
- Work is required to mount arousal; sexual pleasure cannot develop this way.
- The less pleasurable the increase of arousal, the more quickly a habituation to stimuli takes place.
- The aim is usually a rapid increase of excitement, pleasure is drawn from the relaxation associated with ejaculation.

Delayed ejaculation and anejaculation frequently are associated with an AMM with very high muscle tone, where augmenting arousal constitutes an enormous physical effort. Then the risk of developing ED is high.

Men with a long history of trying to prevent premature ejaculation with aversive strategies such as restraining themselves or focusing on non-erotic thoughts run the risk of ED later in life. They have not developed a broad enough range of arousal sources to support the erection as they grow older.

In general, the “autopilot” fails with older age. A first occurrence of ED leads to the already mentioned vicious cycle. Physical tension, performance pressure and fear of failure negatively affect erection. Everything stiffens, only the penis does not!

Inversely, also men with pronounced muscular hypotonia and the inability to maintain and modulate physical and/or emotional tension often experience the increase of arousal as an effort, and more often develop ED.

## 2. Medical Problems promoting erectile dysfunctions

The following is the approximate distribution of organic causes of ED in percentages (Coradi et al., 2008; also see Feldman et al., 1994)

### Vascular/metabolic-related influences: 70%

Arteriosclerosis, myocardial infarction  
Dyslipidemia (increased total cholesterol, low HDL)  
Arterial hypertension  
Diabetes mellitus  
Overweight, obesity, severe underweight

### Neurologic influences: 5%

Injuries, surgeries, radiation in the small pelvis (prostate, bladder, rectum)  
Neurological diseases (multiple sclerosis, Parkinson's disease)  
Injuries to the spine or the pelvis  
Paraplegia  
Diseases of the spine (e.g., intervertebral disc disease)

### Hormonal influences: 3%

Hypothyroidism (low testosterone, increased prolactin)  
Hyperthyroidism (increased SHBG, leading to relative hyperestrogenism, reduced libido)  
Prolactinoma  
Testosterone levels below norm

### Other medical influence factors: 7%

Surgery, radiation, chronic kidney failure, COPD, sleep apnea, chronic pain, fatigue, weakness, diseases that reduce sexual attractiveness, such as Psoriasis, burns, colostomy (artificial anus)

### Medication influencing the arousal function: 15%

*Psycho-pharmaceuticals:* antidepressants (Tricyclic, SSRI), neuroleptics, benzodiazepines

All antipsychotics block dopamine-D2-receptors in the brain, which often increases prolactin output and favors ED.

Sexual side effects like a prolonging of arousal time are more common in SSRI (Fluoxetine, Sertraline, Paroxetine) than by blocking serotonin binding sites or

increasing norepinephrine and dopamine (Reboxetin, Mirtazapin, Moclobemid)

*Hormones:* antiandrogens, estrogens, LHRH-analogues

*Cardiovascular drugs:* thiazides, beta-blockers, alpha-methyldopa, Calcium-antagonists, clonidine, reserpine, digoxin, lipid-lowering agents, ACE inhibitors, diuretics

*Others:* Ranitidine, metoclopramide, carbamazepine

### Drugs:

Alcohol, marijuana, cocaine, anabolic steroids, heroin

### Risk factors:

Age, stress, smoking, lack of movement



### Neurophysiology of the erection

The erection reflex begins in the central nervous system (CNS), close to the preoptic area.

Dopamine as a neurotransmitter appears to have a stimulating effect on the erection. It also leads to an increase in the synthesis of nitric oxide (NO), which plays an important role in vasocongestion and erection at both central and peripheral levels. Many of the receptors in the brain are inhibitory in nature.

Spinal control of erection is carried out by the autonomic nervous system. *Parasympathetic nerves* from S2 to S4 primarily control the *erection* function, while *sympathetic nerves* originating from Th11 to L2 are responsible for *ejaculation* and *detumescence*. Relaxation and contraction of the smooth muscle fibers in the lacunae of the corpora cavernosa are influenced by specific neurotransmitters (NO). This relaxation reduces the resistance and leads to vasocongestion and to an increase in pressure and volume (tumescence) in the erectile tissue. This also reduces venous blood flow, which leads to a stiffening of the penis. Stimulation of the pudendal nerve results in contraction of the pelvic floor, particularly the ischiocavernosus muscles, which further reduce venous blood flow and augment pressure in the cavernous bodies up to full penile rigidity.

The spontaneous erections in the morning and at night are caused by a decrease of central inhibition.

(Alexander, Carson 2006)

## Sexodynamic components and ED

**Definition:** The emotional or sexodynamic components of sexuality comprise the ability to recognize what sexually appeals and excites us (attraction codes), to express this attraction through a sexual desire, to connect it with erotic images, fantasies and feelings as well as with the experience of our own masculinity and femininity and with pleasure both in autoerotic or partnership-based sexuality.

ED can be caused by limitations in any of the emotional components, and conversely influence them all:

- **Sexual pleasure:** underdeveloped
- **Sexual desire:** limited (an erection alone is not yet a sign of sexual desire)
- **Feeling of gender affiliation:** insecure
  - Archetype underdeveloped = penetration into the body of another not eroticized = intrusivity is inhibited, fear of injury
  - Stereotype may be hypermasculinoid to compensate, but can't quite countervail insecurity
- **Sexual self-assurance:**
  - Reduced sexual narcissism (pride about own sex)
  - Reduced exhibitionism (joy of showing one's sex to partner)
- **Sexual attraction codes:** problematic
  - Loves partner, but is not sexually attracted
  - Narrow attraction codes = erection only with fetish or special scenarios
- **Sexual fantasies** may include:
  - Romantic scenarios, little genital content
  - No symbolization of intrusivity and own masculinity
  - Rarely scenarios with sexual activities
  - Or exclusively genitalized scenarios
- **Emotions:** Nervousness, stress, fear of failure and loss, performance anxiety



## Cognitive Components and ED

**Definition:** Cognitions (attitudes, approaches, beliefs, value systems and ideals) promote or inhibit sexual learning. They influence sexual behavior, perception and the emotional experience thereof. They develop in the course of sexual socialization, change during a lifespan and give a personal significance to sexuality. They also reflect parental attitudes and cultural ambivalences about sexuality.

All cognitive components, through their influence on sexual learning, on perception and emotions can facilitate the occurrence of ED.

- **Value systems and norms:** narrow
  - Cultural, religious background that hinders sexual learning (allows only reproductive sex)
  - Thoughts that discredit sexuality create guilt feelings (no right to pleasure)
  - Inner "policeman" (fear of punishment for masturbating or for objectifying the partner)
  - Rejection of obtrusive fantasies that are incompatible with own values
  - Irrational ideas, mystification of sexuality
- **Knowledge:** Lacking
  - In regard to male and especially female sexuality
  - In regard to sexual learning: Sexuality is "natural", a drive that gets out of control when it is not controlled.
- **Belief system:**
  - Performance: erection must always be possible
  - The man is responsible for the orgasm of the woman
- **Ideas** about relationships (dependence) and partners (fear not to suffice)
- **Negative concept** of male intrusivity, rationalization of lack of intrusivity: not wanting to "humiliate" woman, not wanting to be "macho"

- **Gender role:** narrow stereotypes where sensuality and pleasure are experienced as unmanly; distorted perception of women
- **Hetero-centering:** feels responsible for the pleasure of the woman, forgets his own pleasure
- **Mindset:** all-or-nothing, negative prophecies or catastrophizing

## Relationship components and ED

- **Seduction:** Strategies of "anti-seduction", such as clinging and demanding behavior
- **Attachment type:**
  - Not able to keep the distance to objectify the woman in her erotic attractiveness
  - Fear of commitment, can't allow intimacy
  - Coitus motivated by need of closeness and security (affective dependency, no eroticization), fear of loss
- **Erotic communication:** Speechless regarding own sexual needs and desires
- **Erotic skills:** poor. Does not take initiative, has no ideas for erotic games

## "Vicious Cycle": Reactions to ED with self-reinforcing effect

Most men try using self-help techniques to remedy erectile dysfunction and to get a grip on it. These usually lead to a negative spiral, with effects on the cognitive and emotional as well as the behavioral and relationship level. An increasing pressure to perform and fear of failure adds to the physical and psychological stressors that aggravate the problem further. It causes shame and guilt feelings towards the partner and activates the fear of losing her or him.

Sexuality increasingly becomes a tightrope walk.

Fear motivates the men to increased "empathy" into the situation of the partner. They step up efforts to "do it right" for them, believing to know what the

partner expects – which may or may not be the case. The more they are hetero-centered, the more out of touch they are with their own pleasurable sensations, and often also with the reality of the partner.

The vicious cycle increases stress and sympathetic activation. This worsens the physical preconditions of sexual functioning, inhibits vasocongestion, and sometimes can foster a tendency towards rapid ejaculation with an almost flaccid penis.

*The more threatened men feel by the failing penis, the more elaborate and usually dysfunctional the strategies to correct the malady. Thus, a mishap turns into a chronic erection problem.*

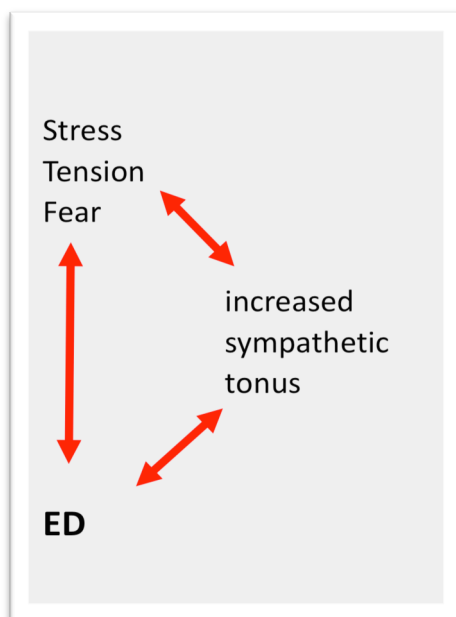


Fig. 17: Negative spiral

## Examples of reactions to ED

### **Attempts to bring the penis under control:**

A loss of erection, initially referred to as a mishap, elicits an anxiety that takes on its own life and manifests itself in the anticipation of failure. In an endeavor to control that which eludes all willful influence, the man remains trapped in fearful self-observation that prevents the pleasurable enjoyment of erotic sensations. The vicious cycle develops momentum.

### **Intensifying stimulation and arousal sources:**

Multiple physical techniques are used to intensify sensations: enhanced muscle tension, strong pressure, faster mechanical stimulation and other manipulations to the point of painful physical injury. Added to that are increasingly extreme pictures (internet) and fantasies.

As result, the man may not be able to feel his penis in the vagina anymore. In a mechanical effort, he tries to conjure up fantasies with harder contents in rapid alternation since their effect is only brief.

### **“Discovering” new attraction codes:**

Some men search for new experiences that include certain sexual scenarios, playmates, domination and submission rituals or fetishes to re-establish an erection.

### **From the search for pleasure to the fight for survival of masculinity:**

The search for pleasure is no longer in the foreground. The sexual encounter becomes a test and a performance that a man must provide to restore his male identity. Performance pressure and fear of failure are dominating his thinking and occupying an ever greater space. More and more, he may avoid closeness and tenderness, out of fear of triggering the partner's desire for sexual intimacy. This dynamic leads to the loss of sexual desire.

### **The man in need:**

Afraid of sharing his issues with friends, convinced that he is the only one with such a problem, the man isolates himself. He no longer feels part of the male crowd, but feels excluded and castrated and fears the loss of his partner. This often leads to depressive symptoms.

### **Phallic fault – from the culpable experience to blaming the partner:**

Trapped in shame and feelings of guilt, some men retreat and conceal their distress, while others look to blame the partners. In the search for reasons, the “inner policemen” announce themselves; for example, ED is fantasized as a punishment for “excessive” masturbation or visits to prostitutes.

**Myths and masculinity:**

A myth concerns the stereotype of the “real” man who does not show weaknesses and deals with everything himself. His masculinity is reflected in the number of vaginal orgasms he “gives” to his female partners. As ridiculous as these ideas appear, we find them deeply rooted in subtle forms in many men.

**The penis in the mirror of fear of unmanliness:**

The syndrome of too small a penis (despite normal size) is an expression of dwindling manhood. Penile dysmorphophobia and ideas of not producing enough male hormones go in the same direction. An examination of the genitals and the testosterone level through a physician is therefore not only important for medical reasons but also to calm these fears.

**Magical thinking is not a thing of the past:**

As early as 1486, *Malleus maleficarum* described examples of how witches robbed men of their penis or – a kind of imaginary castration – prevented them from feeling it. This was one of the reasons for the witchhunt for 200 years. Despite effective medication, even today the market offers no shortage of “potency agents” such as rhinoceros horns, all ineffective, a fascinating symbolism notwithstanding.

**Consequences on the relationship level: expansion of the vicious cycle**

To be desired no longer is unsettling to the partners. They believe they are doing something wrong or are no longer attractive. Fueled by their own insecurities and self-doubt, mistrust gives rise to the suspicion that the man entertains an outside relationship. The partners react furiously, demanding, jealous, or resigned, and avoid sex on their part. Their reactions intensify the man’s risk of failure, performance anxiety, and fear of loss. In the couple dynamics, with increasing frustration, conflicts shift to different realms of the relationship and can escalate. Relationship crises are often the trigger for the utilization of professional help.

From a perhaps banal mishap the vicious cycle evolves to a serious issue on the individual and relationship level. The narrower the limits of sexual appropriation and the more additional problems are present, the faster the negative spiral will turn.

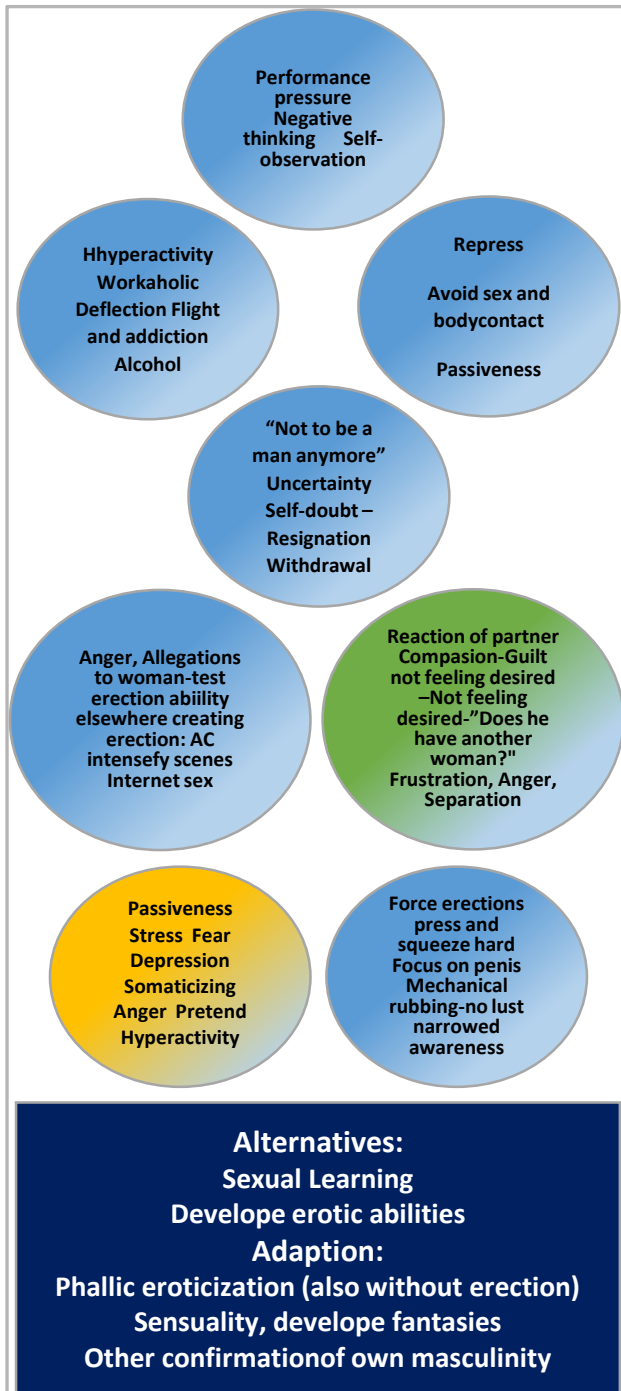
**Summary**

The most important “enemies” of erections are:

- Sexual inexperience, ignorance, negative views of sexuality (“inner policemen”), limiting arousal modes: AM, AMM, MM, and their muscular hypertension of the pelvic floor and the adjacent muscle groups.
- Wanting to willingly produce an erection under stress, fear of failure and performance anxiety: vicious cycle
- Hetero-centering: Wanting to do it right for the other person
- Negative assessment of male intrusivity: doesn’t want to be like all the other guys, wants to do “it” for the woman’s sake.
- No symbolization of intrusivity and no sexual fantasies of own activity
- Loves the partner but doesn’t feel any sexual attraction (desire for love without desire for sex)
- Disgust, aversion, phobia against the partner’s genitals
- Insecurity within own masculinity up to ambivalence in regards to gender affiliation

*Various medical and psychosocial factors of influence:*

- Physical illnesses, surgeries, medication with direct effect on the physiology of the erection
- Diseases which diminish sexual attractiveness
- Chronic pain
- Chronic illnesses with general weakness
- Stress
- Age, when limiting sexual abilities or other risk factors are present
- Difficult relationship or social situation



# Erectile Dysfunction

## Clinical presentation of erectile dysfunction

**Definition: Erectile Dysfunction, ED:** Persistent, temporal or situational inability to achieve and maintain a functional erection (volume and stiffness). Common denominator of different situations of ED is a fragile foundation in the arousal function.

**Medical-psychiatric Definition: National Institute of Health, (NIH), 2012, DSM V: 302.72 (F52.21) Erectile disorder:** At least one of the three following symptoms must be experienced in 75-100% of occasions of sexual activity: Marked difficulty in 1) obtaining an erection during sexual activity, in 2) maintaining an erection until the completion of sexual activity; 3) marked decrease in erectile rigidity; for at least 6 months, and causing significant distress in the individual. This definition excludes ED caused by stressors like relationship distress or medication.

**Lifelong (primary) ED:** Erection with partner has never occurred. **Acquired (secondary) ED:** ED, after erection with partner were previously possible. **Situational ED:** = ED only appears in certain situations, i.e. with a partner of a new relationship, vs. **generalized** = in all situations.

## Lifelong Erectile Dysfunction

*Lifelong* or *primary* erectile dysfunction is rare. Forms and causes are:

- a. Little or no stiffening of penis during self-stimulation, in partnership and spontaneously (night or morning erection), as far as they are remembered: Due to congenital disabilities and impairments of the physiological basis of sexual function: i.e. spina bifida
- b. Spontaneous erections, partial stiffening during self-stimulation, but never in relationships, in young men with special medical problems:
  - Unfavorable results or traumatic mental processing after surgical corrections in

hypospadias or other forms of intersexual development of the genitals

- Other illnesses and surgical interference of the genital area
  - Many diseases and disabilities affecting sexual development and causing relationship anxieties due to being physically different.
- c. Spontaneous erections, erection with self-stimulation, however never in relationships, with mostly young, insecure men without sexual experiences. In part, capacity to fall in love and to connect, in part strong fear of relationship. Their ignorance of female and male sexuality is significant. They are overwhelmed and want to “do it” for the love for the partner. They often suffer



from gender related fears: the penis is too small, too crooked, the vein on the penis is too big = projection of fears related to manhood onto the penis, with anatomically normal genitals. Here we find:

- Men with relationship fears and disgust or phobia with regard to male and female genitals. Some may seek safety with other men, letting themselves be penetrated without an own erection;
- Men with heterosexual attraction codes who are emotionally drawn towards women but have an aversion or even phobia about female genitals;
- Men with homosexual attraction codes who are emotionally drawn towards men but have an aversion or even phobia about the genitals of men;
- Men who negatively experience the penis, partly phobic avoidance of a relationship with own genitals, no arousal mode acquired;
- Men with attraction codes directed exclusively towards objects (as in diaper fetishism)
- Men with aversion, phobia towards own genitals in connection with the feeling of being a woman in a male body.

These men primarily function in AM, AMM or MM. They intend a quick and “hygienic” discharge through masturbation. There is minimal investment into genitality so that phallic eroticization could not be developed. The men are incapable of eroticizing a woman or a man as a sexual partner.

### General Approach

- Medical check, ask specific questions about volume and rigidity of penis!
- Medical treatment, if underlying cause is diagnosed
- Convey information and education
- Identify and amplify sensations of the genitals
- Get to know arousal sources
- Develop, respectively expand arousal mode
- Learn erotic relationship skills

## Acquired Erectile Dysfunction

*Acquired or secondary ED* often appears after an extended period of good functionality. Typically, it is progressive in nature:

- In the beginning, it only appears in partner sex
- Subsequently, it also appears with self-stimulation
- Eventually, spontaneous night- and morning erections become rarer
- And ultimately, erections remain completely absent.

*Situational ED* occurs in special situations with a specific context or in dependency of the type of stimulation by a (specific) partner. We find it often with men who have performance anxiety because of their hetero-centering and fusion desires.

### General approach:

Sexological evaluation, information, learning of sexual skills, often initially with simultaneous support through medication

## Profiles of men with acquired and/or situational ED

### Men between the ages of 45 and 75 years

Medical assistance for ED is most frequently sought by men from this age group. Typically these are men who until now have functioned with an AMM or a MM within the above mentioned “autopilot”. They have hardly developed their capacity to eroticize, hence they cannot compensate the sinking testosterone level through sexual learning steps. Additional factors like retirement, changes in a relationship, or illnesses can become typical triggers. A “moment of weakness” then turns into a chronic erection problem. The first “failure”, “breakdown”, “mishap” is often followed by a “crash” and the entry into the vicious cycle. This leads to the above described dysfunctional compensation

strategies and the development of a chronic erectile dysfunction. Some of the affected men develop anger towards their penis as the organ which denies them its service.

### **Men with performance anxiety**

These men have normal spontaneous erections in the morning and at night. They often experience good erections and ejaculations during self-stimulation, during which they can focus on themselves. Sometimes, a limiting arousal mode can make it difficult to achieve an erection even when they are on their own. In partner sex, ED can occur already during foreplay or at or right after penetration, fostered by hetero-centering (wanting to do it “right” for the partner) and the mental anticipation of a loss of erection. The inability to build up an erection at will leads to self-devaluation and insecurity about their own masculinity. Emotional pressure and desperate attempts to force an erection activate the neurovegetative stress axis with its inhibitory effect on erection. Despite good bonding and loving abilities, anxieties about separation and loss are often triggered when ED occurs, particularly in men who despite a good intrusivity have certain insecurities towards women or are concerned of hurting them during penetration.

### **Hypo-masculinoid men: Emotionally polarized men of the “bonding type”.**

Emotionally polarized men are usually characterized as hyper sentimental – hypo-genital – hypo-masculinoid. There are various sub-types:

#### *Men who are newly in love and are minimally anchored in their genitality and masculinity:*

Freshly in love, they enjoy pleasurable encounters with the admired woman/man and develop many skills in the “above” – on the emotional and relationship level. They often perceive the “below”, genitality, as negative, as animalistic and primitive. Their concept of masculinity as aggressive leads them to favor ideologies of the “feminist” male who is better than the “macho”. These men may start the relationship on an emotional high, while often experiencing problems with sexual arousal. The arousal mode is limiting (AM, AMM, MM). They have hardly developed their capacity to be aware of

their sexual arousal and to increase it. Flooded by emotions, these men miss out on the awareness of their sensations below. They feel “cut-off” from the perception of their penis, they feel “nothing” below the belt: “Above – intense emotions, below – a black hole”. They may not be aware at all of their often normal spontaneous erections.

These men usually find more security in habituation once everyday life has settled in. Their erectile function may normalize, unless the initial erectile problems trigger a vicious cycle of negative anticipation, stress, expectations, and performance anxiety.

#### *Men with fusion desires as principal sexual motivation:*

These men have invested little in genitality and have not developed many sexual skills. The desire for closeness, relationship and intimacy predominates. Penetration takes place in the service of love and fusion and is not eroticized. They rarely have intrusive fantasies, while romantic scenes featuring a beautiful woman are common. Autoeroticism is only practiced when there is no current relationship. As soon as the man enters into a relationship, he views autoeroticism (=sign of autonomy) as a threat to the relationship. The principle of these men is that “sexuality belongs in the relationship”. They often experience normal spontaneous erections that they rarely pay any attention to.

They have a very limiting arousal mode (AM, AMM, MM) both alone and in partner sex. ED is sometimes preceded by a history of premature ejaculation. The occasional problem within the relationship quickly destabilizes these men. They react with fear of loss and with stress. A single event of ED may already trigger the vicious cycle, as it is already experienced as existentially threatening, robbing the man of the opportunity of fusion.

### **Hyper-masculinoid men**

The hyper-masculinoid man stabilizes an insecure feeling of masculinity through a narrow stereotype in regards to his gender role, body and sexual behavior. He avoids anything even faintly implying an association with “female” behavior, looks and gestures. These men are therefore very genitally centered. Usually, they have a limiting arousal mode (AMM, MM) employing high

muscular tension. This muscular strength gives them security. They fear to reduce it as would be necessary to experience a more “fluid” sexual arousal diffusing through the whole body. This, along with the restricted arousal mode, limits the pleasurable experience of sexual arousal. Their insecurity in the feeling of gender affiliation is aggravated by the lack of erotization of the archetype of intrusivity.

## Men with specific problems directly associated with the arousal mode:

### Low Sexual Desire

*Coital sexual desire* (CSD) connects the “above” (emotional experience) and the “below” (genital experience), which means it integrates all components of sexuality in connection with various needs. Both sex drive and motivation for sexual activities are anchored very well within the CSD.

#### Definitions:

In dependence of the underlying needs, we discern different types of desire.

**Coital Sexual Desire (CSD):** Search for sexual arousal through coitus (both with men and/or women), pleasure, emotions, fantasies and surrender in orgasm (accompanied by various psycho-affective needs)

Requirements are: Discovering, adopting and eroticizing the penis and one’s own intrusivity and masculinity, i.e. phallic eroticization; eroticizing the partner and his or her genitals, sexual intensity and activity

**Coital Desire (CD):** motivated by the desire for love, closeness, security, fusion, children, strengthening of affective relationship

**Sexual Desire (SD):** motivated by the search for sexual arousal, discharge, relaxation

With the other forms of desire, i.e. *Coital Desire* (CD) and *Sexual Desire* (SD, see definitions below), limitations of sexual learning create a disharmony by polarizing towards the “above” or the “below”. This can inhibit erectile functioning. Without the driving force of coital sexual desire, sexuality becomes more prone to disruption; i.e. just putting on a condom or changing a position can already create a “sobering-up” and produce a subsequent loss of erection.

### Anejaculation, delayed ejaculation

A missing or delayed ejaculation often impairs pleasure, produces feelings of failure and leads to the loss of sexual desire.

### Various types of premature ejaculation /Ejaculatio Praecox (PE)

Premature ejaculation can be associated with ED.

#### *Rapid ejaculation Ia*

Rapid ejaculation is within 1-2 minutes after penetration, mostly because of a MM on autopilot habitually geared towards discharge. Erectile difficulties appear as a consequence of yearlong anti-erotic strategies which were developed in order to delay the ejaculation, such as aversive thoughts, clenching of muscles, interruption of intercourse.

#### *Premature ejaculation Ib*

Ejaculation less than 1 minute after or prior to penetration is mostly associated with high emotional tension, stress and/or fear. ED can occur if these factors become overwhelming.

#### *Ejaculation just after erection has been achieved IIa*

This appears with men who are at the onset of erectile problems and who try to intentionally ejaculate quickly before the erection disappears.

#### *Ejaculation from a partially erect penis IIb*

Ejaculation from a soft or only partially erect penis typically affects men over 45 or 50 years old who have until now functioned in “auto-pilot”. They have achieved few sexual learning steps and have barely developed any erotic skills. They have a tendency towards muscular hypotonia. Fear develops with the

first indication of erectile problems, and the vicious circle begins. These men perform intercourse without pleasure and only for the benefit of the partner. Similar as PE type I, they present their problem as premature ejaculation because they are not capable of holding back arousal. But on closer evaluation, the difficulty is to produce an erection. The penis erects and goes soft. The glans often remains soft. An erection may also be completely absent. It is just shortly before ejaculation that a certain degree of rigidity develops, which immediately leads to ejaculation. Or there is no erection and ejaculation takes place with a flaccid penis, with contractions of the pelvic floor or outflow of the sperm without tension in the pelvic floor. If penetration is possible then ejaculation follows immediately after reaching an erection.

These men can often observe a good spontaneous erection in the morning. Nocturnal spontaneous erections are androgen dependent, while erections when awake are strongly influenced by personal sexual learning steps. These men may also achieve a good erection during self-stimulation via visual stimuli or during sexual encounters outside of their usual relationship.

In all cases, medical causes such as diabetes or hypogonadism must always be looked out for (accompanying symptoms: fatigue and lack of energy).

*NOTE: It is important to ask precise questions during evaluation!*

### Causes of Erectile Dysfunction with PE IIb

Difficulty of creating an erection

- few arousal sources
- too much attention on penis
- Age

#### A. Difficulty of maintaining necessary tension

- for strong emotions
- for sexual arousal
- lack of muscle tone

Limits in sexual learning

- Arousal mode AM, AMM, possibly MM
- Genitals hardly appropriated
- No intrusivity in sexual fantasies

#### B. High muscle tension

Generalized muscular hypertension during sexual arousal

- prevents erection
- produces stress
- prevents blood supply

“Fighting” for erection: as soon as it is reached, ejaculation happens

- Minimal genital appropriations, few arousal sources
- No phallic eroticization

#### Therapy goals:

- Reinforce erectile function
- Elongate arousal curve

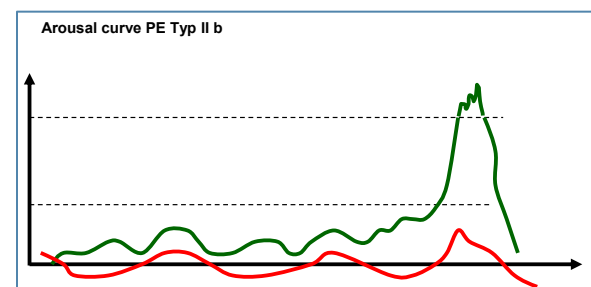


Fig. 19 Arousal curve PE Type II b

### ED in men with problems of narrow or exclusive attraction codes

#### Narrow attraction codes

Erection problems in partner sex often occur with men who only become sexually aroused with the help of specific *fetishes* or *scenarios*. These men are usually psychologically healthy, are capable of love and bonding, with a tendency towards “clinging”.

Example: A 47 year old man functions sexually with his partner and can penetrate her only if he wears female stockings, boots or other articles of female clothing.

These men may seek counseling mostly out of fear of losing the relationship once the partner realizes that they do not sexually desire her and can only reach an erection thanks to these “crutches”. Initially, corresponding fantasies may have sufficed, but with increasing age, wearing these pieces of female clothing becomes imperative. The pronounced need for closeness and the inability to eroticize the body of the woman or the stockings that she wears on *her* body prompt these men to “fuse” with the female “covers” on their own skin. Problems arise because they are unable to *eroticize distance*, that is the partner who is *separate* from themselves.

These men will often have many abilities but will have invested little into their genitality. They function in a narrowly limited arousal mode (AMM, AM) with no investment in their intrusivity, their desire to penetrate. Penetration does not appear in their fantasies. This is accompanied by a sense of insecurity in their masculinity. Their needs are situated almost exclusively on an emotional level.

### **Exclusive Attraction Codes**

Erection problems are also common with men who arouse themselves *exclusively* with *submission scenarios*. Here, the lack of intrusivity and of an intrusive archetype are even more evident. The phallic symbols are in the hand of the dominatrix and not in the hand of the man. In his fantasies, he pictures himself dominated, submitted, penetrated, and humiliated. Over time, these scenarios have a tendency to become more extreme. Confirmation of the equation “erection = male identity” can often only be found in specialized establishments or salons through sometimes extreme rituals. This fight for masculinity is not perverse but requires extensive effort. The dilemma of these men is caused by the anxiety of losing their partner because this sexual exclusivity often threatens the relationship. The men are usually able to love, but are

not capable of sexually desiring their partner. The tendency for increase in the scenarios is rooted in the decrease of excitability coming with age. The struggle for masculinity becomes even more elaborate, and it can take on compulsive and addictive forms. We will not find men in such a dynamic who possess a good relationship to their genitals, an arousal mode in waves, phallic eroticization and coital sexual desire.



# Practical Approach to Erectile Dysfunction

Men with erectile dysfunction are in distress, which is tangible during counseling sessions. In reaction to this distress, the therapist runs the risk to repress his own impotence through activism and expansive investigation from fear of not being able to help.

The patient, consulting an expert, expects to be seen with his sexual problem. "Beating around the bush" creates an embarrassing situation and can lead to misunderstandings. Sex therapy and sexual counseling therefore require precise questions, clear simple words and a direct approach to physical processes, sexual activities and sexual experiences. This makes it easier for the patient to express himself and allows for a better understanding.

It is the sex therapist's task to repeatedly summarize the patient's statements and answers. This allows for verification whether the patient has been properly understood. Precise words and exact and explicit terms are important. In these summaries, the strengths of the patient are pointed out: what he has learned, which erotic skills are available to him and what is currently functioning in his sexual arousal.

The evaluation is based on the expectations of the client:

- Does he want to function in order to retain his partner?
- Does he want to gain something for himself as a man in the relationship?
- What are his perceptions and explanations for the cause of his problem?

In Sexocorporel, an evaluation promotes the self-awareness of the patient by means of precise questions. It imparts sexual knowledge, emphasizes existing skills, signals understanding, and motivates personal responsibility. The approach is solution-oriented and includes suggestions for new experiences. Repeated

short summaries during the evaluation enable to recognize simple correlations.

Example: Brief excerpt of the evaluation session with a 40 year old man whose arousal mode is archaic and who loses his erection during intercourse as his wife's vagina "is too wide".

"...you have the capacity to increase your arousal while pressing your penis against a mattress and you have discovered the connection of muscle tension and sexual arousal. You also learned about the limitation of this capacity during intercourse and realized that the vagina of your partner can not produce the pressure to which you are accustomed to. You interpreted no longer feeling your penis as your partner's "vagina being too wide". A change in your physical technique to increase your arousal will significantly improve the sensitivity of your penis and your capacity for arousal...."

The evaluation includes:

- Evaluation of the individual components of sexual functioning and their interactions
- Analysis of body language
- Evaluation of the sexualization process historically in terms of
  - Development of arousal function
  - Development of sexodynamic components
- Evaluation of relationship dynamic

Evaluation of the sexual dynamic of a person therefore includes:

- **Horizontal reading** (current functionality), from the explicit (physiological components) to the implicit (cognitive and emotional components) to the relationship level.

- **Vertical reading** (sexualization process) of the most important components as well as relevant events in the course of sexual socialization

### Summary:

The evaluation gives us clues to the logic of the functioning of the client. It therefore allows a diagnostic of his sexual functionality and body dynamics. It allows us to show the patient his strengths – what he has learned in his sexuality. These strengths are the basis and the foundation on which therapy is built. The limits within his sexual learning steps become the content of the therapeutic project, which is formulated together with the patient on the basis of his request.

(after Claude Roux-Deslandes). The figure is referring to numbers from the following text.

### First impression, reading body language

Evaluation also includes observing how the client represents himself as a man: How does he dress? What is his body's expression? What's his handshake like, how does he move in the room, how does he sit down? Is his intrusivity mirrored by his body language, by his posture, walk, muscle tension, gesture, mimic, gaze and language? Does he seem more hypotonic, leaning forward, reserved, seeking closeness? What is the first impression he conveys about masculinity? How does he express his emotions, how does he regulate them?

### Evaluation of the individual components

The following list of questions can help with the evaluation. It is not meant as a checklist. Please feel encouraged to vary it, adapted to the particular client.

## Diagnostics and Evaluation of ED

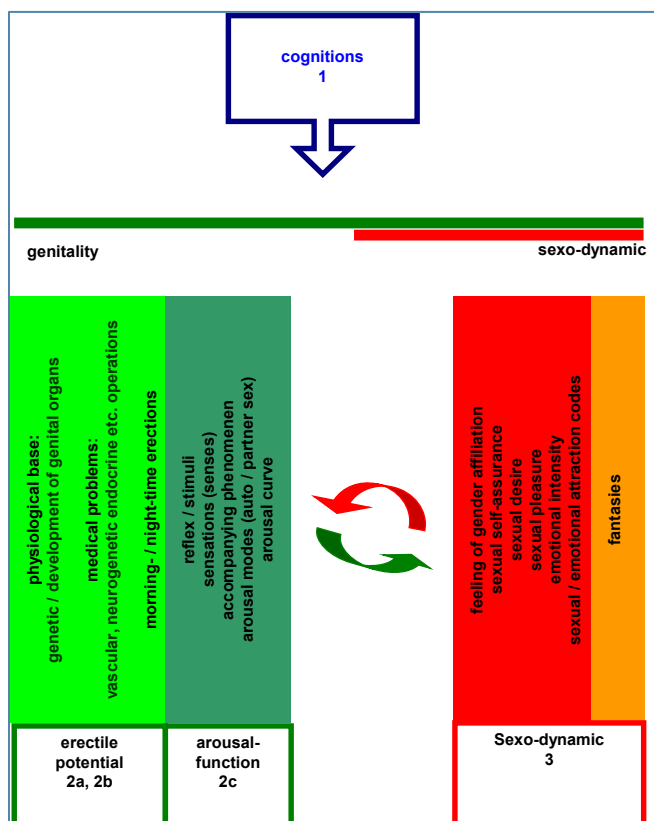


Fig. 20: Evaluation of sexuality's components with ED

## Cognitive Components

*Questions to clarify the demand - description of the problem:*

Do you live in a partnership? In a new relationship or casual relationship? What has changed compared to previous relationships?

Do you desire a better erection for yourself or for your partner?

What do you experience pleurably? Do you enjoy your own arousal or the pleasure of the other person? (Hetero-centering reduces self-awareness!)

Did you come to therapy because your partner says she doesn't feel your penis inside of her? Because your partner wants you to penetrate him anally and you would like to comply?

How long have you had erectile dysfunction?

What are your ideas about the causes?

Did it appear suddenly? In which situation? Did it begin gradually? Does your penis fail to get hard – is the erectile dysfunction always present? Is the erection problem limited to certain situations? Are there exceptions? Are there situations – like on vacation – in

which an erection is possible? When, where, how and with whom?

Can you achieve an erection, but not maintain it? Or is it not at all possible for you to get an erection?

What are your ideas about hardness and duration of an erection at your age?

What do you want to achieve for yourself with this therapy? How do you rate the therapeutic options?

#### *Questions about other potential sexual problems*

Are there other sexual problems? With you, with the partner?

Are there any anxieties, inhibitions, lack of sexual desire, negative feelings about genitals or bodily fluids (own and those of the partner)?

#### *Questions about the “vicious circle”*

What impact does ED have on your sexual behavior, your experience as a man, on your thinking, on your emotions? Which negative thoughts and concerns do you have? Which thoughts are unsettling?

Are there negative thoughts in connection with ED which produce pressure to perform, fear of failure?

What has changed in your relationship/s because of ED?

Are you worried about your relationship?

What have you done to test the function of your penis?

What’s the reaction of your partner?

Do you want your partner to come to therapy with you?

What is the significance of sexuality for you – for you alone and in the partnership?

What do you know about age-related changes in sexuality?

What kind of expectations do you have of the function of your penis? How “perfect” does it have to be?

What have you done until now? Have you run medical tests? Do you have experiences with PDE-5-inhibitors/Caverject/MUSE? What effects have you experienced?

#### *Questions about sexual attitudes*

What are your values, norms, what is your cultural and familiar background on the topic of sexuality? What do your “inner policemen” say to that?

*Further questions can be asked about:*

- Experience of own masculinity, ideas about roles, images of women
- Sexual development
- Psycho-social situations (especially stressors)

## Physiological components

### **Erectile potential: The “Engine”**

#### *Questions about organic causes of ED*

What medical examinations were conducted? *(This question is especially important if erection difficulty also appears with masturbation and if no spontaneous erections are being observed.)*

What risk factors play a role in your life?

Are you taking medication with potential effects on the erection?

Have you been diagnosed with an illness that could affect erectile ability?

*Physical examination through a medical doctor, especially of the genitals, also offers the opportunity to convey knowledge about arousal physiology.*

#### *Questions about spontaneous erections:*

When, where, how often do you notice spontaneous erections/“morning wood”/nocturnal erections?

*(Stress and anxiety are removed during paradoxical sleep [REM-sleep]. This allows for erections at night even when anxious self-observation may inhibit morning erections.)*

Spontaneous erections may be absent in case of:

- Specific medical problems
- Depression, also antidepressant medication
- Certain sleep disorders (lack of REM-sleep)
- Hyper-control, self-observation already when waking up

### **Arousal function: “Starting the engine and keeping it running”**

The arousal function is the basis of sexual functionality and determines the quality of the sexual experience. Its evaluation is indispensable and pivotal for diagnoses and treatment of erectile dysfunction.

*Questions about the arousal function*

Is the arousal reflex present? How do you know that the reflex is triggered? What is the first thing you become aware of? How long does it take until you notice significant blood flow/filling of the penis? What has changed over the years?

How do you perceive your penis when it swells up (but before it becomes stiff)? What sensations do you notice when the penis hardens?

Does the penis become functional, hard enough for penetration?

If a hardening is successful: In what angle does your penis stand up?

Rank the rigidity of your penis on a scale from 1 to 10. 1 means “no reaction” and 10 means “blazing erection”.

Where do you stand?

What form does your penis have? Does it have bends? Painful hardening?

*Questions about the diversity of arousal sources and stimuli during self-stimulation:*

How do you go about self-stimulation? How often do you masturbate? Has the frequency changed? In the past, did it occur more often, less often? How much time do you allow yourself for it?

What prompts you to do it?

What type of stimulation do you need to cause an erection?

What do you do in order to make your arousal pleasurable?

Do you always arouse yourself in the same way, or have you discovered different ways?

How do you play with your penis? Do you include your body during the masturbation? For example; do you caress your nipples, shoulders, belly or the inside of your thighs?

What body position do you prefer (laying on the back, stomach, side, sitting or standing)? Do you stimulate your penis with your hand? How do you take hold of your penis? Do you grab it with your whole hand? With two fingers? Do you only touch one part, like the tip of the penis (glans)? What kind of touch is your penis used to, rather a surface rubbing or more of a pressing, massaging? In which areas is your penis particularly excitable? Do you use lubrication for your hands? How

do you move your hand? Do you modulate the speed of your hand movement? Do you press/squeeze your penis or adjoining areas?

Do you stimulate yourself without the use of your hands, i.e. through pressing your pelvis against the mattress, through contracting certain muscles?

Which other senses take part during your self-stimulation? Do you for example look at pictures or movies, do you chat or read erotic literature? Or do you create pictures in your head and use your fantasy?

Do you use any sexual additives like a vibrating artificial vagina, dolls or any other objects? Do you insert objects into the urethra? Into your anus? Do you use other objects or particular rituals?

**Note:** With the desire to establish an erection by all means in order to confirm their manliness (“he is up, therefore I am”), some men rely on increasingly stronger stimuli. Sometimes they develop sexual practices for which they are ashamed. They often wonder: “Am I perverse, sexually addicted?”, and may not dare to mention their behavior. It unburdens them if the therapist proactively asks about different practices and can explain the logic of this behavior.

*Questions about physical changes during the increase of arousal*

The physical changes of muscle tension, breath and movement that accompany the increase of sexual arousal are a central part of the evaluation of the arousal function. They determine the quality of both sexual functioning and experience. Besides your hand, do you also move your body? What tension do you observe in your muscles? Do you tense up the thighs, stomach, butt and pelvic floor? Do you notice your breathing? When you are sexually aroused, in what part of your body do you feel your breath? Which techniques have you discovered in order to retain your sexual arousal? What do you change when you want to increase your arousal? Do you do it the exact same way alone as when you are together with a partner? What kind of sensations are you aware of in your penis? Where are you aware of them? What kind of sensations are you aware of in your body? Where? Do you enjoy sexual arousal or are you totally concentrated on maintaining the erection?

*Questions about ejaculation:*

How do you reach ejaculation? How do you manage to ejaculate when you are alone, together with the partner, inside of the partner (manual, oral, vaginal, anal)?

Do you ejaculate with a stiff or flaccid penis? In what grade of rigidity do you ejaculate? Does the semen flow or squirt from the penis? What is the volume of your sperm? What color is the semen? Have you noticed changes? Pain during or after ejaculation?

Are you satisfied with the duration of your sexual arousal or do you think you are coming too early or too late? In case there is PE: Have you always come too early? If not, when did you notice this happening? Do you possibly try to ejaculate quickly, before the erection goes away again?

*Questions about partnership sexuality and about arousal modes with the partner*

How often do you have partner sex? How does this happen? How do you experience it? Step by step, what is the course of action, the type of touch, what kind of games or roleplay take place? Is penetration a component of partner sex, meaning, is there any penetration of your partner's body with fingers, tongue, penis (oral, vaginal, anal)? Are you on the receiving end of penetration? Do both partners desire intercourse? Where does sex take place? How is sexual intercourse done, in what positions? Who takes the initiative?

How do you increase your sexual arousal (*3 laws of the body: rhythm, muscle tone, amplitude of movement, breath*)? What kind of movement do you make with your pelvis? Can you influence your sexual arousal, intensify it, prolong it? How? What helps you to have an ejaculation? How does the partner conduct him/herself, how do they increase their own sexual arousal? (*Hypothesis about the arousal mode of the partner*)

Do you use protection? If yes, what kind of preventive method is used? Who takes the initiative here? Are condoms being used? Is putting it on made playful? Does it mean an interruption with the risk of loss of erection? Do you and your partner pass on condoms because of fear of losing the erection?

Are other people included with partner sex? Do you have experience with role plays or sexual practices like BDSM (Bondage & Discipline, Dominance & Submission, Sadism & Masochism)? Do you include objects in partner sex?

*Arousal curves*

With the help of the client, we draw arousal curves both for self-stimulation and for partner sexuality. We elicit what precisely goes on on the physical, emotional and cognitive levels at all timepoints of the curves. This also provides the opportunity to convey knowledge about the physiology of arousal and influencing factors like sexual fantasies, negative thoughts and physical conduct.

*Questions about stimuli, arousal sources, attraction codes: The fuel*

Sexual arousal needs "fuel". This consists of sensory stimuli and sexual fantasies. The more varied these excitation sources can be used, the more effective the stimulation.



### Arousal Sources

Application of three laws of the body tension [T], rhythm [Rhy], amplitude of movement [M] during sexual arousal

Five senses	Touch, smell, taste, hearing, sight
Deep sensibility, Proprioception	Activation of musculature through T, Rhy, M By pressure By vibration
Superficial sensitivity	Touch Touch in genital area: directly stimulating (independent of top-down assessment)
Temperature/Pain receptors	(Frequent arousal sources during BDSM rituals)
Visual sense/sight	Erotic pictures/movies, seeing partner Effect possible despite negative cognitive evaluation
Olfaction/smell	Scent
Sense of hearing	Voice, moan, erotic audio books, music
Inner images, feelings, emotions as arousal sources	Erotic imagination, fantasies, reading, memories of experiences (can be effective as a positive reinforcement or as a negative inhibition) Scenarios, games eliciting certain emotions Strong emotions like feelings of love, fear
Attraction codes	Sexual attractiveness of sexual partner (body, genitals, person, characteristics, voice, actions)

### Emotional components

*Questions about sexual pleasure:*

What are you enjoying when you sexually arouse yourself alone?

What do you enjoy with your partner? Are you looking for a quick release, a longer “erotic journey”?

Do you find pleasure in versatile touches and games? What pleasure has remained since the erectile problems occurred? What changes did you become aware of? What is the course of the pleasure curve along with the sexual arousal curve?

*Questions about sexual desire:*

What needs motivate your sexuality?

Do you enjoy sexual arousal? Being horny? Are you looking for a quick ejaculation? Are you looking for closeness during sex? Reconciliation? Stress reduction? Commonality? Relaxation? Do you have sex because you want to possess the partner? Because of jealousy? Boredom? To feel like a man?

*Questions about sexual attraction:*

What's your sexual attraction for your partner: Physical characteristics, genitals, looks, words, smells, behavior, character? Do you react more to emotional (romantic) situations? Or are you more aroused by genital scenarios?

Does your sexual attraction refer to something specific? (Examples: special partner [age, type of body and size, skin color], special scenarios or rituals, objects, clothing, fabrics, children, animals)

*Questions about manliness and sexual self-assurance:*

In what situations do you feel confident as a male? At what point in your sexuality do you feel masculine? During what kind of situations have you experienced yourself as sexually self-assured? How do you strengthen your sense of being a man? How do you see yourself in comparison to other men?

What do you associate with spontaneous erections? How do you experience them in relation to your masculinity? What do you do with them? Do you "use" them for a sexual activity? Are they annoying? Are you indifferent to them?

How do you experience your erections? Do you wear them with pride? Do you look at yourself in the mirror when aroused? Do you move your pelvis? Do the movements of your pelvis influence your fantasies? How do you feel about your penis in daily life? Do you like it? (Men with ED may be angry at their penis for refusing its service.)

Do you have sexual fantasies, memories and daydreams? What significance do the contents have for the increase of arousal in masturbation? What significance do they have during sexual contact with the partner? What are the contents of sexual fantasies (how is intrusivity reflected in them)? Do you fantasize about actively penetrating? About being penetrated? Who do you penetrate, which orifice? Are you active with it or do you let it happen? How do you enact your

masculinity in fantasies? The same way as you portray it in reality? As a "player", active and seductive or as spectator, passive? Are other men present in the fantasies? What kind of masculinity do they embody, what is their role?

What contents of fantasies arouse you the most? How secure do you experience the boundaries between fantasies and reality? How far do the fantasies influence your sexual behavior? Are there fantasies that worry you?

*Questions about manliness and sexual self-assurance within partner sexuality:*

How do you experience your penis together with your partner? Do you show your penis with pride? Do you let yourself be touched, can you "hand him over" and let someone else arouse you? Are you doing mutual physical explorations? How do you experience your partner's genitals, how and why do you touch, stimulate them? How and who initiates and designs the sexual contacts? What anticipations do you have thereof? Do you plan the sexual activities?

Do you experience penetration as exciting and as a pleasurable encounter with another person? Do you desire it explicitly? Do you do it because it's "what a man does", or does it actually make you feel more masculine? Do you do it automatically, because the erection is there and you might as well? Do you penetrate because your partner desires it or to father a child? Who inserts the penis? How do you experience your partner's genitals in appearance, with their smells and secretions? In case of anal penetration, your partner's anus?

If you like to be penetrated, does this foster your sense of masculinity? Do you have an erection with it? When your partner stimulates you orally, do you passively let it happen or do you actively penetrate their mouth?

*Questions about emotional intensity*

How do you express your emotions (words, gestures, voice, breath)? With what kind of intensity do you enjoy your arousal, your "being a man"? How passionate, how strong do you feel?

## Relationship and partner sexuality

Topics of evaluation of relationship and partner sex include:

- Quality of relationship, experience of intimacy and autonomy
- His ability to seduce the partner erotically (a man with ED rarely seduces anymore because he can't keep up "his end of the promise")
- The ability to talk about sexuality, his own desires, insecurities
- The manner of staging an erotic encounter

*Questions about partner's reaction to the ED:*

What has changed within the relationship? Do other conflicts arise? Do you avoid sexuality or even tenderness? Did you both find possibilities to develop alternatives?

## Diagnostic and logic of the system

Starting from the patient's request and based on the evaluation we try to provide him with a summary of our findings – *the logic of his system of functioning*. We demonstrate his abilities and the limits within his sexual learning, which, together with medical and possibly other problems, constitute the erectile difficulty.

On this basis we formulate the sexual concern of the patient, which is often presented as a deficiency, in the form of a wish. We translate this wish into a realistic and viable therapy project. The therapy project is structured into stages of treatment proposals with limited objectives that enable the improvement of sexual function.

It is essential to clarify the client's expectations for therapy: Therapy goals must remain realistic.

Following further medical diagnostics may be indicated:

- Hormone status: Testosterone (in mornings), Prolactin, FSH, LH, Thyroid hormones
- Fasting blood sugar, HbA1c, blood lipid levels
- Urinalysis

- Urological/andrological assessment

## Sexual Counseling and Sex Therapy

### Therapeutic setting

Focused sexual counseling or therapy with a limited number of sessions includes:

- Face-to-face dialogue
- Working together on the whiteboard
- Physical exercises in various positions
- If necessary, tactile assistance to upper body while teaching the double swing

The therapeutic sessions consist of both the in-office experience and reports of at-home exercises. Practicing together with the client "emotionalizes" the session. It leaves room to intensify the red thread of therapy and the client's relationship to his sex (penis, masculinity) in its cognitive, emotional and erotic dimensions, with a sense of humor. The therapist can also demonstrate the exercises this way and simultaneously imitate the client to experience what he is experiencing.

### Conveying knowledge

The goal of imparting knowledge is to promote the motivation for treatment and to achieve an engagement on the cognitive level. Knowledge includes the following areas:

*Basic knowledge of erectile function:*

- Arousal function: the arousal reflex, its accompanied reactions, learned arousal modes, sensory stimulation, arousal sources and arousal curve
- Conditions for triggering the arousal reflex: Play with stimuli, feeling comfortable without forcing allows relaxation of the smooth muscle fibers in the spongy tissue of the cavernous bodies of the penis
- Strong emotions like stress, fear, worries and high expectations hinder the triggering of the arousal reflex

### *Ways to influence the erection (steps in the sexual learning progress)*

Understanding the function of the penis is necessary. Men with ED often try to deliberately force the reflexive arousal process. They should understand that they inhibit the penis this way. As soon as they perceive that the penis base swells, the reflex is working. This process can be stopped suddenly by hindering influences. Sexual arousal can be influenced and the erection can be maintained through the three laws of the body (T, Rhy, M). It's not the focus on the penis that will bring success, but rather the enjoyment of the sensations.

Understanding the function of the penis also means accepting the difference between a realistic erection and one's expectations. Rigidity and angle of erections change after the age of 45.

### *Effect of physical exercises on the arousal function:*

- Direct influence on the function of the cavernous body of the penis is possible via the pelvic floor muscles. Particularly the isiocavernous muscles determine penile rigidity (Lavoisier et al. 2014).
- The stimuli used for arousal and the way the penis is touched are of importance. The activation of sensory receptors in the whole body can intensify stimulation.
- The body-brain unity is inseparable: Changing the relationship with the body, e.g. via the arousal mode, changes the way we perceive ourselves. This can be made understood through the analogy of dancing or sports: How do you perceive yourself dancing or doing sports in muscular rigidity as opposed to fluidity? It can be very effective to demonstrate and allow the patient to experience such differences during the consultation!

### *Effect of physical exercises on the vicious circle:*

- Changes in self-perception through practice reduce the influence of the negative spiral
- Practice leads from hetero-centering to auto-centering: Self-awareness is not egoism, but a prerequisite for being a good lover

- Personal responsibility takes the place of feeling responsible for the partner
- Wanting to do it right and performance anxiety are being replaced by pleasure

### *Fantasized anatomy:*

Men with penetration anxieties are fearful of injuring either the woman or their penis. Drawings of their own bodies (outline), of a flaccid respectively aroused penis as well as the female genitals (outer and inner parts) reveal cognitive distortions: very often there is a lack of knowledge of one's own sex and – sometimes rather impressively - of the female sex.

## Medical treatment options

### Medical therapy

#### **PDE-5-inhibitors:**

Phosphodiesterase type 5 inhibitor (in short PDE-5-inhibitor) is the generic term for a group of drugs that promote the inflow of blood to the penis by causing a dilation of blood vessels. An increasing number of substances are on the market. The drugs act specifically on the corpus cavernosum by inhibiting the effect of one of the enzymes (PDE-5) necessary for controlling the blood vessels. The blood flow into the cavernous body of the penis is therefore enhanced and allows for an erection to take place and to be sustained.

The erection only occurs with adequate sexual stimulation. It ends with the ejaculation. Repeated application increases the effect, exaggerated expectations inhibit it. PDE-5-inhibitors are prescribed by a physician, individually dosed and taken as needed. In Sexocorporel therapy of ED, patients may benefit from a transient supplementary use of PDE-5 inhibitors when performing exercises to enlarge the arousal mode, particularly an AMM, as the exercises initially tend to weaken the erection.

Here are some *side effects* that may occur with use: Headaches, flush, dyspepsia; hang-over on the morning after, with pressure in the head and nasal congestion. With Tadalafil there may also be back- and other muscle pain.

*Failures of treatment with PDE-5-inhibitors* can be seen especially in men who have very few arousal sources at their disposal. In the following cases, the effect may be reduced or absent:

- If the arousal function is very limited by an arousal mode requiring high muscular tension (AM, AMM, MM)
- If stress, anxiety and pressure to perform led to ED and there are minimal sexual learning steps or knowledge
- If the client is not willing to engage in sexual learning steps/practicing
- With missing sexual desire of the partner, long duration of the preceding abstinence
- If too high expectations and self-observation prevent a pleasurable mood
- If a “pill” is experienced very negatively, as a “prop/crutch”, “artificial” and therefore is “not an expression of one’s own masculinity”
- If the partner is against the medication, e.g. because the erection is “artificially produced and not a consequence of her female attractiveness”
- Fear of becoming dependent on a “sexual enhancer”
- If intrusivity was not acquired and not eroticized, meaning that penetration fantasies are not possible or are even viewed negatively. The man does not want to be “Macho”, “respects women” and sees penetration as a risk of injury.

Things to consider for physicians when *prescribing PDE-5-inhibitors*:

1. Don’t hurry
  - Listen, take your time, take the issue seriously, possibly schedule a second consultation
  - Make sure the indication is correct
2. Avoid writing a prescription at the end of the appointment or using statements like “Try this, it works great“. This creates an illusion and enhances performance anxiety. It also creates fear of not satisfying the physician if the patient can’t “deliver” success (hetero-centered patient).

3. Do not use the explanation “the problem is in your head”, therefore psychological.

- “Psychological” signifies incomprehension, judgment. What is psychological produces fear, awakens negative associations.
- It is central to understanding a client’s ED to perform a primary assessment of his sexual functionality, i.e. an evaluation of the components of his sexuality as direct causes of ED, before indirect causalities are solicited.
- In addition to the direct causes, certain emotions (anxiety, pressure, stress) do have a negative influence on the physiology of erection.

4. Continuous medication (application three times per week or daily) is preferable

- Test medication with masturbation using particular exercises for better stimulation
- Medication decreases fearful expectations, allows for sexual arousal (bodily anchor) and re-instates the patient’s confidence

5. Emphasize: “It takes time for the medication to take effect.”

- Reduces expectation anxiety
- Consider paracetamol as prophylaxis against side effects in first two applications of medication

#### **Testosterone:**

Without the presence of actual hypogonadism, erectile dysfunction should not be treated with testosterone.

#### **Yohimbine**

Yohimbine, or Yohimbe, is an indole alkaloid extracted from leaves and bark of the Yohimbe tree (*Pausinystalia yohimbe*) in Central Africa. Yohimbine blocks alpha2-adrenergic receptors in the blood vessels of the male sex and in the central nervous system. The effect is minor. Yohimbine is prescribed by the physician and taken daily. The daily dosage is individual (3 to 6 pills per day).

#### **Apomorphine:**

Apomorphine is a dopamine agonist used in therapy of Parkinson’s disease. It is no longer being sold for the

small-dose use in ED (Uprima®) due to low sales. Apomorphine is still the subject of ED research.

### Methods which require an invasive manipulation in the genital area

#### CCIT:

Corpus Cavernosum Auto-Injection Therapy (CCIT) enables an erection through the patient who injects a drug into his penis. This used to be papaverine/phentolamine, whereas today the body-borne and more reliably reacting prostaglandin E<sub>1</sub> is used. It relaxes the muscles of the erectile tissue and arteries. The ensuing erection is “pharmacological”, which means it is independent of sexual stimulation.

Under medical supervision, injection procedures can easily be learned by most patients.

CCIT is prescribed by a physician and the injection is carried out when needed.

CCIT may be indicated for patients after radical prostatectomy who are not responsive to PDE-5-inhibitors.

The following are possible side effects of CCIT: Hematomas, pain, prolonged erection to the point of priapism. If the erection lasts more than 4 hours, there is a risk of erectile tissue thrombosis. After prolonged use of CCIT erectile tissue fibrosis can occur.

#### MUSE:

MUSE® (Medicated Urethral System for Erection) is applied in the urethra. The active ingredient alprostadil (Prostaglandin E<sub>1</sub>) is inserted into the urethra. The drug enters the corpus cavernosum, where it leads to increased inflow of blood. In addition, the cavernous bodies are dilated which reduces the exit flow of blood from the penis. This can lead to an erection lasting about 30 to 60 minutes. MUSE® is prescribed by a physician and applied when needed. The effect is weaker than with CCIT.

The following are possible *side effects* of MUSE: Burning in the urethra. A burning in the vagina may also occur as an unpleasant side effect. Other side effects are similar to that of CCIT.

### Mechanical and surgical procedures

**Penile Prosthesis:** (Corpus Cavernosum Implant)

The surgical implantation of an artificial cavernous body can be performed when all non-surgical procedures are unsuccessful. However, this procedure cannot be reversed without permanent loss of erectile function. Therefore, a careful benefit assessment by the physician and patient is required. With permanently rigid cylinders, the penis is bent upwards for intercourse. With hydraulic prostheses, a pump that is implanted in the scrotum pumps fluid into the cylinders in the cavernous bodies, thus inflating them.

#### Vacuum pump (= Vacuum Erection Help)

The vacuum pump is a well-established therapy for erectile dysfunction. A plastic cylinder is placed over the penis; a vacuum is generated with a hand pump. As a result, venous blood flows into the penis and it stiffens. Subsequently a strong rubber ring is stripped over the penis shaft. This prevents blood outflow from the penis. The resulting erection is “hanging”, and feels cool to the touch. The vacuum pump is not always acceptable for couples because its use is associated with a certain effort.

*Side effects:* The penis bends at the base, turns bluish and can be painful.

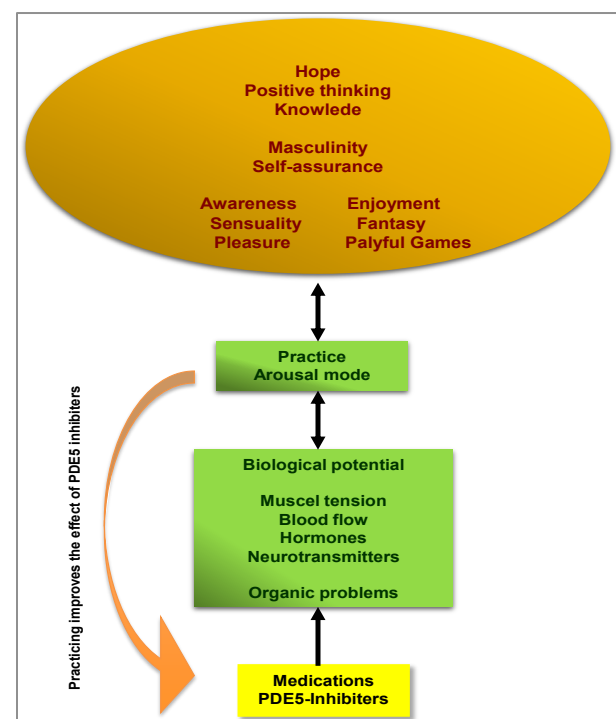


Fig.21 Effect of PDE-5-inhibitors and sexual learning, practicing



For one man, support through medication signifies restoration of his potency; another man experiences it as an estrangement in his self-perception.

The acceptance of medical treatment is very much dependent on how counseling takes place and on the attitude of the doctor.

## Establishing sexual functionality

Actual practice of physical processes is fundamental in Sexocorporel therapy. Repeated practicing results in a change in the relationship to one's own body and one's own sex. The arousal function, the erection, must be secured as a first goal before working on eroticization.

- **Sensory rehabilitation of the penis:**  
Discovery and appropriation of the penis through expansion of stimuli and arousal sources
- **Broadening of the sexual arousal mode:**  
Learn to increase arousal through the arousal mode in waves.  
Enjoyment of sexual arousal
- **Increased perception of one's own masculinity**  
Work on body awareness and body expression: posture, gait, centering, etc.

### *Awareness of the penis in everyday life:*

Goal: Shifting the focus from negative thoughts to the real sensations in the genitals and the body

- “Morning greeting”: Conscious play with the penis when waking up. If it greets you with a morning erection, reciprocate the greeting, try to extend arousal.
- Conscious soaping up, playing in the shower
- Awareness of penile sensations in different everyday situations: while urinating, while walking, while playing sports etc.
- “Evening prayer” with one’s own sex: rest your hand on it to fall asleep

### *Intensifying stimuli:*

From a mechanical approach to a dialogue with the penis:

- Awareness of different sensations with flaccid and increasingly stiffening penis
- Touch and explore the different areas of glans, shaft and testicles.
- Experiment with different qualities of touch: fine stroking up to pressing, pulling, shaking, massaging with oil.
- Play with the three laws of the body: Variation of rhythms, range of motion and pressure.
- Care instead of contempt for the penis.
- Extend the sensory discovery journey to the perineum, anus, thigh, buttocks and abdomen.
- Extend the touch to the whole body. Especially hyper-masculinoid men will associate such touches with being gay. The following picture can be helpful at that point: He who plays with the whole orchestra of sensory cells of the body instead of only with the kettledrums will find more response.

*From a fixation on failure to discovering the penis as a “sensory organ”:*

Awareness and sensory exercises divert the man from a negative fixation on his penis. Through new sensory experiences, he can become a “penis-interested” man, a man who values himself and is curious about his own sex as a place to encounter himself. He can discover new sensations through play with the pelvic floor, with the muscles of the cavernous bodies. A helpful picture: External manual touching of the genitals and “touching” with the pelvic floor as the “internal hand” establishes the contact between inside and outside. Simultaneous external and internal awareness of the penis usually goes along with the impression of having a larger sex. Thus, the body image may change and enable a “penis enlargement” even without surgery. Depending on the swelling and stiffness of the penis, different sensations arise. The man can practice to observe them and to describe them: he can develop his “GPS” for varying degrees of erection. Conscious awareness of the location and quality of sensations associated with sexual arousal broadens the base of the erection.

Frequently it is only in the course of their explorations of the pelvis - from the bony scaffold over the muscles to the openings of the anus and the urethra – that men realize a previously unperceived

enormous tension of individual muscle groups (sphincter muscles of the anus, adductors, and abdominal muscles). This restrains pelvic mobility and perception of the sex. During practicing, we focus on the different levels of letting go and on the sensations, feelings and fantasies that are being triggered. This means to allow for space for the sex between the legs instead of constantly holding it tight. For most men, letting go of the anal sphincter is fraught with meaning. Widening the abdominal interior through breathing, often uncomfortable in the beginning, becomes pleasant and a precursor for expanding sexual arousal. From letting the penis jerk up and down and activating the muscles that lift the testicles to moving it through swinging and circular pelvic motions, the penis will be enabled to discover the environment.

**Note:** Restoring and strengthening the erection needs appropriate arousal sources and an arousal mode that allows to increase sexual excitement through pelvic swings, play with muscle tone, movement, rhythms and breathing.

*The penis in motion: Introducing the pelvic swing:*

We begin with circular pelvic movements, so that the man can become conscious of the mobility of the pelvis, and then proceed to swinging motions. The pelvic movements enhance the outer space and can be perceived as "taking up space".

One's own breathing room can be identified through the placement of the hand. Breathing should be deepened to the point that the lower abdomen rises and falls. Abdominal breathing expands the internal space and thus the internal experience.

At home, the man has the task of combining these exercises with sexual arousal and repeating them in different positions and possibly every day.

Exercises are always adapted to the individual, based on the client's arousal mode. Conscious awareness of one's own arousal mode is therefore always a prerequisite. This is followed by a step-by-step introduction of the new elements into sexual arousal

during masturbation. The sensations and movements become familiar through repetition until new automatisations develop.

*From old automatisms via awareness to competency in the new mode:*

The transition from becoming aware of old automatisms towards learning of new competencies is often unsettling. With the limiting types of arousal modes (AM, AMM and MM), the man usually focuses his awareness on a small area of rubbing or pressing in addition to the local and general muscular tension. The new forms of moving and stimulating initially make it difficult to maintain sexual arousal because the perception is broader and does not match the old pattern, and men at first tend to feel distracted from their sexual arousal.

The goal of the first phase of exercises is to move and navigate the penis via the pelvis - to let it slide within the oiled hand and to be able to penetrate the "orifice of the fist".

*1. Example: Client in MM*

In his mechanical arousal mode the man rubs his penis mechanically in order to increase his sexual excitement. During the stimulation he tenses his gluteal and pelvic floor muscles. He rubs quickly with the aim to ejaculate. A first goal of exercises is to introduce small changes within the rhythm, range of motion and the pressure on the penis while maintaining sexual arousal. Rhythmic tightening and letting go of the "corpus cavernosum muscles" (pelvic floor muscles) allows the blood to be "pumped" into the penis instead of being cut off. This can be synchronized with breathing (tightening while exhaling, relaxing while inhaling). The internal space is opened with the abdominal breathing which can temporarily decrease sexual excitement. With the regular practice of the pelvic swing (exhalation with the penetration movement, inhaling while lowering the muscle tension) the man learns to perceive the back and forth motion of the penis in his hand and the rhythmic activation of the muscles as a stimulus for his arousal. Initially, he may intermittently resume his habitual arousal mode to help improve the erection.

This way he can successively integrate new elements up to new and different positions.

Regular medication support may be useful in the first phase of practicing: exercising three times a week with a small dose of a PDE-5-inhibitor can facilitate the learning process.

## 2. Example: Patient in AM/AMM

With the archaic or archaic-mechanical arousal mode, the man presses his penis to increase his arousal, for example against the mattress. He may lie on his stomach, without touching his penis, while tightening up the muscles of his whole body to the point of blocking his breathing. The pattern may be very precise and any deviation may entail a loss of erection. So as not to discourage the man, it is important to introduce only minimal changes of behavior. Instead of constantly tightening his muscles he may try the following: While he is lying on his stomach, he may try to influence his sexual arousal with fine pulsating muscular variations; a gentle back and forth gliding of the body and minimal movement of the pelvis. He can put the hand under the penis and tentatively change the position to lying on his side. He then creates the familiar pressure, but with the hand instead of the mattress. Only when sexual arousal can continuously be held while making these small, incremental changes, movement and breathing space can be expanded without loss of the erection.

Here, too, in the first phase of practicing, medical support can be useful. The path from a stiff and inflexible arousal mode to a moving one can be rocky and steep and requires perseverance, patience and regular practice.

### **From an upright penis to an upright masculinity**

The body is the mirror of our feelings, emotions, and awareness. Working with the body, posture, gait, and centering changes self-awareness. Men with ED devalue themselves, suffer from feelings of failure and anxieties which "embody" themselves and thus further strengthen the vicious circle. With modifications on the level of the body, we can witness and experience the unity of body-brain. Here is an example of Paul Ekmann (2005): Pull the corners of your mouth downwards and think about something positive, pull

up the corners of your mouth, think something negative and perceive contradictions. Similar exercises with posture give the client the opportunity to actively influence his mood and his masculine feelings in everyday life. Walking exercises focus on the movement of his pelvis and the way he carries his sex in conjunction with an upright posture and abdominal breathing.

## **Eroticization of the sensations associated with sexual arousal**

### *From self-stimulation to pleasurable enjoyment in auto-eroticism: The penis as an organ of pleasure*

Based on the changes the client experienced in the practice of the pelvic swing, we explain to him that feelings are expressed with the upper swing ("emotional swing"). This becomes most evident both physically and sensually in laughter and crying. Abdominal breathing helps to become aware of the pelvic space and to regulate affects. Knowing the benefits of abdominal breathing is particularly important for anxious men who require a precise explanation and the practice and experience of abdominal breathing during the session. Thanks to explanations and exercises, the patient also learns to distinguish between pleasure in general and sexual pleasure: the movement of the double swing combines the emotional pole (upper swing) with the genital pole (pelvic swing). As a further learning step, emotions can be intensified through the voice which lends expression to one's own sexual pleasure and passion in moans and words.

### *Increasing arousal as a sensual whole-body experience: The penis as an "exorcist"*

With the double swing, sexual arousal can be channeled (with concentration in the pelvis) and increased to ejaculation by means of escalating muscle tension and rhythm. In contrast, fluid movements and a circular motion of the pelvis lead to a diffusion (spreading throughout the body) of sexual arousal, to pleasurable perceptions, thus extending sexual arousal. Increasing confidence and familiarity with a variety of exercises lead to improved erections and to

the discovery that slowness and pauses are at the base of increased sensuality and more conscious pleasure.

Broadening the realm of sensory perception gives sexual fantasies more of a flow (in contrast to the effort to hang on to them). Fantasies encompass all of the senses (visual images, odor images, audio images, body images). Body fantasies are often the first signs of improving arousal. First visualizations of the penis sliding back and forth in the hand and of the moving pelvis are the beginning elements of stories with other bodies. A change in the relation to the own body affects the experience and inner symbolizations that will in turn increase sexual arousal. This results in a positive reinforcing of the "arousal circle" that replaces the "vicious circle" of negative expectations and thoughts.

*Phallic eroticization: The penis in phallic robes*

The pleasurable awareness of the "pelvic-driven" penis strengthens its integration into the symbolism of one's own masculinity. *Narcissism*, i.e. the appreciation of one's own person, one's own body and gender, grows. The sight of one's own aroused body in the mirror generates the desire and the ability to show one's own sexual excitement to others: *Exhibitionism* - the desire to share one's sexual arousal with sexual partners - is being strengthened.

Pleasurably penetrating the hollow of the fist with the penis with pelvic motions that can be subtle to powerful intensifies *sexual aggressiveness* (the intensive enjoyment of the idea to penetrate, thus being intrusive) without the fear of injuring. This altered experience of one's own masculinity causes symbolism of penetration in sexual fantasies. The reality of the aroused and sensually perceived penis entails the symbol of the *phallus* as an expression of intensity in the experience of one's own masculinity. The penetration experience is amplified by this symbolic dimension and enables the construction of a feeling of masculine intrusivity through body expressions, posture, voice and gaze.

*Eroticization of partner and penetration – Development of coital sexual desire: The penis is "looking".*

The aforementioned sexual learning steps allow the expansion of one's own attraction codes and broaden

the view onto others. This way of seeing may adorn the long-term partner, it will make her or him appear sexually exciting and sexually desirable (just as the intensity of one's love makes the other appear lovable). The more intensely a man perceives his own masculine identity in sexual arousal, the more aspects of the partner will receive erotic significance, i.e. her/his personality, her/his body and sex.

Penetration thus signifies encounter with the partner. This sexual encounter also means to surrender to one's own erotic intimacy, to one's feelings of pleasure and to the pleasure of the partner who is enjoying this intimacy. An erotic relationship is deepened when the man experiences himself as a subject, and when he has integrated his aroused penis and his intrusivity into his masculinity. The paradox here is to remain related to oneself at the moment of penetration, even though it's the moment of symbolic fusion in a love relationship. Such auto-centering is the prerequisite for lustful enjoyment.

*Relapse incidents*

"I didn't have any time/desire to practice, everything else was more important...." are common responses in therapy. Possible reasons for motivation problems are:

- The patient has no understanding how his problem should improve with our approach, especially with the exercises. This is a challenge for the therapist. Did he/she really understand the patient's concern and the logic of his functioning? On the one hand, was the client sufficiently explained the context and significance of the exercises? On the other hand, it's mostly the experience of doing them that will improve motivation to do new exercises.
- Some men emphasize the importance of sexuality, especially when it no longer works, but are not willing to devote more time to it.
- Hetero-centric men practice for the therapist, they want to be good students – which is in accordance with the logic of their functioning. To take their penis into their own hands awakens an inner moral voice and the fear of autonomy. It leads to uncertainty and worries about the partner and about not being able to control "it" any longer (= desire other women). Fantasy content and emotional intensity may also unsettle them. Letting go is experienced as a loss of

control, while male intrusivity and aggressiveness are often devalued as destructive.

- Influence of couple dynamic (see below)

Ups and downs, good and bad days, difficult moments are all normal! It takes realistic expectations in regards to the progress. Learning requires many experiences, including disappointing ones.

## Relationship skills

Relationships skills include showing oneself to be attractive, developing strategies of seduction, creating erotic encounters, and communicating one's own experiences and desires.

### *Session with a couple:*

This can be used to clarify the effects that ED has on the partner and the relationship. Attitudes and aspects of the relationship dynamic that possibly impede cooperation can be addressed. Usually, it is beneficial to separately evaluate the partner and work on the partner's own limitations (sexual dysfunctions) in subsequent individual sessions. Couple sessions are held in a second phase, and joint exercises to explore at home are then proposed.

### *Modified sensate focus exercises:*

Exercises are adapted to the abilities and limitations of the couple.

Here is a small selection.

### **Creating a pleasant atmosphere as a prerequisite for learning:**

Overcoming mutual inhibitions and shame regarding nudity and showing one's own arousal

- **Talking with partner about sexual needs, desires and fears**

Talk about arousing topics (ways of being touched, behavior); positive anticipation is thereby enhanced.

- **Enjoyment of sensual touching**

Naked, for 5 minutes touch the entire backside of the partner, then change roles; then the front side without touching genitals and breasts; then again the backside. This is not about massage, but about

free touching, stroking and kneading in accordance with one's own needs (instead of doing it right for the partner). In both roles, awareness remains focused on one's own body.

Experiment with different sensual touches: stroking, holding, kissing, licking, using oil, powder or objects. Also visit smaller places such as the eye-lids, toes, hair, back of the knees, ridge of the nose.

In being touched, learn how to amplify own sensations with the help of breath and fine movements instead of chronic relaxation that will in subsequent exercises prevent sexual arousal. For many men with ED, it is much more difficult to concentrate on their own sensations, to cause pleasure to themselves during giving and taking than to try to create pleasure for the partner.

- **To become mutually acquainted with the sexual organs**

The partner leans back comfortably, buttocks on pillows, the man sitting opposite of her. She instructs him for 15 minutes to explore her erogenous zones, discussing the sensations she enjoys and the ones she does not enjoy. He can explore her sensations on the breasts, nipples, abdomen, hips, inside of the thighs, vulva lips, pelvic muscle and vagina internally. The partner is guiding his hand. He imagines her vagina like the face of a clock...the top being 12 o'clock. She describes her sensations according to the numbers on the clock.

The man guides his partner in the exploration of his body, beginning with his breast and the nipples. He tells her his sensations. She explores his genitals, holds his testicles. Then she puts his penis on his stomach, explores the shaft with her fingers. He gives her precise feedback and lets her ask questions.

- **Stimulating touches:**

The man is instructing the partner to slowly and sensually touch his penis, testis, groin, and thighs. His attention remains on the sensations in his penis, his abdominal breathing, play with the pelvic floor, pelvic swing (movement instead of continuous muscle tension or relaxation). He can play with intensifying tension, rhythm, movement, breath, voice, and enjoy his partner, her movements, breasts, etc.

Touching with oil and lubrication triggers sensations as during intercourse.

Trying out different positions.

- **Penetration**

He can enjoy the sensations of the penis, the warmth of the vagina, having his penis grasped by it, try out pelvic movements. Deliberately letting the erection decrease while pausing during penetration can create the feared event of losing the erection. This letting go of expectations can even trigger a spontaneous erection.

- **Intensifying intercourse:**

Start with reciprocal stroking, massaging, talking, laughing and playing. Place the knees between the thighs of the partner and explore the vulva with the penis, tap on the clitoris, showing the penis the entrance. Try out small movements in the tighter area of the vaginal entrance, penetrate more deeply through pelvic movement, play with rhythms, movement amplitudes, and muscle tension. Allow arousal to decline by means of pauses and breathing together.

- **Practicing changes of positions with intermittent self-stimulation:**

More and more spontaneous behavior of the partner. Both focus on pleasurable excitement and enjoy being aroused.

- **Partner games:**

The partner tries to arouse the man in any way, while he does everything in order not to get excited. The winner will get a prize. Games with higher physical intensity/aggressiveness: both are naked and wrestle, fight (being held and getting free), pillow fight, etc.

- **Learning new touch with films:** (DVDs: penis massage, vulva massage, tantric massage, i.e. [www.eroticismassage.com](http://www.eroticismassage.com))

### *Practicing with condoms*

Putting on a condom during partner sex often causes an interruption, a sobering-up, accompanied by negative thoughts (the vicious circle remains in mind latently), and triggers the loss of erection. In addition, men with ED experience condoms as disturbing and as reducing the excitement. Putting on the condom can also be seen as stimulation; the man can get used to

the new sensations while practicing alone. He can look for suitable condoms and can win over his partner for a playful approach.

### *Self-stimulation in front of the partner:*

Heterosexual men of the fusion-type dislike and feel shameful about self-stimulation in front of their partner. Mutual self-stimulation promotes eroticization of distance, sexual self-assurance and leads to “being seen” to be experienced as a source of arousal.

### *Erotic Teamwork in the day-to-day of the relationship:*

Everybody is personally responsible for his sexual learning. Spending time as a couple can be experienced as an appreciation of mutual sexuality, of the exchange of emotions and empathetic interactions with each other.

“Good enough” sexuality lies on a broad spectrum ranging from banal to passionate.



## Special counseling situations

### Men in advanced age

Sexuality in advanced age requires a deceleration: Late works sound different than those of Storm and Stress. Aging requires skills at adapting and at taking leave of rigid ideas of masculinity.

Example: A 78-year-old overweight man complains that his penis no longer works. He describes it as "flabby stuff". Due to his waist size, he also has no more visual contact to it. He is able to ejaculate after long and strenuous stimulation of his flaccid penis. He experiences this with shame, misses the "shooting" of old times and describes his sparse ejaculate as yellowishly discolored, "like the face of death." Except for his hands he doesn't experience anything manly about himself and he fears a further "feminization".

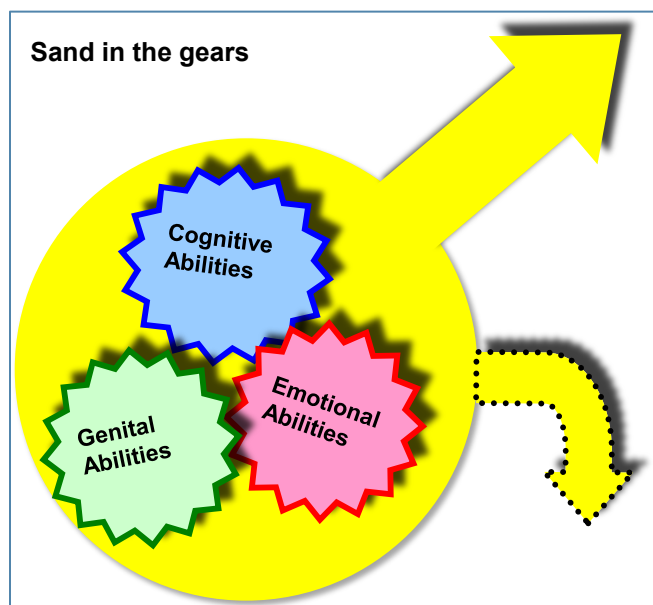


Fig: 23

#### Erection problems of older men:

Is the loss of erectile ability a sign of illness or of age? With aging, sexuality changes, just like all of the man undergoes biological changes. If erectile ability is to be maintained, it needs an enrichment in its qualitative dimension through more learning processes at the level of conscious perceptions. Initially, men experience the loss of impulsive and urgent functioning of their sexuality as threatening. Their "natural", automatic functioning provided security. It takes an extra effort to consciously motivate oneself and to learn how to enjoy.

Changes in relationships are also a great challenge and require new learning and behavioral adaptation. A lack of role models makes things more difficult, as the aging parents have often been perceived as asexual.

#### Normal changes in physical function in the older man – parting from the hormonal automatism

A wide range of changes happens with increasing age and with great individual variety. Everything is possible, from a fluctuating strength of the erection to the complete loss of functionality. These changes in sexuality occur in a phase of life in which existential threats such as retirement, diseases, surgery or losses of beloved ones must be mastered. Many men ask themselves: is this the "beginning of the end"?

#### Normal changes

A decrease in spontaneous erections at night and in the morning is normal, as they are androgen-dependent, and testosterone levels decrease. When awake, erections are additionally influenced by personal sexual learning steps. They occur more slowly during masturbation, and the intensity of their stiffness fluctuates. The desire to ejaculate tends to

decrease. Ejaculations may also happen from a flaccid penis. The volume of the ejaculate decreases and at times changes color. A general decrease of muscle strength also affects the pelvic floor. A weakening of the bulbospongiosus muscle diminishes the strength of expulsion, the "shooting". Training of the pelvic floor would counteract this - a fact most older men are not aware of. The sensitivity of the glans decreases, which is why it requires more intense and prolonged stimulation. The refractory period after the ejaculation becomes extended.

In the laboratory, testosterone deficiency and decreased androgenic activity lead to weakened contractions of the smooth muscles of the corpora

cavernosa, however, thresholds for testosterone are not clearly defined for different age groups. Below average testosterone levels within the normal threshold value do not correlate with poor sexual function.

Signs of a clinically relevant testosterone deficiency are nonspecific symptoms such as fatigue, muscle weakness, general weakness, decrease in concentration and drive as well as a loss of libido.

In this context, "partial androgen deficiency in the aging male" (PADAM) is currently a topic of discussion and research.

Short info: Testosterone –deficiency -syndrome/PADAM

Symptoms: Decrease in sperm production and testicular volume, loss of libido, erectile disorders, diminishing muscle strength, decrease in bone mineral density, decreased beard growth, decreasing performance abilities, dry and brittle skin, increase in body weight with increase in body fat percentage, reduced oxygen supply to the organism by decrease of red blood cells, chronic fatigue, hot flashes and sweating, sleep disturbances, drive disorders, depressive moods, weakness in concentration, diminished self-esteem, increased irritability

Therapy: Hormone replacement

Cited from: [www.medizininfo.de/endokrinologie/andropause/testosteronmangelsyndrom.shtml](http://www.medizininfo.de/endokrinologie/andropause/testosteronmangelsyndrom.shtml)

#### **Hormone level in the course of aging:**

**Testosterone levels drop by 30% from puberty up to age of 70 years, free testosterone (testosterone that is not bound to a protein) by 50%.**

**Total testosterone level in an adult male is between 12 and 40 nmol/l (depending on lab) with fluctuations depending on the time of day. In the evening between 6pm and 10pm, values are the lowest, in the early morning they are 35% above average values. With an aging man, values first only decrease in the morning. Eventually the testosterone level drops slowly. A 70-year-old man often reaches only 2/3 of the testosterone level of a young man.**

**But there are significant individual differences. Some men have testosterone levels in the normal range at 70. Even in old age they are capable of procreation. Other men may have clear signs of testosterone deficiency at 50. These differences are in part genetically determined.**

Many aging men are worried by these normal physical changes, creating a self-reinforcing mechanism, a vicious cycle. It can come as a relief when missing information regarding normal changes is implemented.

Sexuality of older men is often fraught with misconceptions and prejudices. For example, it is often assumed that sex in old age becomes irrelevant. Sexual interest, however, decreases only slowly with increasing age, a stronger decline is only observed in men over 75 years of age.

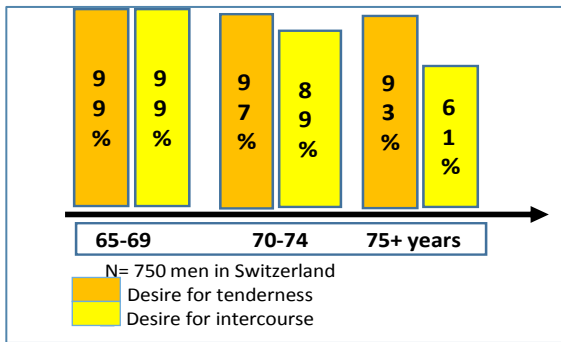


Fig. 24 Age and sexual interest of Swiss men (Hornung 2004)

### Old lecher, dirty old man – wise old man

Sexual desires and activities in a disabled or old body stir up ambivalent feelings with many people, even if films like Andreas Dresen's "Wolke 7", addressing sexuality in old age, find much appeal. Participants of our physician workshops, after watching a film depicting explicit sex in an elderly couple, associated: *Sex is healthy; late bloomer; wanting but no longer being able to; hidden; taboo; like porn; shame; voyeuristic; strange; images of parent; too genitally focused; embarrassing; exciting; unaesthetic; and unimaginable.*

"It takes courage to come and see you" is a not an uncommon initial remark by older men in sex therapy. They often feel ashamed to seek help because of "that". It should be remembered that the sexual socialization of these men took place in the 1930's – 1950's. Their value system often resembles a Russian Matryoshka doll, it encompasses all developmental phases both personally as well as of society, and earlier phases can still have an effect. That is why prescribing PDE-5 inhibitors in treatment of ED can trigger shame in older men, because they "need something like that" and are ostensibly interested in sexuality.

### Erotic wisdom or sexual retirement?

It can be unsettling and frightening to personally experience the process of getting older. The Anti-Aging-Movement with its vassals, the medical-cosmetic industry, its anti-oxidant salesmen and wellness-gurus, has become an answer to the fear of aging. Driven by the new "religion of health", its audience is tormented by the commandment of youthfulness. They must and want

to stay young and experience aging as a nightmare. The guild of medieval flagellants pales in view of this collective submission to fitness studios and plastic surgeons. But the god of youth is inexorable! In the collective staging of narcissistic defenses, sexuality is sanctified as wellness, as a life-lengthening health-elixir that polishes skin and soul. Getting old and growing old is repressed, deferred and hushed up.

### What if the hormones no longer do the work?

With aging, biology is less supportive of the man's functioning on "autopilot". Many men experience their first erection problem as a decisive point that makes them enter the vicious cycle of ED. Only learning steps, self-evident in all other areas of life, can enrich the erotic relationships with oneself and others, and often a change in the arousal mode will allow PDE-5 inhibitors to retake effect. This encourages the patient to practice, even to the point of erections becoming possible without medicinal support.

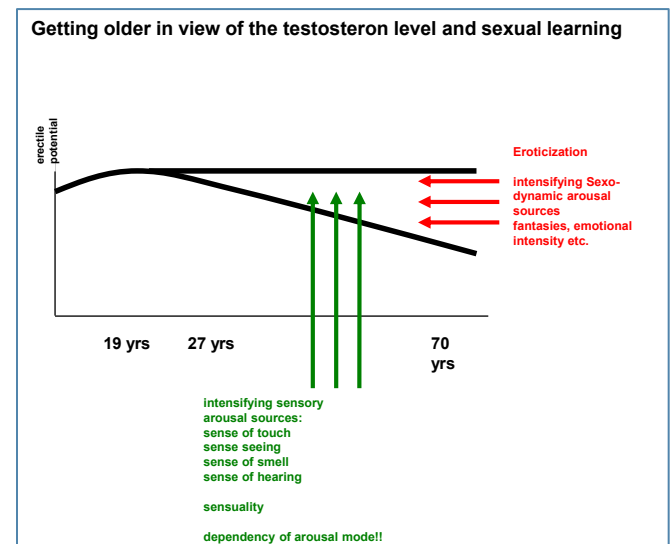


Fig. 25 Dr. Claude Roux-Deslandes

### What is the meaning of eroticism beyond face-lifts, firm bodies and super erect penises?

Erotic "pro-aging" is an alternative: to live out what is possible in the face of finite existence. To deepen perception within shrinking spaces, to find expansion in slowness. To oppose pain with inner images. To think and think ahead.

Experience, maturity and humor open up possibilities to design the remaining lifetime within the frame of biological restrictions. Through sensuality and fantasies, sexuality can receive new meaning beyond the impulsiveness and urges of juvenile sexuality and hormonal automatism. Adapting to the changing possibilities of the body, new learning can take place.

Eroticism in aging requires deceleration. Sexuality can be experienced as a transient exaltation that alleviates pain and loneliness – humorously batting an eye at one's own mortality. Sexuality can be consolation, a sleeping-aid, or a source of one's own vitality and identity.

Aging confronts the man with his own mortality so that timeless fantasies of grandeur and immortality can no longer be sustained. The loss of autonomy and self-control poses a threat, as well as powerlessness, dependency, and loneliness. Men, in particular, follow established life patterns and role models of masculinity and are tempted to counteract this threat with external activism. If denial of the physical and psychological changes of aging is coupled with current stress and physical exhaustion, symptoms of ED may manifest. If the man views sexual problems as taboo and tries to cope with them alone, erectile dysfunction may be amplified and may become chronic.

William Howell Masters (1915-2001, gynecologist) and Virginia Johnson (1925-2013, psychologist), two leading sexologists in the United States, already stipulated that the goal of treatment of erectile dysfunction should not exclusively be sexual functionality, but should also be a positive influence on the experience, well-being and behavior of the couples (Masters and Johnson, 1970). Most sexual problems of older men can be satisfactorily resolved in medical practice if the physician has a holistic sexual-medical and sexual-therapeutic point of view. ED in older men is often a somatic, psycho-, socio-, cultural and partnership issue and should be treated as such.

#### *A phallic man despite ED – is that possible?*

For most men, the greatest challenge of their lifelong sexual development presents itself if illness, accidents and/or surgical procedures lead to an irreversible loss of erectile function, particularly when medical measures or penis implants are no longer

helpful or not desired. Some men manage to express their masculinity through a symbolic phallic eroticism and manage to overcome physiological limitations. They derive satisfaction from enjoying their physical sensuality with hands and tongue and from the development of fantasies and an erotic language. In therapy, this process can be encouraged.

Adaptation also means finding other ways to assert one's masculinity. Quite a number of men, however, react with resignation and withdrawal in this situation.

#### **Medical counseling after medical diagnoses or treatments**

Aging often corresponds with medical problems that require surgical interventions and drug treatment. Often, these procedures have a serious impact on sexuality.

#### **ED after radical prostate operation**

An increasing number of men and their partners seek out sexual counseling before or after prostatectomy. There is a twofold existential threat - of cancer and of impotence (at times also incontinence) - that some men describe as "mutilation of their masculinity" or "death, starting between the legs".

The slightly reproachful phrase: "Be grateful to survive the cancer" and the reference to medical aids will satisfy the least amount of affected men. After the medically well-attended postoperative phase, some men become emotionally challenged, partly with depressive moods, or rebellion and anger against the treating physicians, while others can adapt well or repress.

I developed an own therapeutic approach over the past 10 years with over 100 cases of men with prostatectomies. It is based on a combination of medical treatment and sex therapy. A treatment with PDE-5-inhibitors alone is insufficient, and cavernous injections are usually abandoned after some time. Currently, I first prescribe a "perineal and genital rehabilitation" treatment in collaboration with a sexologically trained physiotherapist who specializes in pelvic floor and incontinence treatment. Exercises are

based on the previously described Sexocorporel-concept. The active process consists of daily exercises, initially in combination with low-dose PDE-5-inhibitors. This provides the affected men with the feeling of being able to support the maintenance of the smooth muscles of the corpora cavernosa and a possible regeneration of the nerves - a first glimpse of light in this situation of despair. Further treatment is based on the findings of the sexological evaluation in order to exhaust all resources for efficient stimulation and to modify an arousal mode that may come with limiting functionality. In further steps, the partner is involved in order to encourage adaptations and learning of new erotic skills. Treatment lasts for 1 to 3 years with ever increasing intervals of the sessions. The process will require adjustments depending on additional medical (contraindications for PDE-5-inhibitors), couple-dynamic or sexological limitations. In one case, I was able to witness an improvement of the erection even 6 years after surgery, despite a relapse, additional radiation and hormone therapies. I use this example to give men courage and to urge them not to give up. In principle, the qualitative dimension of sexuality is the main treatment goal.

## ED in coronary heart disease, heart attack

What is more dangerous: sex, fear of a recurrence of a heart attack during sex, PDE-5-inhibitors or the arousal mode?

The effects of the arousal modes on the cardiovascular system differ considerably. Pleasurable sexual intercourse in a lateral position and in an undulating arousal mode is heart-refreshing, even after multiple bypass operations. The body is stressed to a far greater extent by stubborn efforts to maintain an erection through high muscular tension (archaic mode) or exhausting mechanical "fucking".

"Sexual rehabilitation" through learning a moving, enjoyable, less stressful arousal mode with improved self-awareness fosters the ability to pay attention to one's own stress limit. It reduces physical performance during sexual intercourse from climbing half a high-rise to a few realizable flights of stairs.

## ED and Diabetes

Many men with diabetes, cardiovascular problems and other chronic illnesses worry about their sexual function. They observe their body with more anxiety and are more insecure in their masculinity. They tend to develop fear of failure more easily than healthy men.

Diabetes is not synonymous with ED. However, in our achievement-oriented society, a chronic illness produces fears and uncertainties in one's own masculinity that, coupled with possible organic issues, encourage the occurrence of ED.

Our clinical experience shows that even in the case of measurable organic changes, an improvement of erectile ability is possible with adequate sexual counseling that includes exercises as mentioned above, PDE-5-inhibitors, and the involvement of the partners.

## Appendix: Arousal Modes

### Archaic Arousal Mode (AM)

The archaic arousal mode is the first verifiable arousal mode. It can be observed in children's sexual development from the 4th month onwards (Yang et al., 2005; Wunsch, 2017) and is found in approximately 10 to 12% of adult men (Santarelli 1987). This mode is close to "neuro-vegetative" functioning, at times even without any fantasies, and allows an increase in arousal until discharge. Arousal is increased in various manners, e.g. by compressing the penis between the thighs while contracting the leg muscles. In the prone position, the genital region may be pressed against the ground. Other men use pressure on the groin, press a finger into the inguinal canal, compress the penis base with the fist, or apply pressure with the pelvic floor muscles. Some pinch the penis with devices or objects. One client described standing on the tip of his toes, supporting himself with one hand on the wall, and pinching the glans with three fingers, while his whole attention would need to be centered on the tension in his calf muscles. Often, the stimulation patterns are very precise and demand a strict adherence to the ritual in order for sexual arousal to be maintained and raised.

The different types of stimulation in the archaic mode have in common the application of pressure and high muscle tone (rhythmically or continuously), usually to the point of rigidity of the whole body. Activation of the deep receptors in the musculature and in the genital region causes sexual excitation and can at times produce an orgasmic discharge within a short time. Muscle tension is more important as an arousal source than the sensations in the penis! Not infrequently, compression of the buttocks and pelvic floor musculature may redirect the focus of perception onto the anal region.

*Sexual fantasies* during increasing arousal are influenced by physical sensations, hence the arousal mode has a significant impact on internal images. High, almost "violent" muscle tension fosters fantasies of

forcibly penetrating or dominating, or, in turn, of being tied up, submitted. An intense perception of the anal region may elicit fantasies to be penetrated. In men with heterosexual attractions codes, the latter may give rise to fears of being gay. Fantasies of having a vagina, located between the testes and the anus, may also arise and may engender problems with the perception of one's own masculinity.

#### *Strengths of the AM:*

- Ability to elicit sexual arousal
- Ability to increase arousal up to a discharge
- Activation of deep sensory receptors (proprioception)
- Reduction of tension and stress through the discharge, often followed by a pleasant feeling of relaxation

#### *Limitations of AM in general:*

- Requires concentration on the location of the increase of excitement, barely leaves room for the integration of emotional, symbolic levels
- Little allowance for experiencing sexual pleasure and enjoyment; relaxation after ejaculation constitutes the main pleasure
- Diminished sexual fantasies or, on the contrary, extreme fantasies or practices to support arousal
- No eroticization of the penis, reduced genital sensations during sexual excitement ("penis feels numb"). At times sensations in the anal area are stronger than in the compressed penis.
- No eroticization of the archetype of intrusivity, the increase of arousal is hardly associated with an experience of one's own masculinity.
- Frequent trouble producing or maintaining an erection, as this is only possible via muscular tension
- At times genital pain due to pelvic floor hypertension (dyspareunia, painful ejaculation, pain after



ejaculation, chronic pelvic pain); post-orgastic complaints due to high general muscle tension (headache, muscle pain): everything becomes stiff with getting older - except for the penis!

#### *Limitations of the AM in the relationship*

High ongoing muscle tension reduces the possibility to move, communicate and enjoy penetration and sexual intercourse. This limits the emotional involvement and interaction with the partner. Feelings of erotic intimacy can hardly arise. Over time, the awareness of penile sensations inside the vagina diminishes. At first, this leads to ejaculation problems (retarded or anejaculation), later it becomes increasingly difficult for the man to maintain his erection because the intravaginal pressure does not match his need for strong stimulation. There is a high risk of ED during intercourse. In some circumstances, the man seeks stronger pressure through anal penetration or through manual stimulation by the partner or by himself. He may achieve ejaculation only through self-stimulation.

The archaic arousal mode prevents the development of an eroticized sexual desire for penetration (coital sexual desire).

*The AM is not a sign of psychological problems. It is found in mentally healthy and loving men, but it often has a massive impact on the experience of oneself and on one's relationships.*

## Mechanical Arousal Mode (MM)

The mechanical arousal mode is associated with a quick increase of arousal ("jacking off", "rubbing", "jerking off"). This happens through rubbing the penis with a rhythm that increases and becomes mechanical, i.e. automated. Pressure may increase (transitioning to an archaic-mechanical arousal mode) and muscle tension in the pelvic area gradually increases. High muscle tension eventually extends throughout the whole body, but with less intensity than in the archaic arousal mode. The penis is the main focus of attention. This limits sensual perception, which is often only on the tip of the penis, the place of the rubbing.

The space of movement is narrow, breathing is shallow, short and sometimes blocked. The goal is "cumming", a quick discharge and the associated relief and relaxation.

#### *Strengths of the MM:*

- Ability to elicit sexual arousal
- Ability to increase sexual arousal to the point of an orgasmic discharge
- Activation of superficial sensory receptors

#### *Limitations of the MM in general:*

- Increase of sexual excitement requires a certain concentration and is associated with physical exertion ("work").
- Increase of arousal with high muscle tension and little movement allows little access to sexual pleasure.
- Awareness is limited to the sensations of the area of rubbing.
- Arousal often declines quickly if the penis is let go.

#### *Limitations of the MM in the relationship:*

The personal ritual of stimulation may not be applicable with another person and may be somewhat unsuitable for heterosexual intercourse. In advanced age, this entails a tendency towards losing the erection and a lack of sensations inside the woman, which may be rationalized as the woman being "too loose down there". In order to compensate, men typically try to stimulate themselves with powerful rubbing and then proceed rapidly to penetration. They need renewed manual stimulation when losing the erection, for example through a change of positions or by putting on a condom. Thus the maintenance and increase of arousal turns into stress, performance and work.

## Archaic-mechanical Arousal Mode (AMM)

The archaic-mechanical arousal mode combines elements of AM and MM. Stimulation occurs through strong rubbing and pressing in the genital area. This

activates both superficial (rubbing) as well as deep sensitivity (pressing and muscular tension). The rhythm is fast and continuous. There is a tendency towards generalized muscular hypertension throughout the body, mobility is limited, and breathing is shallow, short and partially blocked.

*Strengths of the AMM:*

- Ability to elicit sexual arousal
- Ability to augment arousal to the point of an orgasmic discharge
- Activation of superficial and deep sensory receptors

*Limitations of the AMM:*

- Tendency to develop ejaculation problems during intercourse (retarded ejaculation, anejaculation)
- Erection problems during intercourse

## Vibration induced Arousal Mode (VIM)

The vibration induced arousal mode is similar to the AMM. Superficial and deep sensory receptors are being stimulated with extremely rapid impulse. We find this mode less frequently with men than with women. With the aid of a vibrator or water jet, usually the glans is directly stimulated, sometimes with a flaccid penis. There is a tendency towards generalized muscular tension. Movement happens within a narrow space, with short and sometimes blocked superficial breathing.

*Strengths of the VIM:*

- Ability to elicit sexual arousal
- Ability to increase arousal to the point of an orgasmic discharge
- Activation of vibration receptors

*Limitations of the VIM in general and in the relationship:*

- Limitations are individually different, depending on the exclusiveness or variability of the VIM

- Physically strenuous because of high muscular tension
- Little allowance for sexual pleasure during the increase of arousal
- Development of phallic eroticization is not being supported
- Dependency on devices (vibrator, shower etc.) sets limits when alone and also in partner sexuality
- Ritual of stimulation may only be reproduced in an analogous way with the partner. Extremely rapid rhythms cannot be reached through manual or oral stimulation.
- Low perceptions of the penis and the sensations that accompany sexual excitement can lead to erection problems during intercourse.
- It is difficult to reach ejaculation during vaginal intercourse.

## Undulating Arousal Mode (UM)

In contrast to the previous modes, the undulating mode allows access to sexual pleasure during arousal. Flowing movements during sexual arousal enable intense enjoyment. In the UM, the pleasure function is highly developed, thanks to the ability to diffuse sexual excitement, i.e. spreading the excitation (both an augmented blood flow and perception of associated sensations) throughout the whole body. In some cases, if pelvic muscle tension is too low, it is not possible to achieve an orgasmic discharge due to inadequate channeling of excitation. To reach a discharge, the person may switch to another mode (MM, AM), experiencing a reduction of pleasure upon arresting the flowing movement. The UM promotes the perception of high emotional intensities, while the genital sensations sometimes receive less attention.

Movement rhythms vary from slow to fast. Muscular intensities vary and allow flowing movements without the presence of muscular hypertension or hypotension. The external and internal body space can be experienced through these movements with varying amplitude and deep abdominal breathing.

*Strengths of the UM:*

- Ability to experience and intensify sexual pleasure
- Ability to diffuse sexual arousal throughout the body, opens access to pleasurable sensations (voluptuous pleasure)
- Play with activation of a wide range of sensations (sensory function of skin and proprioception)
- Variety in playing with the 3 laws of the body
- High emotional intensity, ability to enter into intense contact with partner
- Opens the area of erotic imagination, pictures, fantasies

*Possible limitations of the UM:*

- Difficulty increasing sexual arousal up to the point of no return
- Erection problems are possible with increasing age
- Genitality is given little significance because the quest to extend the pleasure experience is central – this may eventually weaken sexual arousal
- Imagination and fantasies tend to be emotionally polarized with less genital contents

## The arousal mode in waves (WM)

The WM promotes a flowing movement that combines sexual arousal and sexual pleasure through the double swing (pelvic swing and upper swing, combined by deep abdominal breathing). The increase and channeling of sexual arousal occurs with flowing and varied mobility throughout the whole body. There is a double release during orgasm; genital sexual arousal is released through the lower swing (pelvis), emotions are released through the upper swing (shoulder girdle, head, and face).

*Strengths of the WM:*

- Activation of superficial and deep sensitivity
- The pelvic swing promotes blood flow to the cavernous bodies and can support erections
- The upper swing and deep abdominal breathing augments the emotional experience

- Eroticization of sexual archetypes: phallic eroticization with men
- Development of an eroticized sexual desire for penetration (coital-sexual desire) – the WM is a prerequisite for this

*Moving with the double swing:*

In contrast to AM, AMM and MM, where arousal is increased locally, in the WM this happens via the activation of the whole body. The movement of the double swing can be observed in many animals as a reflex sequence in penetration as well as defecation. Humans can acquire this movement, which in coughing or laughing is likewise reflexive, through learning steps and make it accessible to their conscious perception. It allows for an in-depth perception of sexual arousal and its accompanying emotional charges.

The movement of the double swing promotes the development of the sexual archetypes in both genders (intrusivity/receptivity).



Pelvic/Genitals back (Anti-version)  
Inhale with stomach  
Abdomen muscles are letting go  
Head straight up (chin slightly back)  
Shoulders slightly back



Pelvic/Genitals forward (Retro-version)  
Shoulder movement forward  
Exhale with stomach  
Tightening up of abdomen muscles  
Letting go of the head( slightly backwards)  
Opening of the mouth

**Fig. 26 Pelvic Swing** (from: The ejaculatory Control – A Love Story, J. Y. Desjardins u. N. Audette, Institut Sexocorporel International, Montréal, Canada)

*Variety of rhythmic structuring of the movements*

The movement comes into play with variable muscle tension, without extreme rigidity or complete relaxation. Sexual arousal requires a certain degree of muscular tension. Both excessive tension or rigidity as well as muscular hypotonia or total relaxation hinder the build-up of sexual arousal. By contrast, the wave-like mode allows flowing movements in a wide spatial range with flowing, deep breathing, supporting the blood flow to the genitals as well as the whole body. The increase in arousal is accompanied by an increasing intensity of movement. The channeling of sexual excitement via the double swing allows its increase to the point of release within an orgasm.

*Further strengths of the WM:*

The channeling of sexual arousal is possible in high emotional intensity. Diffusion of arousal allows to pleurably enjoy excitement spreading over the whole body. It can be controlled and modulated up to the decision to let go with an orgasm. The orgasmic discharge is intense.

Intense sensuality and a variety of erotic fantasies become possible.

This arousal mode is slow, which allows the integration of all perceptual components into physiological arousal, both during its increase as well as in orgasm:

- Sexual pleasure
- Development of coital-sexual desire
- Strengthening the feeling of masculinity
- Ability to be present in the reality of the sexual encounter
- Development of varied inner pictures and erotic fantasies

The movement of the double swing also allows the designing of sexual encounters and intercourse with others. The more we function with a reflexive, rapid process, the more automatisms with little conscious perception control the increase of arousal. Slowness expands the range of conscious perceptions.

*The WM enables men:*

- Improved erection ability through activation of physiological processes and more intense

perceptions of sensations that accompany sexual arousal

- Development of phallic eroticization, support for the feeling of one's own masculinity
- Control and modification of the arousal curve, thus increasing the ability to choose the time of ejaculation

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