Chapter Sex: An Overview of Sexual Dysfunctions

Before we describe sexual dysfunction, it's important to note that the problems that arise in the context of sexual interactions may occur in both heterosexual and homosexual relationships. Inability to become aroused or reach orgasm seems to be as common in homosexual as in heterosexual relationships, but we discuss them in the context of heterosexual relationships, which are the majority of cases seen in clinics. Of the different stages in the sexual response cycle, three of them—desire, arousal, and orgasm (see Figure 10.2)—are each associated with specific sexual dysfunctions. In addition, pain can become associated with sexual functioning in women, which leads to an additional dysfunction.

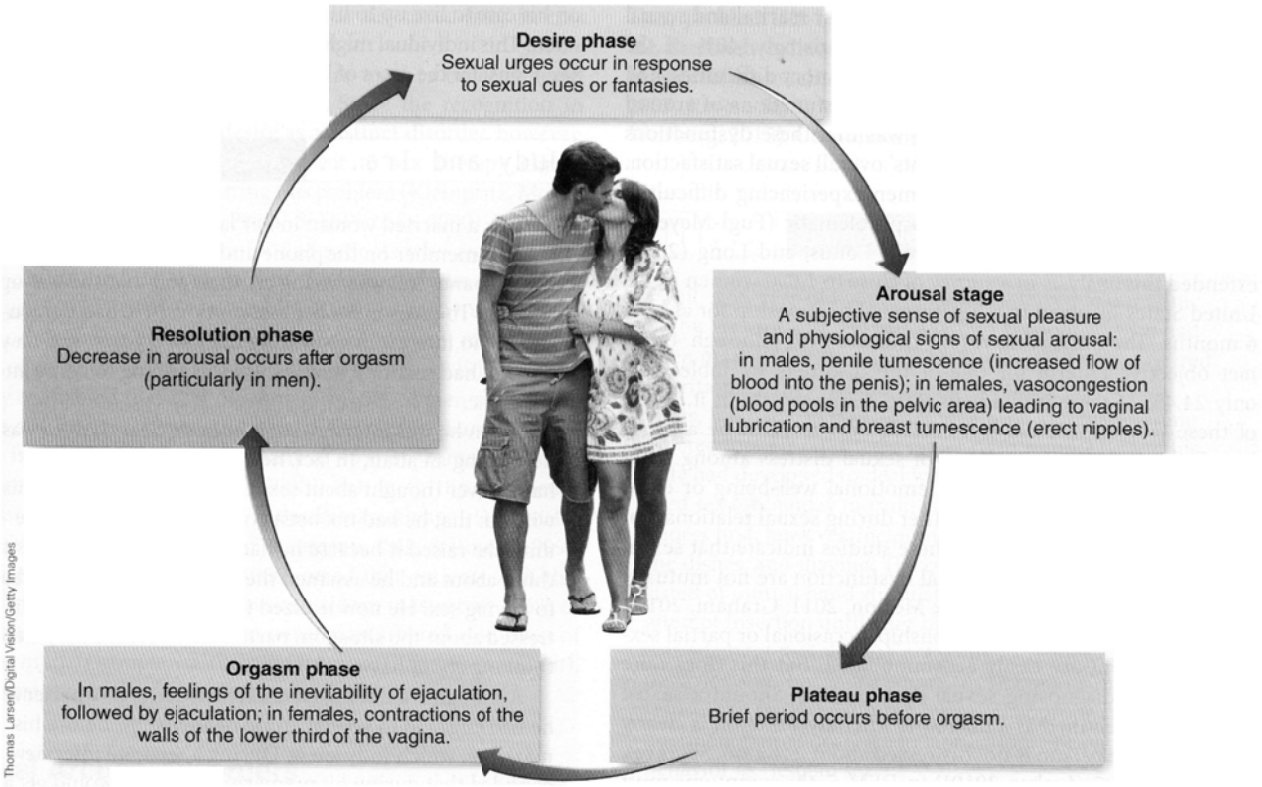


FIGURE 10.2

The human sexual response cycle. (Based on Kaplan, H. S. [1979]. *Disorders of sexual desire.* New York, NY: Brunner/Mazel, and Masters, W. H., & Johnson, V. E., [1966]. *Human sexual response.* Boston, MA: Little, Brown.)

An overview of the DSM-5 categories of the sexual dysfunctions we examine is in Table 10.3. As you can see, both males and females can experience parallel versions of most disorders, which take on specific forms determined by anatomy and other gender-specific characteristics. However, two disorders are sex specific: Premature (early) ejaculation occurs only in males, and genito-pelvic pain/penetration disorder—which includes difficulties with penetration during intercourse due in many cases to painful contractions or spasms of the vagina—appears only in females. Sexual dysfunctions can be either lifelong or acquired. Lifelong refers to a chronic condition that is present during a person's entire sexual life; acquired refers to a disorder that begins after sexual activity has been relatively normal. In addition, disorders can either be generalized, occurring every time the individual attempts sex, or they can be situational, occurring with some partners or at certain times but not with other partners at other times.

TABLE 10.3 Categories of Sexual Dysfunction Among Men and Women

Type of Disorder	Sexual Dysfunction: Men	Sexual Dysfunction: Women
Desire	Male hypoactive sexual desire disorder (little or no desire to have sex)	Female sexual interest/arousal disorder (little or no desire to have sex)
Arousal	Erectile disorder (difficulty attaining or maintaining erections)	Female sexual interest/arousal disorder (little or no desire to have sex)
Orgasm	Delayed ejaculation; premature (early) ejaculation	Female orgasmic disorder
Pain		Genito-pelvic pain/penetration disorder (pain, anxiety, and tension associated with sexual activity; vaginismus, i.e., muscle spasms in the vagina that interfere with penetration)

Before we describe the prevalence of specific sexual dysfunctions, we need to note a classic study by Ellen Frank and her colleagues (1978), who carefully interviewed 100 well-educated, happily married couples who were not seeking treatment. More than 80% of these couples reported that their marital and sexual relations were happy and satisfying. Surprisingly, 40% of the men reported occasional erectile and ejaculatory difficulties, and 63% of the women reported occasional dysfunctions of arousal or orgasm. But the crucial finding was that these dysfunctions did not detract from the respondents' overall sexual satisfaction. In another study, only 45% of women experiencing difficulties with orgasm reported the issue as problematic Bancroft, Loftus, and Long (2003) extended this analysis in a survey of close to 1,000 women in the United States involved in a heterosexual relationship for at least 6 months. The interesting results indicate that, although 44.3% met objective criteria for one of the disorders in Table 10.3, only 24.4% of these individuals were distressed about it. Many of these women just did not consider the issue to be a problem. Indeed, the best predictor of sexual distress among these women were deficits in general emotional well-being or emotional relationships with the partner during sexual relations, not lack of lubrication or orgasm. These studies indicate that sexual satisfaction and occasional sexual dysfunction are not mutually exclusive categories, i.e. they can occur together. In the context of a healthy relationship, occasional or partial sexual dysfunctions are easily accommodated. But this does raise problems for diagnosing sexual dysfunctions. Should a sexual problem be identified as a diagnosis when dysfunction is clearly present but the person is not distressed about it? In DSM-5, the symptoms must clearly cause clinically significant distress in the individual or in the couple.

Sexual Desire Disorders

Three disorders reflect problems with the desire or arousal phase of the sexual response cycle. Two of these disorders are characterized by little or no interest in sex that is causing significant distress in the individual or couple. In males, this disorder is called **male hypoactive sexual desire disorder**. In females, low sexual interest is almost always accompanied by a diminished ability to become excited or aroused by erotic cues or sexual activity. Thus, deficits in interest or the ability to become aroused in women is combined in a disorder called **female sexual interest/arousal disorder**. For males, there is a specific disorder of arousal—erectile dysfunction.[1]

[1] So for men, they can have desire and arousal problems separately. It used to be considered that way for women too until just recently when researchers and clinicians realized that arousal and desire are more closely linked in women than in men. So arousal and desire problems were combined into one disorder for women. For example, women are less likely to have spontaneous desire like men. It isn't unusual for women to experience arousal first (as when their partner initiates sexual activity) and then subsequent desire.

Male Hypoactive Sexual Desire Disorder and Female Sexual Interest/Arousal Disorder

Males with hypoactive sexual desire disorder and females with sexual interest/arousal disorder have little or no interest in any type of sexual activity. It is difficult to assess low sexual desire, and a great deal of clinical judgment is required. You might gauge it by frequency of sexual activity—say, less than twice a month for a married couple. Or you might determine whether someone ever thinks about sex or has sexual fantasies. Then there is the person who has sex twice a week but really doesn't want to and thinks about it only because his wife is on his case to live up to his end of the marriage and have sex more often. This individual might have no desire, despite having frequent sex. (You can find a description of 2 cases: Judy & Ira, and Mr. & Mrs. C on our web site);

Best estimates suggest that more than 50% of patients who come to sexuality clinics for help complain of low sexual desire or interest. In many clinics, it is the most common presenting complaint of women; men present more often with erectile dysfunction. The U.S. survey confirmed that 22% of women and 5% of men suffer from low sexual interest (hypoactive sexual disorder in man). But in a larger international survey, as many as 43% of women reported this problem (Laumann et al., 2005). For men, the prevalence increases with age; for women, it decreases with age. Schreiner-Engel and Schiavi (1986) noted that patients with this disorder rarely have sexual fantasies, seldom masturbate (35% of the women and 52% of the men never masturbated, and most of the rest in their sample masturbated no more than once a month), and attempt intercourse once a month or less.

Sexual Arousal Disorders

Erectile disorder is a specific disorder of arousal. The problem here is not desire. Many males with erectile dysfunction have frequent sexual urges and fantasies and a strong desire to have sex.

Their problem is in becoming physically aroused: For females who are also likely to have low interest, deficits in arousal are reflected in an inability to achieve or maintain adequate lubrication. (The case of Bill is presented on our web site).

The old and somewhat derogatory terms for male erectile disorder and female interest and arousal difficulties are impotence and frigidity, but these are imprecise labels that do not identify the specific phase of the sexual response in which the problems are localized. A man typically feels more impaired by his problem than a woman does by hers. Inability to achieve and maintain an erection makes intercourse difficult or impossible. Women who are unable to achieve vaginal lubrication, however, may be able to compensate by using a commercial lubricant. In women, arousal and lubrication may decrease at any time but, as in men, such problems tend to accompany aging. It is unusual for a man to be completely unable to achieve an erection. More typical is a situation like Bill's, where full erections are possible during masturbation and partial erections occur during attempted intercourse, but with insufficient rigidity to allow penetration.

The prevalence of erectile dysfunction is startlingly high and increases with age. Although data from the U.S. survey indicate that 5% of men between 18 and 59 fully meet a stringent set of criteria for erectile dysfunction (Laumann et al., 1999), this figure certainly underestimates the prevalence because erectile dysfunction increases rapidly in men after age 60. Rosen, Wing, Schneider, and Gendrano (2005) reviewed evidence from around the world and found that 60% of men 60 and over suffered from erectile dysfunction. Data from another study suggest that at least some impairment is present in approximately 40% of men in their 40s and 70% of men in their 70s; incidence (new cases) increases

dramatically with age, with 46 new cases reported each year for every 1,000 men in their 60s (Johannes et al., 2000). Erectile disorder is easily the most common problem for which men seek help, accounting for 50% or more of the men referred to specialists for sexual problems (Hawton, 1995).

The prevalence of female interest and arousal disorders is somewhat more difficult to estimate because many women still do not consider absence of arousal to be a problem, let alone a disorder. The U.S. survey reports a prevalence of 14% of females experiencing an arousal disorder (Laumann et al., 1999). A more recent study (Rosen et al., 2014) reported a prevalence of 7.4%. Because disorders of desire, arousal, and orgasm often overlap, it is difficult to estimate precisely how many women with specific interest and arousal disorders present to sex clinics (Basson, 2007; Wincze & Weisberg, 2015 Wincze & Weisberg, 2015).

Orgasm Disorders

The orgasm phase of the sexual response cycle can also become disrupted in one of several ways. As a result, either the orgasm occurs at an inappropriate time or it does not occur.

An inability to achieve an orgasm despite adequate sexual desire and arousal is commonly seen in women and less commonly seen in men. Males who achieve orgasm only with great difficulty or not at all meet criteria for a condition called delayed ejaculation. In women the condition is referred to as female orgasmic disorder . (Consider the case of Greta and Will presented on our web site).

An inability to reach orgasm is the most common complaint among women who seek therapy for sexual problems. Although the U.S. survey did not estimate the prevalence of female orgasmic disorder specifically, approximately 25% of women report significant difficulty reaching orgasm (Heiman, 2000; Laumann et al., 1999), although estimates vary widely (Graham, 2010). The problem is more likely among younger rather than older women. Additionally, unmarried women were 1.5 times more likely than married women to experience orgasm disorder. In diagnosing this problem, it is necessary to determine that the women "never or almost never" reach orgasm (Wincze & Weisberg, 2015). This distinction is important because only approximately 20% of all women reliably experience regular orgasms during sexual intercourse (Graham, 2010; Lloyd, 2005). Therefore, approximately 80% do not achieve orgasm with every sexual encounter, unlike most men, who tend to experience orgasm more consistently. Thus, the "never or almost never" inquiry is important, along with establishing the extent of the woman's distress, in diagnosing orgasmic dysfunction.

In the U.S. survey, approximately 8% of men report having delayed ejaculation or none during sexual interactions (Laumann et al., 1999). Men seldom seek treatment for this condition. It is quite possible that in many cases some men reach climax through alternative forms of stimulation and that this condition is accommodated by the couple (Apfelbaum, 2000).

Some men who are unable to ejaculate with their partners can obtain an erection and ejaculate during masturbation. Occasionally men suffer from retrograde ejaculation, in which ejaculatory fluids travel backward into the bladder rather than forward. This phenomenon is almost always caused by the effects of certain drugs or a coexisting medical condition and should not be confused with delayed ejaculation.

A far more common male orgasmic disorder is premature ejaculation, ejaculation that occurs well before the man and his partner wish it to, defined as approximately 1 minute after penetration in DSM-5. (Consider the rather typical case of Gary presented on our web site).

The frequency of premature ejaculation seems to be quite high. In the U.S. survey, 21% of all men met criteria for premature ejaculation, making it the most common male sexual dysfunction (although not the one that drives men into sex therapy clinics for help).

Although DSM-5 specifies a duration of less than approximately 1 minute, it is difficult to define "premature." An adequate length of time before ejaculation varies from individual to individual. Patrick and colleagues (2005) found that men who complain of premature ejaculation ejaculated 1.8 minutes after penetration, compared with 7.3 minutes in individuals without this complaint. A perceived lack of control over orgasm, however, may be the more important psychological determinant of premature ejaculation (Wincze et al., 2008). Although occasional early ejaculation is normal, consistent premature ejaculation appears to occur primarily in inexperienced men with less education about sex (Laumann et al., 1999).

Sexual Pain Disorder

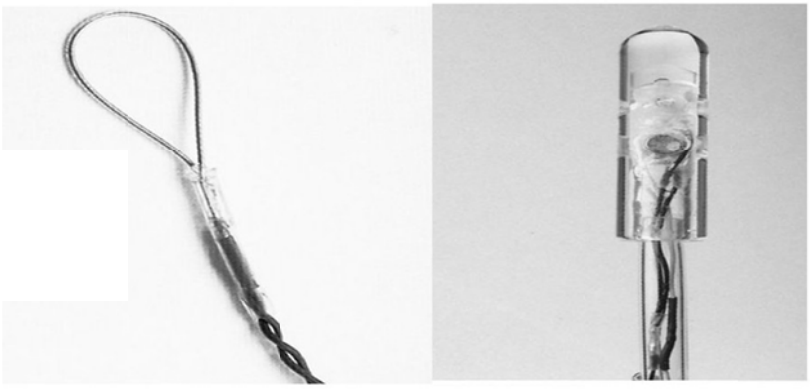
A sexual dysfunction specific to women refers to difficulties with penetration during attempted intercourse or significant pain during intercourse. This disorder is called genito-pelvic pain/ penetration disorder. For some women, sexual desire is present, and arousal and orgasm are easily attained, but the pain during attempted intercourse is so severe that sexual behavior is disrupted. In other cases, severe anxiety or even panic attacks may occur in anticipation of possible pain during intercourse. But the most usual presentation of this disorder is referred to as **vaginismus**, in which the pelvic muscles in the outer third of the vagina undergo involuntary spasms when intercourse is attempted (Binik et al., 2007; Kleinplatz et al., 2013). The spasm reaction of vaginismus may occur during any attempted penetration, including a gynecological exam or insertion of a tampon (Beck, 1993; Bradford & Meston, 2011). Women report sensations of "ripping, burning, or tearing during attempted intercourse" (Beck, 1993, p. 384). (Consider the case of Jill that is presented on our web site)

Although there are no data on the prevalence of vaginismus in community samples, best estimates are that it affects 6% of women (Bradford & Meston, 2011). Twenty-five percent of women who report suffering from some sexual dysfunction experience vaginismus, according to Crowley, Richardson, and Goidmeir (2006). Because vaginismus and the experience of pain during intercourse overlap quite a bit in women, these conditions have been combined in DSM-5 into genito-pelvic pain/penetration disorder. Results from the U.S. survey indicate that approximately 7% of women suffer from one or the other type of sexual pain disorder, with higher proportions of younger and less educated women reporting this problem (Laumann et al., 1999). Somewhat higher estimates of 15% of women in North America reporting recurring pain during intercourse have been reported in DSM-5 (APA, 2013).

Psychophysiological Assessment of problems

Many clinicians assess the ability of individuals to become sexually aroused under a variety of conditions by taking psycho- physiological measurements while the patient is either awake or asleep. In men, penile erection is measured directly, using, for example, a penile strain gauge (see pic next page). As the penis expands, the strain gauge picks up the changes and records them on a polygraph. Note that participants are often not aware of these more objective measures of their arousal; that is, their self-report of how aroused they are differs from the objective measure, and this discrepancy increases or decreases as a function of the type of sexual problem they have. Measuring penile rigidity is also

important in cases of erectile dysfunction, because large erections with insufficient rigidity will not be adequate for intercourse (Wiegel et al., 2002).



Changes in penile erection and vaginal lubrication were measured with penile strain gauges and photoplethysmographs.

The comparable device for women is a vaginal photoplethysmograph). This device, which is smaller than a tampon, is inserted by the woman into her vagina. A light source at the tip of the instrument and two light-sensitive photoreceptors on the sides of the instrument measure the amount of light reflected back from the vaginal walls. Because blood flows to the vaginal walls during arousal, the amount of light passing through them decreases with increasing arousal.

Typically individuals undergoing physiological assessment view an erotic videotape for 2 to 5 minutes or, occasionally, listen to an erotic. The patient's sexual responsivity during this time is assessed psycho-physiologically using the strain gauge or photoplethysmograph just described. Patients also report subjectively on the amount of sexual arousal they experience. This assessment allows the clinician to carefully observe the conditions under which arousal is possible for the patient. For example, many individuals with psychologically based sexual dysfunctions may achieve strong arousal in a laboratory but be unable to become aroused with a partner. The strain gauge can also be used to help assess erectile dysfunction in men, particularly to help determine if the cause is more biological or psychological. Men are instructed to wear the device while they sleep because most all men experience arousal in their sleep and you are assumed to be less anxious about performance while sleeping.

Biological Contributions to Sexual Disorders

Neurological diseases and other conditions affecting the nervous system, such as diabetes and kidney disease can be a cause of erectile dysfunction. Some studies have reported that as many as 28% of men with diabetes experienced complete erectile failure. Vascular disease can constrict arteries and cause insufficiency of blood flow. Venous leakage, where blood flows out of the penis too quickly can also be a problem. Individuals who have had heart attacks can be wary of the physical exertion required for sex. Prescription medications can interfere with sexual functioning: high blood pressure medications, or SSRIs. Some research reports that as many as 80% of individuals who take Prozak-like antidepressants experience some type of sexual dysfunction. Chronic alcohol abuse may cause permanent nerve damage and interfere with sexual function. Nicotine is associated with impaired sexual performance. One study that assessed 4,0000 male army veterans found that cigarette smoking alone was associated with increased erectile dysfunction after controlling for other factors such as alcohol and vascular disease. Men and women both have shown decreased erectile responses in men (and decreased arousal in women) immediately after smoking.

Social and Cultural Contributions

Erotophobia, negative beliefs about sex presumably learned in early childhood can predict dysfunction. Sexual victimization, especially for women, predicts problems. A deterioration in close personal

relationships contributes to sexual dysfunction. Women who perceived themselves as less attractive, may have sexual dysfunctions. Poor sexual skills can also certainly contribute.

Psychosocial Treatments

Among the many advances in our knowledge of sexual behavior, none was more dramatic than the publication in 1970 by William Masters and Virginia Johnson of Human Sexual Inadequacy. The procedures outlined in this book literally revolutionized sex therapy by providing a brief, direct, and reasonably successful therapeutic program for sexual dysfunctions. Underscoring again the common basis of most sexual dysfunctions, a similar approach to therapy is taken with all patients, male and female, with slight variations depending on the specific sexual problem (for example, premature ejaculation or orgasmic disorder). This intensive program involves a male and a female therapist to facilitate communication between the dysfunctional partners. (Masters and Johnson were the original male and female therapists.) Therapy is conducted daily over a 2-week period.

The actual program is quite straightforward. In addition to providing basic education about sexual functioning, altering deep-seated myths, and increasing communication, the clinicians' primary goal is to eliminate psychologically based performance anxiety. To accomplish this, Masters and Johnson introduced sensate focus and non-demand pleasuring. In this exercise, couples are instructed to refrain from intercourse or genital caressing and simply to explore and enjoy each other's body through touching, kissing, hugging, massaging, or similar kinds of behavior. In the first phase, nongenital pleasuring, breasts and genitals are excluded from the exercises. After successfully accomplishing this phase, the couple moves to genital pleasuring but with a ban on orgasm and intercourse and clear instructions to the man that achieving an erection is not the goal.

At this point, arousal should be reestablished and the couple should be ready to attempt intercourse. So as not to proceed too quickly, this stage is also broken down into parts. For example, a couple might be instructed to attempt the beginnings of penetration; that is, the depth of penetration and the time it lasts are only gradually built up, and both genital and nongenital pleasuring continue. Eventually, full intercourse and thrusting are accomplished. After this 2-week intensive program, recovery was reported by Masters and Johnson for the vast majority of more than 790 sexually dysfunctional patients, with some differences in the rate of recovery depending on the disorder.

After these results were published, specialty sexuality clinics based on the pioneering work of Masters and Johnson were established around the country to administer these new treatment techniques. Subsequent research revealed that many of the structural aspects of the program did not seem necessary. For example, one therapist seems to be as effective as two (LoPiccolo, Heiman, Hogan, & Roberts, 1985), and seeing patients once a week seems to be as effective as seeing them every day (Heiman & LoPiccolo, 1983). It has also become clear in the succeeding decades that the results achieved by Masters and Johnson were better than those achieved in clinics around the world using similar procedures. Reasons for this are not entirely clear. One possibility is that they were highly motivated because patients had to take at least 2 weeks off and fly to St. Louis to meet with Masters and Johnson.

Sex therapists have expanded on and modified these procedures over the years to take advantage of recent advances in knowledge. For better treatment of specific sexual dysfunctions, sex therapists integrate specific procedures into the context of general sex therapy. For example, to treat premature ejaculation, most sex therapists use a procedure developed by Semans (1956), sometimes called the

squeeze technique or the pause-and-squeeze, in which the penis is stimulated, usually by the partner, to nearly full erection. At this point, the partner firmly squeezes the penis near the top where the head of the penis joins the shaft, which quickly reduces arousal. These steps are repeated until (for heterosexual partners) eventually the penis is briefly inserted in the vagina without thrusting. If arousal occurs too quickly, the penis is withdrawn and the squeeze technique is employed again. In this way, the man develops a sense of control over arousal and ejaculation. Reports of success with this approach over the past 20 years suggest that 60% to 90% of men benefit. Lifelong female orgasmic disorder may be treated with explicit training in masturbatory procedures (Bradford & Meston, 2011). For example, Greta (from case study on our web site) was still unable to achieve orgasm with manual stimulation by her husband, even after proceeding through the basic steps of sex therapy. At this point, following certain standardized treatment programs for this problem (see, for example, Heiman, 2000; Heiman & LoPiccolo, 1988), Greta and Will purchased a vibrator and Greta was taught to let go of her inhibitions by talking out loud about how she felt during sexual arousal, even shouting or screaming if she wanted to. In the context of appropriate genital pleasuring and disinhibition exercises, the vibrator brought on Greta's first orgasm. With practice and good communication, the couple eventually learned how to bring on Greta's orgasm without the vibrator. Although Will and Greta were both delighted with her progress, Will was concerned that Greta's screams during orgasm would attract the attention of the neighbors! Summaries of results from a number of studies suggest 70% to 90% of women will benefit from treatment, and these gains are stable and even improve further over time. To treat vaginismus and pain related to penetration in genitopelvic pain/penetration disorder, the woman and, eventually, the partner gradually insert increasingly larger dilators at the woman's pace. After the woman (and then the partner) can insert the largest dilator, in a heterosexual couple, the woman gradually inserts the man's penis. These exercises are carried out in the context of genital and nongenital pleasuring so as to retain arousal. Close attention must be accorded to any increased fear and anxiety that may be associated with the process, which may trigger memories of early sexual abuse that may have contributed to the onset of the condition. These procedures are highly successful, with a large majority of women (80% to 100%) overcoming vaginismus in a relatively short period.

A variety of treatment procedures have also been developed for low sexual desire (see, for example, Pridal & LoPiccolo, 2000; Wincze, 2009; Wincze & Weisberg, 2015). At the heart of these treatments are the standard reeducation and communication phases of traditional sex therapy with, possibly, the addition of masturbatory training and exposure to erotic material. Each case may require individual strategies. Remember Mrs. C., (from our web site) who was sexually abused by her cousin? Therapy involved helping the couple understand the impact of the repeated, unwanted sexual experiences in Mrs. C's past and to approach sex so that Mrs. C. was more comfortable with foreplay. She gradually lost the idea that once sex was started she had no control. She and her husband worked on starting and stopping sexual encounters. Cognitive restructuring was used to help Mrs. C. interpret her husband's amorousness in a positive rather than a skeptical light. In general, approximately 50% to 70% of individuals with low sexual desire benefit from sex therapy, at least initially (Basson, 2007; Brotto, 2006).

For some time, testosterone (Schiavi, White, Mandeli, & Levine, 1997) has been used to treat erectile dysfunction. But although it is safe and has relatively few side effects, only negligible effects on erectile dysfunction have been reported (Forti, Corona, Vignozzi, & Maggi, 2012; Mann et al., 1996). Some urologists teach patients to inject vasodilating drugs such as papaverine or prostaglandin directly into the penis when they want to have sexual intercourse. These drugs dilate the blood vessels, allowing blood to flow to the penis and thereby producing an erection within 15 minutes that can last from 1 to 4

hours (Rosen, 2007; Segraves & Aithof, 1998). Because this procedure is a bit painful (although not as much as one might think), a substantial number of men, usually 50% to 60%, stop using it after a short time. In one study, 50 of 100 patients discontinued papaverine for various reasons. A soft capsule that contains papaverine (called MUSE [Medical Urethral System for Erections]) can be inserted directly into the urethra, but this is somewhat painful, is less effective than injections, and remains awkward and artificial enough to preclude wide acceptance (Delizonna, Wincze, Litz, Brown, & Barlow, 2001). Insertion of penile prostheses or implants has been a surgical option for almost 100 years; only recently have they become good enough to approximate normal sexual functioning. One procedure involves implanting a semirigid silicone rod that can be bent by the male into correct position for intercourse and maneuvered out of the way at other times. In a more popular procedure, the male squeezes a small pump that is surgically implanted into the scrotum, forcing fluid into an inflatable cylinder and thus producing an erection. A newer penile prosthetic device is an inflatable rod that contains the pumping device, which is more convenient than having the pump outside the rod. However, surgical implants fall short of restoring presurgical sexual functioning or assuring satisfaction in most patients (Gregoire, 1992; Kim & Lipshultz, 1997); they are now generally used only if other approaches don't work. On the other hand, this procedure has proved useful for men who must have a cancerous prostate removed, because this surgery often causes erectile dysfunction, although newer "nerve-sparing" surgeries lessen the effect to some extent (Ramsawh, Morgentaler, Covino, Barlow, & DeWoif, 2005). Another approach is vacuum device therapy, which works by creating a vacuum in a cylinder placed over the penis. The vacuum draws blood into the penis, which is then trapped by a specially designed ring placed around the base of the penis. Although using the vacuum device is rather awkward, between 70% and 100% of users report satisfactory erections, particularly if psychological sex therapy is ineffective (Segraves & Althof, 1998; Witherington, 1988). The procedure is also less intrusive than surgery or injections, but it remains awkward and artificial (Delizonna et al., 2001). Given the awkwardness of these interventions, it is easy to see how wonderful a drug like Viagra could be to men with erectile disorder if the drug works for them.

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