Combination Therapy for Sexual Dysfunction: Integrating Sex Therapy and Pharmacotherapy


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INTRODUCTION: THE FALSE DICHOTOMY

The 20th century marked huge strides in our knowledge of sexual disorders and their treatments, however, advancements were followed by periods of reductio-
nistic thinking. Etiology was conceptualized dichotomously, first as psychogenic
and then organic. Early in the 20th century, Freud highlighted deep-seated
anxiety and internal conflict as the root of sexual problems experienced by
both men and women. By mid-century, Masters and Johnson (1) and then
Kaplan (2) designated “performance anxiety” as the primary culprit, while pro-
viding a nod to organic factors. Together, they catalyzed the emergence of sex
therapy, which relied on cognitive and behavioral prescriptions to improve
patient functioning. For the next two decades, a psychological sensibility domi-
nated discussions of the causes and cures of sexual dysfunctions (SDs). However,
during the late 1980s, there was a progressive shift toward surgical and predomi-
nantly pharmaceutical treatments for male erectile dysfunction (ED). By the
1990s, urologists had established hegemony, with the successful marketing of
various penile prostheses, as well as intracavernosal injections (ICI) and inter-
urethral insertion (IUI) systems [e.g., Caverject (Pharmacia, Teapak, NJ,
USA), Muse (Vivus, Mountainview, CA, USA)]. The monumentally successful
1998 sildenafil launch (Pfizer, New York, NY, USA) and its subsequent publicity
at the end of the 20th century symbolized the apex of biologic determinism. Most
physicians and most of the general public saw SD and its treatment solely in
organic terms.

The new millennium finds us moving forward toward a more enlightened
and sophisticated paradigm where the importance of both organic and psycho-
genic factors is appreciated for their role in predisposing, precipitating, main-
taining, and reversing SD. The pharmaceutical industry has developed other
phosphodiesterase-5 inhibitor (PDE-5) based treatments for ED as evidenced
by the successful 2003 launches of vardenafil (Bayer, New Haven, CT, USA and
GSK, Philadelphia, PA, USA) and tadalafil (Lilly, Indianapolis, IN, USA and ICOS, Seattle, WA, USA). All three FDA-approved PDE-5 inhibitor compounds are selling well worldwide, and new pharmaceutical delivery systems for treating SD are in development. The FDA has approved EROS (UroMetrics, Inc., Anoka, MN, USA), a mechanical device, for the treatment of female SD (FSD). Indeed, multiple products (pharmaceutical, nutriceutical, and mechanical) are being introduced, or are in development, to treat a host of complaints under the market driven heading of “FSD.” Despite this juggernaut of pharmaceutical activity, a renewed sensitivity to psychosocial issues is emerging and a more balanced perspective is shaping our discussions of the understanding and treatment of male and female SD. These discussions are the focus of symposia at important international meetings (American Urological Association, World Health Organization, International Society for the Study of Women’s Sexual Health, etc.). Yet, they are underwritten (directly or indirectly) by the same pharmaceutical companies that develop and manufacture the drugs, which essentially catapulted a biologic medicalized view of SD onto the world stage, to the exclusion of psychosocial sensitivity. This rebalancing of perspective, reflected a growing consensus of thought, catalyzed by mental health professionals (MHPs). These MHPs have once again successfully advanced the obvious concept: psychosocial factors are also critical to the understanding of sexual function and dysfunction. Sexual pharmaceuticals can very frequently restore sexual capacity. Yet, rewarding sexual function is experienced only when psychosocial factors also support restored sexual activity. Medicine today emphasizes an evidence-based research. There is a seeming inherent tension between this concept and the qualitative “art and science” of psychotherapy (3). This chapter will attempt to bridge that gap by discussing combination treatments (CTs) for SD, where the use of sex therapy strategies and treatment are integrated with sexual pharmaceuticals. There is a synergy to this approach, which is not yet supported by empirical evidence, but is rapidly gaining adherents which over time will document its successful benefits. Although there has been an explosion of research regarding the efficacy of PDE-5s for ED in the last 5 years, there is no doubt in this author’s mind that combination therapy (CT) will be the treatment of choice for all SD, as new pharmaceuticals are developed for desire, arousal, and orgasm problems in both men and women. Yet, owing to the paucity of current data available for other sexual disorders, this chapter will primarily emphasize CT for ED.

MODELS FOR TREATING SEXUAL DYSFUNCTION

Sex Therapy

Sex therapy theory and technique were derived from the pioneering works of both Masters and Johnson (1) and Kaplan (2). Initially Masters, a gynecologist, used an innovative 2 week, mixed-gender, co-therapy team, quasiresidential approach.
Sex therapy rapidly morphed into weekly sessions provided within a solo MHP’s office based practice. Treatment continued to emphasize “sensate focus exercises” and the reduction of performance anxiety. By the 1980s, sex therapy reflected a cognitive-behavioral theoretical bias, while typically utilizing Masters and Johnson variations, such as Kaplan’s, four phase model of human sexual response: desire, excitement, orgasm, and resolution (1,4,5). The models were not necessarily linear and causes could become effects. For instance, an ED might cause diminished desire. However, generally speaking, sex therapy was and is, the diagnosis and treatment of disruptions in any of these four phases and/or the sexual pain and muscular disorders. These dysfunctions occurred independent of each other, yet they frequently clustered.

Sex therapy was based on the development of a treatment plan conceptualized from the rapid assessment of the immediate and remote causes of SD while maintaining rapport with the patient (6,7). The sex therapist assigned structured erotic experiences carried out by the couple/individual in the privacy of their own homes. These exercises were designed to correct dysfunctional sexual behavior patterns, as well as positively altering cognitions regarding sexual attitudes and self-image. This “home play” modified the immediate causes of the sexual problem, allowing the individual to have mostly positive experiences and created a powerful momentum for successful treatment outcome. Interventions aimed at correcting or challenging maladaptive cognitions were incorporated into the treatment process (8). The individually tailored exercises acted as “therapeutic probes” and were progressively adjusted until the individual or couple was gradually guided into fully functional sexual behavior (4,6). However, each dysfunction had its own cluster of immediate causes. Certain exercises were typically used with a particular dysfunction. For example, almost all men with premature ejaculation (PE) were taught the “stop–start” technique, because failure to recognize and respond properly to sensations premonitory to orgasm, characterized that syndrome.

Patients might be single or coupled. The single patients were seen alone, but their new sexual partner might join them in treatment, once an ongoing relationship was formed. Couples were usually seen conjointly, however, during the evaluation phase of treatment, they were typically seen alone for at least one session of history taking. Other individual sessions were reserved for management of resistance where it may be more strategic to discuss the obstacles to success privately. To facilitate the success of this rapid approach, individuals/couples at times needed to explore other aspects of their relationship and/or intrapsychic life. Nevertheless, establishing sexual harmony typically remained the primary focus. Despite the concrete goal orientation, the therapeutic context was humanistic, emphasizing good communication, intimate sharing, and mutual respect.

Sex therapy was an “efficacious” treatment for primary anorgasmia in women, some erectile failure in men, and was “probably efficacious” for secondary anorgasmia, . . . , vaginismus in women and PE in men (9). Clinical
experience supported efficacy in treating hypoactive sexual desire, sexual aver-
sions, dyspareunia, and delayed orgasm in men (9). Despite its potency, there
were and are drawbacks to this approach, particularly from a cost-benefit stand-
point. Although considered as a “brief treatment” within a mental health context,
it typically required many appointments with a trained specialist and a high
degree of motivation on the part of the patient. Historically, healthcare systems
have discarded labor intensive, expensive approaches once “easier” and more
rapid alternatives were available. Sex therapy receded as a treatment of choice
during the 1990s, as medical and surgical approaches performed by urologists
established hegemony over the treatment of ED, in particular. The pinnacle of
this transition was reached during 1998, with the launch of sildenafil.

Medical Treatments for Erectile Dysfunction

The 1980s saw a progressive shift away from psychological treatments of SD to
an emphasis on surgical and medical solutions for improving sexual health. Sim-
ultaneously, there was a progressive shift within the medical community and
public at large, towards viewing the etiology of SD as organic, rather than the
psychogenic understanding emphasized by sex therapists. Use of improved soph-
isticated diagnostic procedures, such as duplex sonography and cavernograms
(although not necessarily improving treatment) added credibility and imprimatur
to the importance of organic pathogenesis (10). This was particularly true in the
area of ED, where urologists established dominance, with the successful market-
ing and use of various intracavernosal and intraurethral systems. Although highly
touted by urologists, the treatment efficacy of these products was offset by their
intrusiveness into the patient’s bodies and reduction in spontaneity, their patterns
of use required.

Initially, there were few oral treatments for ED, being used by urologists,
such as yohimbine based products, trazodone, and bupropion. They had only
modest proerectile capability (11). Pharmaceutical companies were inspired to
pursue oral treatments with the promise of less intrusiveness and even greater
profits. The first visible evidence of fulfilling that promise was the sildenafil
launch. Subsequent to Pfizer’s success, multiple companies simultaneously
pursued clinical trials of easy-to-use treatments for male SD. Among others,
these included additional PDE-5 type compounds and other oral treatments,
such as ixense (TAP Holdings, Deerfield, IL, USA), and topically applied com-
pounds (MacroChem, Lexington, MA, USA). Additionally, PT-141 (Palatin
Technology, Cranbury, NJ, USA) is a nasally administered peptide that is
under development, which is presumed to work through a central nervous
system mechanism.

Currently, there are three highly efficacious PDE-5, FDA-approved treat-
ments for ED: sildenafil, vardenafil, and tadalafil. Reviews of long-term
extension studies and published accounts of use in clinical practice show that sil-
denafil’s effectiveness was maintained with long-term treatment. “Significantly
improved erectile function was demonstrated for sildenafil compared with placebo for all efficacy parameters analyzed \((P < 0.02 \text{ to } 0.0001)\), regardless of patient age, race, body mass index, ED etiology, ED severity, ED duration, or the presence of various comorbidities. Long-term effectiveness was assessed in three open-label extension studies (12).” Vardenafil (launched in 2003) “is a potent, selective PDE-5 inhibitor, which improved erectile function in a broad population of men with ED and in characteristically challenging-to-treat groups such as diabetic and post prostatectomy patients (13).” Tadalafil also launched in 2003, when taken, “as needed before sexual activity and without restrictions on food or alcohol intake, significantly improved erectile function. It allowed a substantial proportion of patients to achieve a normal IIEF erectile function domain score, exhibited a broad window of therapeutic responsiveness and was well tolerated in a representative population of patients with broad-spectrum erectile dysfunction (14).”

NEW SEXUAL PHARMACEUTICALS: SUCCESS OR FAILURE

Success of the New Treatments

The new PDE-5 inhibitors have resulted in more people being treated than ever, with high success rates. There is much greater awareness of sexual and psychosexual issues surrounding dysfunction, simultaneous with a reduction of the stigma previously associated with ED. Treatment is now conducted by an expanding number of helping professionals, primarily PCPs. Treating ED is now a billion-dollar business with millions of men treated and many helped.

Barriers to Treatment Success

Approximately 90% of men who seek assistance for ED are treated with PDE-5s, all of which are reasonably safe (15). All are completely contraindicated with concomitant nitrate use; with some additional warnings and/or contraindications attached to use of alpha-blockers. Generally, PDE-5 inhibitors are highly effective, restoring erections in ~70% of men, yet there is a growing body of evidence suggesting that the frequently quoted 20–50% drop-out rate for medical treatments is true for PDE-5 treatment as well (15). Why? The adverse event profile is excellent for all three PDE-5s, with few patients terminating treatment, because of adverse events. Of course, not all discontinuation of sexual pharmaceuticals are due to failure or complications. There are some who tried the medications out of curiosity and never intended to continue using a PDE-5. There are some reported cases of men with psychogenic ED experiencing a “cure” after temporary use of a PDE-5 (16).

Reciprocally, some people will discontinue PDE-5 because of the severity of their ED. For these individuals, the pharmaceuticals simply do not work. Regardless of the mode of administration, a certain percentage of the population will not experience restored capacity, because the degree of organicity is so
profound as to overwhelm the salutary effects of the drug. In particular, some diabetics and radical prostatectomy survivors may need more powerful medical treatments.

Importantly, PDE-5 treatments do have significant psychosocial limitations and consequences which have created “born-again” roles for sex therapists, albeit more complex and sophisticated ones (17). Previously, many presumed that high discontinuation rates were due to the objectionable nature a specific treatment, such as self-injecting the penis. They thought that the introduction of efficacious and safe oral agents would decrease this high drop-out rate (18). However, there is great complexity to the barriers to success story. Although definitely improving, the reported success rate, the ensuing publicity (following PDE-5 launches) still resulted in just a small percentage of people worldwide receiving pharmaceutical therapy. ED treatment, even with its juggernaut of publicity and advertising has penetrated <15% of the estimated market place. In fact, industry information suggested that a geometrically small number of individuals were actually successfully treated and satisfied repeat “customers” (19). Apparently, a limited number of men were treated and a large percentage of those who tried it, apparently discontinued rather abruptly (19). There was also a high relapse rate when medication was stopped. The model for all three PDE-5s, as well as ICI and IUI treatments for ED, was chronic pharmaceutical use in order to relieve symptoms. To date, very little was written about “weaning” patients from pharmaceuticals or effectively maintaining them on lower doses. Concepts of “weaning” and relapse prevention offer opportunities for MHPs (20).

Identifying Psychosocial Barriers to Success

Importantly, pharmaceutical advertising and educational initiatives have altered the delivery of sexual medicine services, especially in the United States. Specifically, these changes in practice patterns resulted in PCPs becoming the principal healthcare providers for men who present with a primary complaint of ED, with urologists typically seeing the more recalcitrant cases. MHPs rarely are the initial treating clinicians anymore. This both helps and contributes to the problem of success and failure. The large number of PCPs treating ED has dramatically increased the number of patients seen, and the accessibility of medical treatment. Unfortunately, the history obtained by PCPs and urologists is frequently limited to an end-organ focus, and fails to reveal significant psychosocial barriers to successful restoration of sexual health. These obstacles or “resistance” represent a significant cause of noncompliance and nonresponse to treatment (2). These barriers manifest themselves in varying levels of complexity, which individually and/or collectively must be understood and managed for pharmaceutical treatment to be optimized (15,20).

Only recently, have physicians begun incorporating sex therapy concepts, and recognized that resistance to lovemaking is often emotional. Clearly, medical treatments alone are often insufficient, in helping couples resume a satisfying
sexual life. There are a variety of bio-psychosocial obstacles to be recovered that contribute to treatment complexity. All of these variables impact compliance and sex lives substantially, in addition to the role of organic etiology (20). There are multiple sources of patient and partner psychological resistance, which may converge to sabotage treatment: (i) What is the mental status of both the patient and the partner and how will this impact treatment, regardless of the approach utilized? What is the nature and degree of patient and partner psychopathology (such as depression)? What are the attitudinal distortions causing unrealistic expectations, as well as endpoint performance anxiety? (ii) What is the nature of patient and partner readiness for treatment? When and how should treatment begin, and be introduced into the couple’s sex life? What is his approach to treatment seeking? What should be the pacing of intimacy resumption? The average man with ED waits 2–3 years, before seeking assistance (21). By that time, a new sexual equilibrium has been established within the relationship, which may be resistant to the changes a sexual pharmaceutical introduces. Furthermore, although partner pressure is a primary driver for treatment seeking, some men who sought treatment at their partner’s initiation do not necessarily confide in them about the treatment (21). (iii) What is their emotional and attitudinal readiness for change? The sexual history will provide information regarding premorbid and current sexual desire. What is her motivation or desire for sex? What are her concerns regarding his safety? What are her belief systems regarding the treatment process which now enables coitus? Her compliance may be affected by her perception of the treatment being artificial or mechanical: “Is it the sildenafil, or me?” (iv) What is her health status (vaginal atrophy, etc.) and physical readiness for sex; her capacity for lubrication and need for stimulation, etc.? We know from the Massachusetts Male Aging Study that frequency of ED increases with age (22). We know that older men tend to have older, post-menopausal partners. Female partner’s additional and sometimes complex medical needs are frequently not addressed in the brief evaluation interview, often conducted by the average physician. (v) What are the relevant contextual stressors in the patient and/or partner’s current life, such as work, finances, parents, and children, etc.? (vi) What is the couple’s overall quality and harmony of relationship? Interpersonal issues impact outcome through a variety of manifestations? Intimacy blocks and power struggles may cause failure. (vii) What are the patient and partner’s sexual script? Overtime, incompatible sexual scripts, interest, and arousal patterns may predetermine SD. For instance, PDE-5s require stimulation, for the man to respond sexually; stimulation is frequently more than merely adequate friction. There are many divergent sexual scripts and a variety of unconventional patterns of sexual arousal (homosexuality, sadomasochism, etc.), which may sabotage arousal. Additionally, over time, there are reality-based alterations in a partner’s sexual desirability, which may also affect both arousal and orgasmic response.

Although most of these barriers to success can be managed as part of the treatment, too few physicians are trained to do so (20,23). What is a model for
this situation? These various sources of psychological resistance manifest themselves in a diverse manner, which Althof conceptualized as three “scenarios” of psychosocial complexity (15). Each level would lead to an alternative treatment plan. Importantly, this concept can be expanded to conceptualize treatment for all SD, and regardless of who provides care—they all would be CT.

COMBINATION THERAPY: THE ROAD TO SUCCESS

Combining sexual pharmaceuticals and sex therapy is the “oral therapy” of choice to optimize treatment for all SDs. This is true for men with ED, PE, or retarded ejaculation (RE) and will also be true for FSD. Less medication is required when you modify immediate causes while appreciating other psychological obstacles (20). However, CT is by no means a new idea, and sexual medicine is not the first specialty utilizing a broad-spectrum approach to increase efficacy and satisfaction.

Combination Therapy: A Brief Relevant History

During the 1970s, psychiatrists and psychoanalysts argued, with analysts insisting that psycho-pharmaceuticals interfered with analysis. Today, mainstream psychiatry is characterized by a CT of psychotherapy and psychopharmacology. In the 1990s, psychiatrists finally integrated SSRIs synergistically with cognitive-behavior therapy to treat depression. Indeed such a model, frequently practiced in modified form by PCPs, probably dominates the treatment of depression today. There is an emerging literature demonstrating the benefit of combining both pharmacological and psychological treatments for a number of psychiatric conditions (24–26).

In urology and many medical specialties, CT usually referred to a, two or more drug regimen, such as the 2003, AUA guidelines for BPH (27). There already is a history of using CT in sexual medicine. In the 1990s, sex therapists worked with urologists combining either ICI or vacuum tumescence therapy. Turner et al. (28a) found that psychological counseling was necessary to augment a pharmaceutically induced erection, for a man with a psychogenic ED. Kaplan managed “resistance to ICI,” helping five couples find satisfaction with pharmaceutical restoration of potency (28b). Hartmann and Langer (29) integrated injection therapy and sexual counseling concluding that a combined approach was beneficial. Colson described the results of a study integrating cognitive-behavior therapy and ICI technique. Of their patients, 51% were still able to experience satisfactory sexual intercourse after discontinuing injection therapy (30). Lottman et al. (31), integrated short-term therapy with intracavernosal injections and counseling, improving erectile function and facilitating couples communication. Wylie et al. (32) reported a successful combining of “vacuum treatment” and couple’s therapy for primarily psychogenic ED patients using a group approach.
Multiple case reports have summarized the benefits of combining sexual pharmaceuticals with cognitive or behavioral treatments for ED (33–37). There were also multiple articles recommending the combination of medical and psychological approaches to the treatment of ED (15,20,32,38,39). Unfortunately, at this point there are no well-designed randomized control studies focused on integrated approaches to the treatment of SD. However, many are optimistic that the data supporting this approach will be forthcoming. An excellent summary of this material on CTs, primarily for ED, with a few FSD studies, can be found in Table 10 of the WHO 2nd Consultation on Erectile and Sexual Dysfunction, Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction Committee report (40).

**Combination Therapy for Sexual Dysfunction: Integrating Sex Therapy and Sexual Pharmaceuticals**

We know, clinically, that many PDE-5 nonresponders will be restored to sexual health through a CT integrating sex therapy and sexual pharmaceuticals. Yet how do we conceptualize such a model so that standard treatment algorithms could be stretched to incorporate this concept? The answer is twofold. We need a schema for understanding psychosocial obstacles (PSOs) to successful treatment, integrated into a model that executes that understanding.

Combination therapy is the therapeutic modality of choice for any SDs. Combination therapy refers to a concurrent or step-wise integration of psychological and medical interventions. We have previously described developing adherence for this approach to ED, with enthusiasm growing within the FSD treatment community (36). Combination therapy is already being recommended for PE, and is likely to be recommended for the full range of ejaculatory disorders (41). Although desire disorders for men and women have a strong psychosocial cultural component, there is little doubt that sexual “desire” has biological underpinnings and is likely to be distributed on the same bell-shaped distribution curve as other human characteristics. This simply means that all SDs have a biopsychosocial basis and that treatment must incorporate medical and psychological dimensions. Without adequate desire, motivation, and realistic expectations, treatment outcome is likely to be disappointing and with high discontinuation rates. Medical interventions do not motivate the sexually reluctant patients or partners to try treatment, nor do they help overcome psychological obstacles to success. Reciprocally, it would constitute malpractice to only focus on psychological factors to the exclusion of all possible organic etiology for an individual seeking assistance. Then, how can an ethical and motivated clinician proceed?

**Combination Therapy Guidelines: Who, How, and When?**

There are two alternative models for CT: both will likely be adopted within the framework of sexual medicine, by different clinicians. First, working alone, PCPs, urologists, psychiatrists, and eventually gynecologists will integrate sex counseling with their sexual pharmaceutical armamentarium to treat SD. “Sex
counseling” in this situation, is utilizing sex therapy strategies and techniques to overcome psychosocial resistance to sexual function and satisfaction (20). In a second model, the above clinicians will collaborate with nonphysician MHPs (sex therapists), resolving SD(s) through a coordinated multidisciplinary team approach to treatment. The clinical combinations will vary according to the presenting symptoms, as well as the varying expertise of these health care providers. The utilization of these two different models will require three steps. (i) The clinician first consulted by the patient will consider their interest, training, and competence. (ii) The bio-psychosocial severity and complexity of the SD as a manifestation of both psychosocial and organic factors will be evaluated. (iii) The clinician in consideration of the two previous criteria, together with patient preference, will determine who initiates treatment, as well as, how and when to refer. The guidelines for managing the relative severity of the dysfunction will essentially be expanded, but continue to match the type of treatment algorithm described in “The Process of Care” and other step-change approaches (42).

Categorizing Psychosocial Obstacles to Treatment

Whether or not a physician works alone, as in the first model, or as part of a multidisciplinary team, as in the second, will be partially determined by the psychosocial complexity of the case. This CT model adapts Althof and Lieblum’s “Proposed Integrated Model for Treating Erectile Dysfunction” (15,40). However, it must be emphasized that this author is advocating a CT model for all SD. The treating clinician would diagnose the patient(s) as suffering from mild, moderate, or severe PSOs to successful restoration of sexual function and satisfaction. This characterization would be based on an assessment of all the available information obtained during the evaluation. This would include an assessment of the issues/factors described in this chapter’s earlier section on “Psychosocial Barriers to Success.” This assessment would essentially include the psychosocial (cognitive, behavioral, cultural, and contextual) factors predisposing, precipitating, and maintaining the SD. This would be a dynamic diagnosis, continuously reevaluated as treatment progressed. The consulted clinician would continue treatment and/or make referrals on the basis of progress obtained. These PSOs are categorized as follows:

1. **Mild PSOs**: No significant or mild obstacles to successful medical treatment.
2. **Moderate PSOs**: Some significant obstacles to successful medical treatment.
3. **Severe PSOs**: Substantial to overwhelming obstacles to successful medical treatment.

Sexual Dysfunction Treatment Guidelines

Although no objective data determines the criteria for diagnosing these three PSO categories, they will become a useful heuristic device to help clinicians know
when to refer. For instance, “Severe” PSOs may require psychotherapeutic and/or psychopharmacologic intervention prior to the initiation of treatment utilizing sexual pharmaceuticals in order to restore sexual functioning and satisfaction. Most nonmedical MHPs will collaborate with physicians to augment their own treatments, as sexual pharmaceuticals are likely to provide an ever-increasing role in MHP’s treatment strategies and armamentarium for SD (15,17,20,43). Additionally, this treatment matrix will provide a useful tool for sex therapist physicians (usually psychiatrists), when deciding whether to treat themselves, or seek collaborative assistance. The matrix determining who might treat is presented in Table 2.1.

**Table 2.1** SD Management Guidelines Based on PSO Severity

<table>
<thead>
<tr>
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<th>Mild PSO</th>
<th>Moderate PSO</th>
<th>Severe PSO</th>
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<tr>
<td>Physician sex coach</td>
<td>Frequently</td>
<td>Often</td>
<td>Rarely</td>
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<tr>
<td>Multidisciplinary team</td>
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PSOs = Psychosocial obstacles.

The following discussion illustrates how Table 2.1 could be used in clinical practice. Clearly, a multidisciplinary team including a sex therapist and multiple medical specialists could attempt to treat almost every case. Although severe cases would usually require a greater number of office visits with lower success rates, than moderate or mild cases. However, a team is a very labor-intensive approach and frequently unrealistic, both economically and geographically in terms of available expertise and manpower. However, in the first two cells, which reflect common scenarios in clinical practice, a physician who first evaluates a patient suffering from SD, could integrate sex counseling with their sexual pharmaceuticals, often resulting in a successful outcome.

**SEX COUNSELING TIPS FOR CLINICIANS**

A sex counseling model is frequently being recommended by CME courses for physicians, under the rubric of “optimizing” care when using PDE-5 treatments. As discussed earlier, multiple MHPs have attempted to raise awareness of the importance of psychosocial factors in the etiology and treatment of ED (15,17,20,32). However, this sex counseling model will apply to clinicians treating both men and women for the entire range of SDs, not merely those treating ED. Clinician difficulty with either moderate or severe psychosocial complexity would lead to appropriate referral and presumably the use of the multidisciplinary team model.

A recent article, “Sex Coaching for Physicians” provided a comprehensive discussion for nonpsychiatric physicians on incorporating psychotherapy into their office practice to enhance sexual pharmaceutical efficacy (20). The article
emphasized augmenting pharmacotherapy with sex therapy when treating ED specifically, or SD generally. Although intended for the nonpsychiatric physician, the article served as a good model for any clinicians interested in integrating use of sexual pharmaceuticals with their sex therapy practice, using a multidisciplinary model. That multidisciplinary approach constitutes the second alternative for “combination treatment” and will be addressed more fully, later in this chapter. The following section on counseling, incorporates key issues from the article in addition to other tips, helpful to clinicians counseling SD patients.

Clearly, clinicians treating SD must consider the psychological and behavioral aspects of their patient’s diagnosis and management, as well as organic causes and risk factors. Integrating sex therapy and other psychological techniques into their office practice will improve effectiveness in treating SD. Psychological forces of patient and partner resistance, which impact patient compliance and sex lives beyond organic illness and mere performance anxiety must be understood. The following key areas of therapeutic integration will be highlighted: Focusing the sex history; sexual scripts and pharmaceutical choice; “follow-up” and “therapeutic probe” to manage noncompliance; partner issues; relapse prevention; and referral.

The Focused Sex History

A focused sex history is the clinician’s most important tool in evaluating SD, as it is most consistent with the “review of systems” common to all aspects of medicine. This limited history gives clinicians critical information in <5 min. Both sex therapists and physicians juxtapose detailed questions about the patient’s current and past sexual history unveiling an understanding of the causes of dysfunction and noncompliance. A good, focused sex history assesses all current sexual behavior and capacity. The interview is rich in detail, providing a virtual “video image,” clarifying many aspects of the individual’s behavior, feelings, and cognitions regarding their sexuality. A flood of useful material emerged when actively and directly evoked. A focused sex history critically assists in understanding and identifying the “immediate cause”—the actual behavior and/or cognition causing or contributing to the sexual disorder. Armed with this information, a diagnosis could be made and a treatment plan formulated. These sexual details provide important diagnostic leads. Significantly, the sexual information evoked in history taking will help anticipate noncompliance with medical and surgical interventions. Kaplan’s “Cornell Model” heuristically used immediate, intermediate, and remote causal layering to help determine timing and depth level of intervention (7). Modifying immediate psychological factors results in less medication being needed for men and women, regardless of their specific SD. Sex therapist’s interventions are exercises and interpretations. In general, physicians will intervene with pharmacotherapy and brief “sex counseling,” which address “immediate causes” (insufficient stimulation)
directly, intermediate issues (e.g., partner) indirectly, and rarely focuses on deeper (e.g., sex abuse) issues. Nonpsychiatric physicians typically manage current obstacles to success, which are both organic and psychosocial in nature. In fact, when deeper psychosocial issues are the primary obstacles, it is usually time for referral (4).

Many clinicians learned about the statistically significant increase in the incidence of depression in individuals with SD. Treatment of SD may improve mild-reactive depression, whereas depressive symptoms might alter response to therapy of SD (44). A clinician’s history taking must parse out this “chicken or egg problem”: Is SD causing depression, or is depression and its treatment (e.g., SSRIs) causing the SD? Here, the value of direct questioning about sex becomes clear in particular. If clinicians did not ask, the patients may not tell. When asked direct questions, SSRI patients reported an increase, from 14% to 58%, in the incidence of SD vs. spontaneous report (45). True incidence was probably underestimated as PDR data was based on patient spontaneous report (46). To manage adverse effects of medication, physicians must adjust dose or, combine with other drugs, to ameliorate the problem. For instance, many might reduce the SSRI and supplement with bupropion or try sildenafil as a possible adjunct (43,47). Although “alternative medicine” (herbs, etc.) or other treatment approaches might be effective, sex therapy enhances all of these strategies. In particular, teaching immersion in the sexual experience through fantasy is helpful to eroticize both the experience and the partner. However, fantasy could be about anything erotic; masturbatory fantasies are usually quite effective. Fantasy of an earlier time with the current partner may be especially helpful for those who feel guilty about fantasizing in their own partner’s presence. Referral to a sex therapist can help when extensive and specific discussions of masturbation are useful to develop, recalibrate and/or restore the sexual response (20).

The focused sex history allows the clinician to initiate therapy with the least invasive method available; literally an “oral therapy.” For this author, one question helps pin down many of the immediate and remote causes: “tell me about your last sexual experience?” Common immediate causes of SD are quickly evoked by the patient’s response. The most important cause of SD is lack of adequate friction and/or erotic fantasy, in other words, insufficient stimulation. Sex is fantasy and friction, mediated by frequency (20). To function sexually, people need sexy thoughts, not only adequate friction. Although fatigue may be the most common cause of SD in our culture, negative thinking/anti-fantasy, whether a reflection of performance anxiety or partner anger, is also a significant contributor. Of course, the clinician initiating the discussion of sex with the patient, in a mutually comfortable manner, transcends the importance of which question is asked. The clinician follows-up, with focused, open-ended questions to obtain a mental “video picture.” Inquiries are made about desire, fantasy, frequency of sex, and effects of drugs and alcohol. Did arousal vary during manual, oral, and coital stimulation? What is the masturbation style, technique, and
frequency? Idiosyncratic masturbation is a frequent hidden cause of ED, as well as RE (41a,41b). The clinician becomes implicitly aware of the patient’s sexual script and expectations, leading to more precise and improved recommendations and management of patient expectations (20). For instance, a clinician would improve outcome by briefly clarifying whether a patient was better-off practicing with masturbation, or reintroducing sex with a partner? A recently divorced man, who was using condoms for the first time in years, was probably better-off masturbating with a condom rather than attempting sex with his partner, the first time he tried a new sex pharmaceutical.

**Patient Preference, Sexual Scripts, and Pharmaceutical Choice**

Patients suffering from SD, first express preference when they choose to seek help from a MHP vs. a nonpsychiatric physician. Most MHPs (having ruled out organic etiology) will initially proceed with sex therapy in cases where psychogenic etiology is paramount. For many of these patients, sex therapy will be effective in and of itself. For others, the MHP will facilitate incorporating sexual pharmaceuticals into the treatment process, to help “bypass” or overcome PSOs. The use of sexual pharmaceuticals for these patients may be a temporary recommendation, until a more pro-sexual equilibrium is established for the patient and partner. Reciprocally, pharmacotherapy may be either continually or intermittently integrated with other attitudinal and behavioral changes necessary for a successful sexual and emotional experience. This will vary based on patient and partner pathologies interacting with the progressive organicity, often secondary to aging. Understanding relapse prevention requires consideration of these issues and factors (16,20,48). How these issues are currently managed by MHPs is illuminated within this chapter’s Case Studies.

Owing to multiple factors including the organization of health care delivery, attitudinal beliefs, and pharmaceutical advertising; the majority of patients suffering from ED (when they do seek treatment) are likely to consult their PCP or a nonpsychiatric physician specialist (21). Although a few select physicians (primarily multiskilled psychiatrists) will provide sexual counseling as an exclusive modality when appropriate, most nonpsychiatric physicians will initiate treatment with a PDE-5 regardless of etiology. All three PDE-5s are used worldwide and are now FDA approved in the USA. All have good success rates! Simple cases do respond well to oral agents, with proper advice on pill use, expectation management, and a cooperative sex partner. However, physicians should offer patients choices, especially those who are pharmaceutically naive. Providing an unbiased, fair-balanced description of treatment options, including pharmaceutical benefits on the basis of the pharmacokinetics, efficacy studies, and the physician’s own patients’ experience will result in the patient attributing greater importance to the physician’s opinion. Incorporating patient preference provides important guidance and will enhance
healer/patient relations, minimize PSOs, and improve compliance. Preliminary comparator data, abstracted from the 2003 European Society of Sexual Medicine, suggested, patient preferences reflected, key marketing messages of the respective pharmaceutical companies (49). Prescribing physicians might take advantage of that hypothesis to increase efficacy. If safety and long-term side effects are the primary concern, sildenafil has the oldest/longest database (12). If, pressed by questions regarding hardness of erection; in vitro selectivity may or may not translate to clinical reality, yet some patients believe vardenafil provides the best quality erection with the least side-effect (13). What is the physician’s experience with their own patients?

By taking a sex history and evaluating the premorbid sexual script (what used to work sexually), a skillful clinician may make an educated guess, as to which pharmaceutical to first prescribe. This transcends, “try it, you’ll like it.” Knowledge of pharmacokinetics (onset, duration of action, etc.) and sexual script analysis helps optimize treatment, by improving probability of initially selecting the right prescription. Many physicians initiated treatment with sildenafil and will continue to do so. However, psychosocial factors and previous sexual scripts, may suggest a different drug on the basis of pharmacokinetic profile. Partner issues help determine correct pharmaceutical selection on the basis of analysis of the couple’s premorbid sexual script and relationship dynamics. Understanding the couples “sexual script” can help the physician fine tune pharmaceutical selection, leading to better orgasm and sexual satisfaction, not merely improved erection (50). Sexual script in this situation refers to style and process of the couple’s premorbid sex life (51). For those fortunate enough to have had a good premorbid sex-life, dosing instructions should focus on returning to previously successful sexual scripts—as if medication was not a necessary part of the process. This maximizes patient likelihood of getting adequate stimulation in a manner likely to be comfortable and conducive to partner sensitivities. Awareness of within individual differences improves the quality of recommendations made for that person or couple’s sexual recovery. Differences between individuals in sexual style (sex script analysis) can determine which medication might be used by a couple effectively, with less change required in their “normal” sexual interactions. For instance, some couples mutually presume that the man is “in charge” and should initiate and seduce like he used to. As he is planning the sexual encounter, sildenafil or vardenafil might be good choices. However, tadalaafil may be preferable, if a more spontaneous response to an externally evoked situation is desired.

Fitting the right medication on the basis of pharmacokinetics to the individual/couple will increase efficacy, satisfaction, compliance, and improve continuation rates. Rather than changing the couples’ sexual style to fit the treatment, try to fit the right medication to the couple (50). A sensitive clinician may be tempted to facilitate a relationship of greater egalitarian and psychological balance. However, a symbiotic relationship with decades of history must be respected. For the most part, clients are seeking restoration of sexual function not a
“make over,” defined and reflecting a “politically correct” professional bias. Success requires consumer sensitivity. For instance a “rejection sensitive” woman may function as the couple’s sexual “gatekeeper,” yet may never initiate sex. She may require him to respond to explicit initiations or her implicit initiations through signs of sexual receptivity (leg touching in bed, a subtle caress). The astute clinician might ask “Couldn’t these merely be signs of partner affection and not subtle sexual initiation?” Yes. However, for such a women, his willingness and ability to be sexual, is experienced positively even if she declines sex. She needs to feel both affirmed and in control. They agree that she is the gatekeeper and she may encourage sexuality, or limit the process to affection. Yet, his initiation is an important aspect of their sexual script and relationship equilibrium. By serving as a source of affirmation for her, it reduces the noxious (toxic) manifestations of her insecurity and rejection sensitivity. They both expect that she will decline some initiations. Yet, if he is only willing and able to initiate once dosed, then sildenafil or vardenafil is a poorer choice. For their relationship, multiple initiations are required, and predosing with longer acting tadalafil may be a better choice. Harmony will be restored and satisfaction will increase. Two to three doses of tadalafil weekly, for a month, might be useful for such men who are essentially “on-call” in order to initially facilitate their capacity. As confidence and capacity improves and predictability increases, dosing could be titrated down or the pharmaceutical even weaned away. If the previous sex script was weekend sex, then a Friday night dose may be sufficient. If he has become resistant to her “controlling domination,” then a referral for couples counseling would be appropriate. Although the suggestion of referral may be enough to compel him to try the drug, given the reaction many men have to MHPs. The physician simply makes an educated guess regarding pharmaceutical selection. Follow-up may indicate greater PSO complexity. Then, the case would be better managed utilizing a multidisciplinary integrated approach, with a sex therapist working collaboratively with the prescribing physician. Later in this chapter, this multidisciplinary method is illustrated with the case of Jon and Linda.

Follow-up and Therapeutic Probe

Discussions of follow-up most vividly illustrate the importance of integrating sex therapy and pharmacotherapy. Urologists, Barada and Hatzichristou improved sildenafil nonresponders by emphasizing patient education (e.g., food/alcohol effect), repeat dosing, partner involvement, and follow-up (52,53). Patient education about the proper use of sildenafil was crucial to treatment effectiveness. Physicians can increase their success by scheduling follow-up, the first day they prescribe. As with any therapy, follow-up is essential to ensure an optimal treatment outcome. Initial failures examined at follow-up reveal critical information. The pharmaceutical acts as a therapeutic probe, illuminating the causes of failure or nonresponse (2,15,20). Retaking a quick current sexual
history provides a convenient model for managing follow-up. Other components of the follow-up visit include monitoring side effects, assessing success, and considering whether an alteration in dose or treatment is needed. Future comparator trials will help determine which drug works best, for which person(s), under which context. Until then, physicians will likely trust their own judgment and experience. However, physicians must provide ongoing education to patients and their partners, as well as involving them in treatment decisions whenever possible. A continuing dialogue with patients is critical to facilitate success and prevent relapse. The numerous psychosocial issues previously discussed may evoke noncompliance. These are important issues in differentiating treatment nonresponders from “biochemical failures,” in order to enhance success rates. Early failures can be reframed into learning experiences and eventual success.

Partner Issues
Regaining potency does not automatically translate into the couple resuming sexual intercourse. Psychological issues may render the best treatments futile. PDE-5 discontinuation or failure rates of 20–40% are not due to adverse events. Resistance to lovemaking is often emotional and the most common “mid-level” psychological causes of SD are relationship factors (15,20,23). As discussed previously, partner dynamics can help determine correct pharmaceutical selection on the basis of analysis of the couple’s premorbid sexual script and relationship (50). Yet numerous partner related psychosexual issues may also adversely impact outcome.

Cooperation vs. Attendance
Mild immediate causes of SD are often amenable to brief counseling in the physician’s office. Still the most common mid-level relationship causes may present considerable difficulty for the nonpsychiatric physician treating SD within the context of a typically brief office visit. How might this challenge be met? The complexity of this conundrum can be reduced or resolved. The physician’s challenge is not necessarily requiring an office visit with the partner, as many CME programs have advocated. Instead, the emphasis should be on evaluating the level of partner cooperation and support. Since Masters and Johnson, sex therapists have recognized that SD is a “couples problem,” not just the identified patient’s problem (2). However, almost equally long ago, this author and others noted that the key partner treatment issue was supportive cooperation, independent of actual attendance during the office visit (5,20). Generally speaking, encourage partner attendance with committed couples, allowing assessment and counseling for both. However, the issue is never forced. Treatment format is a psychotherapeutic issue and rapport is never sabotaged. Although conjoint consultation is a good policy, it is not always the right choice! A man or woman in a new dating
relationship is probably better-off seeing the physician alone, than stressing a new relationship by insisting on a conjoint visit (20,54).

Partner Consultation?

Although CME courses recommended that patient–partner–physician dialogue was best enhanced through patient–partner education during conjoint visits, there was anecdotal evidence that physicians were not regularly meeting with partners of SD patients. This author undertook a 2002 Internet survey of the Sexual Medicine Society of North America, member’s practice patterns. These urologists are all sub-specialists in sexual medicine in general, and ED in particular. Although methodologically limited, the results were interesting. The data pointed to a striking disparity between urologist attitude and actual practice. An overwhelming 79% of the responding urologists considered partner cooperation with ED treatment “important,” regardless of whether the partner actually attended sessions or not? Yet, only 39% of the responding urologists saw only one partner or less in their last five ED patient’s office visits. Nor was there any contact by phone, e-mail, or other means between doctor and partners for 90% of the responding urologists, despite the vast majority of patients were married or coupled. However, there were good reasons for not having a conjoint visit, as long as the importance of partner issues in treatment success was understood. Indeed, many urologists reflected thoughtfully on the burden of the treater to not invade the privacy beyond what was freely accepted by the patient. Urologists noted that the men saw ED as their problem, and were not interested in involving their partner. These urologists gently encouraged partner attendance, but appropriately did not require it (20). So why are pharmaceutical ED treatments so effective? Does this data suggest that partner issues do not impact outcome? No, but it does support the thesis that “partner cooperation” is even more important than “partner attendance.” Why are many physicians successful even when not seeing partners? Sex pharmaceuticals with sex counseling and education work for many people, if the partner was cooperative in the first place. Fortunately, many partners of both men and women are cooperative, which partially accounts for the high success rates of medical and surgical interventions. Indeed, most of the cooperation goes unexplored. The cooperation is assumed based on post hoc knowledge of success. Importantly, many women were cooperating with their partners, or facilitating sexual activity, independent of their knowledge of the use of a sexual aid or pharmaceutical. In other words, serendipitous matching of sexual pharmaceutical and previous sexual script equaled success: “we did, what we used to do, and it worked.” (20,54).

The existence of large numbers of cooperative, supportive women who themselves have partners with mild to severe ED account for much of the success of many ED patients who see their physicians alone, for evaluation and subsequent pharmacotherapy. Many of these partners were never seen by the treating physician, nor was their attendance necessary for success. This is likely to be true for other male and female dysfunctions as well, depending on
the degree of psychosocial barriers to success. Obviously, the most pleasant, supportive, cooperative partners would rarely be discouraged from attending office visits with any patient. Ironically, these same patients would probably have successful outcomes even if their partners never attended an office visit. However, good becomes better by evaluating, understanding, and incorporating key partner issues into the treatment process (54).

The patient–partner–clinician dialogue is best enhanced through patient–partner education. Partner attendance during the office visit would allow for such education. Yet, many clinicians do not regularly meet with partners of SD patients. Although working with couples was often recommended: sometimes there was no partner; sometimes the current sexual partner was not the spouse, raising legal, social, and moral sequella. The reality and cost/benefit of partner participation is a legitimate issue for both the couple and the clinician, and not always a manifestation of resistance. Finally, the patient’s desire for his partner’s attendance may be mitigated by a variety of intrapsychic and interpersonal factors, which, at least initially, must be respected and heeded (15,20).

There are other solutions. When evaluation or follow-up reveals significant relationship issues, counseling the individual alone may help, but interacting with the partner will often increase success rates. If the partner refuses to attend, or the patient is unwilling or reluctant to encourage them; seek contact with the partner by telephone. Ask to be called, or for permission to call the partner. Most partners find it difficult to resist speaking “just once,” about “potential goals” or “what’s wrong with their spouse.” The contact provides opportunity for empathy and potential engagement in the treatment process, which may minimize resistance and improve further outcome. This effective approach could be modified depending on the clinician’s interest and time constraints. Clinicians should counsel partners when necessary and possible. They need to be a resource in treating with medication, counseling, and educational materials. Education needs to be a greater part of SD practice, whether provided within a physician’s practice or externally by other competent healthcare professionals. Success rates can be enhanced through patient–partner–clinician education, which will reduce the frequency of noncompliance and partner resistance, and minimize symptomatic relapse. Organic and psychological factors causing SD, and noncompliance with treatment, are on a multi-layered continuum. Although some partners will require direct professional intervention, many others could benefit from obtaining critical information from the SD patient and/or multiple media formats both private and public (20,54).

**Weaning and Relapse Prevention**

In general, the concept of relapse prevention has not been incorporated into sexual medicine. Yet SD is recognized as a progressive disease in terms of underlying organic pathology, which may play a role in altering threshold for response and potential re-emergence of dysfunction. Both McCarthy and Perelman have
recommended that the clinician schedule “booster” or follow-up sessions in order to help the patient stay the course and provide opportunity for additional treatment when necessary (20,48). These concepts are derivative of an “addiction” treatment model where intermittent, but continuous care is the treatment of choice. Additionally, utilizing sex therapy concepts in combination with sexual pharmaceuticals offers potential for minimizing dose and temporary or permanent weaning from medication depending on the severity of organic and psychosocial factors. SDs are frequently progressive diseases, but this is especially true for ED. Over time the progressive exacerbation of either organic factors (endothelial disease, etc.) or PSOs may adversely impact a previously successful treatment regimen. Furthermore, although there is no current evidence for tachyphylaxis, neither are there extensive studies beyond 10 years indicating long-term efficacy of PDE-5s. No doubt, escalating dose and providing alternative medications would be most physician’s initial response of choice. However, both these processes may be modulated and mediated by sexual counseling and education. Sex therapy and other cognitive-behavioral techniques and strategies could be extremely important in facilitating long-term medication maintenance, and helping to ensure continuing medication success. As such, clinicians caring for ED patients, are well advised to incorporate these counseling techniques into the treatment they provide themselves, or through referral. Each case requires individual consideration in part determined by patient preference regarding level of outcome success desired. Levine (16) presented an interesting discussion on multiple dimensions of treatment success.

When to Refer?

The physicians “time crunch” can be managed, when brief counseling of the SD patient is sufficient. If the partner’s support for successful resolution of the SD is not present, then active steps must be taken to evoke it. Sometimes, a conjoint referral for adjunctive treatment to a sex therapist for the partner may also be required (20). Of course, the more problematic the relationship, the more profound the marital strife, the less likely that patient–partner sex education will be able to successfully augment treatment in and of itself. Inevitably, a referral to a MHP would be required, albeit not necessarily accepted successfully. Additionally, there are numerous organically determined reasons making referral to a multiplicity of medical specialists (urologists, gynecologists, neurologists, psychopharmacologists, endocrinologists, etc.) necessary and appropriate. However, elaborating all of them is beyond the scope of this chapter.

Integration vs. Collaboration

Does a multidimensional understanding of a SD always require a multidisciplinary team approach? Clearly, the answer is no. When there is a question of collaboration vs. integration within an individual clinician; how does one decide whether to be a multitalented physician or part of a multidisciplinary team?
There are a variety of sexual medicine thought leaders conversant with both organic and psychosocial predisposing, precipitating, and maintaining factors of SD, including some notable PCPs, psychiatrists, and urologists. Additionally, there is a convergence towards a bio-psychosocial consensus initially reflected by the “Process of Care Guidelines,” and elaborate upon, in the published Proceedings of the WHO 2nd International Consultation on Erectile and Sexual Dysfunction (40,42). These publications are the result of multidisciplinary cooperation, with collaborative knowledge being appreciated, independent of specialty of origin. These consensus reports, speak to the importance of integrating medical, surgical, and psychosocial treatments for SD. Sometimes, the physician’s treatment is only partially successful, and the lack of psychosocial sensitivity causes an exacerbation of the problem. This may be corrected. Reciprocally, psychotherapists may be fairly criticized for failing to refer quickly enough for medical consultation, in order to benefit from incorporating a sexual pharmaceutical to speed-up the recovery process and reduce the time and cost of treatment. Discussed subsequently is Roberto’s ED case, treated by the author and two different urologists; when an expert sexual medicine physician, who had adequate time and motivation, may have managed equally well.

Case Study: Roberto

A 32-year-old Italian man was suffering from primary ED. Roberto had “two hypospadias operations” at ages 3 and 6. He reported “at 8 years old, circumcision removed excess skin.” He remembered friends teasing, about his urinating from the “underside.” He had primary ED and 2 years ago (as a visiting student), he consulted a US urologist who prescribed sildenafil. The urologist reportedly told Roberto that he would never function normally, because of his congenital hypospadius. Roberto left that consultation devastated, fearing he was sexually handicapped for life. No great surprise, the sildenafil did not work when he used it with masturbation. He was afraid to date women. The same urologist observed on follow-up that Roberto seemed depressed and was not using the sildenafil, or dating. He referred Roberto to the author. Accurate information incorporated within a cognitive-behavioral sex therapy, improved Roberto’s self-esteem, reduced his fear of rejection, decreased performance anxiety, and encouraged dating. His confidence was increased through his masturbation, augmented with sildenafil and fantasy. It worked! He began dating and had erections with foreplay.

Vacationing in Italy, Roberto began a sexual relationship with a woman. He went to an Italian urologist who complemented his sex therapy progress, and provided him with samples of sildenafil, vardenafil, and tadalafil. All worked wonderfully, but he preferred tadalafil, because of the 36 h duration of action. He reported that his new girlfriend supposedly “had six orgasms in 27 years with all her boyfriends; yet with me, she had five in one day.” He suspected, she knew, he used “sex drugs.” They reportedly had sex twice daily. Back in the
USA, he used 1/3, of a 100 mg sildenafil and fantasy about sex in Italy, to masturicate successfully. Roberto was gradually weaned from the sildenafil when he masturbated. When his girlfriend visited 6 months later, he initially used low dose sildenafil successfully. Then, she seduced him one night when he had no medication available. She remained with him in the US. Reportedly, they now have twice weekly coitus, fully weaned from medication, for the past 5 months. The author will see him again in 2 months for follow-up to minimize relapse potential. Roberto recognizes, “it is mostly in the brain.” He wisely said, “If we break up or in a period of stress, okay let me take a pill a couple of times. I will use it as a crutch once in a while. When I feel less secure or very stressed.”

WORKING TOGETHER: A MULTIDISCIPLINARY TEAM APPROACH

The concept is a simple one with a long history; sometimes, two heads are better than one. Treatment may require a multidisciplinary team in cases of severe dysfunction, and may be recalcitrant to success even under this ideal circumstance. There are many models for working together. Team approaches and composition will vary according to clinician specialty training, interest, and geographic resources. Although some expert physicians work alone, other PCPs, urologists, and gynecologists have set up “in house” multidisciplinary teams where nurses, physician associates, and master’s level MHPs provide the sex counseling. This approach has obvious advantages and disadvantages. In cases of more severe PSOs, the patient(s) will be “referred out” for psychopharmacology, cognitive-behavioral therapy, and marital therapy in various permutations, provided by doctoral level MHPs (55–57). However, typically a clinician refers within their own academic institution, or within their own professional referral network—a kind of “virtual” multidisciplinary team. Endocrine, gynecologic, or urologic referrals for the patient or partner may be required, and would usually be readily available. However, MHPs trained in sex therapy will experience the greatest number of new opportunities for interdisciplinary participation to enhance and optimize patient response to sexual pharmaceuticals. Identifying psychological factors does not necessarily mean that nonpsychiatric physicians must treat them. If not inclined to counsel, or, if uncomfortable, these physicians should consider referring or working conjointly with a sex therapist. All clinicians should be encouraged to practice to their own comfort level. Indeed, some PCP will not have the expertise to adequately diagnose PSOs, independent of their ability or willingness to treat these factors. Awareness of their own limitations will appropriately prompt these physicians to refer their patients for adjunctive consultation. Physicians who prescribe PDE-5s and future sexual pharmaceuticals may need adjunctive assistance, referring to sex therapists, because of their own psychological sophistication or due noncompliance on their patient’s part. Whether the referral is physician or patient initiated, sex therapists are ready to effectively assist in educating the patient about maximizing their response to the sexual situation. They are able to help re-motivate people
who have failed initial medical treatments, as well as helping patients to adjust to “second and third line” interventions. They help make patients receptive to trying again. Sex therapists are also equipped to help resolve the intrapsychic and interpersonal blocks (resistance) to restoring sexual health (20,42). Some clinicians are uncomfortable discussing sex, and many important issues remain unexplored because of clinician anxiety and time constraints. Sex therapists can manage event and process based developmental factors, which predisposed the patient to manifest the SD. They are trained to manage the most difficult cases involving process-based trauma that are replicated in the current relationship. Sex therapists working adjunctively with the PCP, urologist, or gynecologist could provide all the previously discussed sex counseling, as well as managing PSOs with greater therapeutic depth. Sex therapists can enhance hope, facilitate optimism and maximize placebo response. There can be an increased individualization of treatment format, by fine-tuning therapeutic suggestions, as well as improving response to medication by optimizing timing and titration of dose. Sex therapists have a sophisticated appreciation of predisposing (constitutional and prior life experience), precipitating factors triggering dysfunction, and factors maintaining SD. Finally, sex therapists are skilled in using cognitive-behavioral techniques for relapse prevention. All of these issues impact potential and capacity for successful restoration of sexual health. Delineating all permutations, of multidisciplinary team approaches likely to be utilized for the next decade, is beyond the scope of this chapter. However, a useful glimpse of this process is provided in the following case, where this author collaborated with a PCP, a urologist, and a psychopharmacologist, in a “virtual” multidisciplinary team approach to CT.

Case Study: Jon and Linda

Jon and Linda were referred to the author by Jon’s current psychopharmacologist. Jon is a 62 years old financier who has been married to Linda (53 years old) for over 20 years. She began HRT 4 years ago, which successfully stopped her hot flashes. This is his second marriage and her first marriage. They had three teenage children together. Their marriage was marked by periods of disharmony secondary to multiple etiologies. Jon and Linda had a symbiotic relationship where she dominated much of their daily life. She tended to be explicitly critical of him, which he resented but managed passive-aggressively. This, of course, merely exacerbated their marital tension. Linda was particularly sensitive to rejection, and was considerably upset when Jon withdrew from her in response to her criticism. This infuriated her and she provoked confrontations. He eventually responded, becoming loud and aggressive, which initially dissipated his tension. He then felt guilty as she expressed hurt and disappointment in his behavior. This push–pull process would begin anew, characterizing the rhythm of their marriage. Despite all these difficulties in the relationship, both Jon and Linda were fortunate enough to be capable of engaging in successful sex to reduce their stress and anxiety; unlike those needing to be stress free in order
to function. Jon and Linda enjoyed high frequency successful coital activity with mutually enjoyable coital orgasms, despite their intermittent marital disharmony over a 15-year period.

Three years ago, Jon started SSRI treatment for depression, secondary to work stress. His depression exacerbated his insecurity about his intelligence and abilities. He developed ED and could not erect, but his sexual desire was still strong. Medication helped his moodiness and reduced his depression. They both wanted Jon on the antidepressant medications, yet their marital conflict increased. His psychopharmacologist tried reducing the SSRI and augmenting with bupropion. This did not help! If anything, it uncharacteristically, worsened his sex life. They tried switching him from paroxetine to bupropion to escitalopram. During this time, he lost his job, and money problems became worse. He needed to move to a different city in order to find work, uprooting Linda and the kids. He also used a low dose, blood pressure (BP) medication, which had not caused ED, although it was a risk factor. Possibly, the BP medication exacerbated the anti-sexual impact of the SSRI, culminating in his severe ED. His typical male withdrawal from sex and affection once the ED emerged, only exacerbated her rejection sensitivity and deep feeling of abandonment. This left her slightly depressed, but predominantly, critical of him and doubting the viability of their marriage.

His Chicago psychopharmacologist referred them to a well-known NYC urologist, when they first moved from Chicago. The urologist prescribed 50 mg of sildenafil, which was increased to 100 mg. There were multiple attempts at 100 mg, which all failed. The urologist then prescribed “trimix.” They used “trimix” ICI, 15 times, resulting in three coital erections and orgasms. Neither Jon, nor Linda liked the “lack of spontaneity.” The urologist recommended a penile prosthesis, but Jon declined and terminated that treatment.

Some months later, still on 10 mg of escitalopram, a new, NYC psychopharmacologist referred Jon to this author. Jon and Linda were seen six times conjointly and three times individually. She was helped to reframe his withdrawal, as insecurity, not rejection or abandonment of her. This reduced her anger and resentment. He was encouraged to be affectionate when not angry at her. Her criticalness was reduced, which led to a reduction in his passive-aggressive behavior. Although not resolving the individual and marital dynamics, these insights increased harmony enough, for a sexual pharmaceutical to become effective. The author recommended tadalafil to Jon’s PCP, because of Linda’s rejection sensitivity. The drug’s longer duration of action allowed him to respond to her receptivity cues, which she “dropped like a hankie.” For 1 month, he took tadalafil, Friday and Tuesday. Quoting her: “it covered him for the week.” They now use it, as needed, and are back to twice weekly coitus. She said, “I could do a commercial. It’s doing a fabulous job. It’s a really good drug for us. It is causing greater emotional warmth that leads to physical intimacy.” This, of course tends to be true for all the PDE-5s when they work, not just tadalafil. He reported, “it takes away the uncertainty, allowing me to feel able.”
Reportedly, both individual and relationship satisfaction were increased and Jon continued to be followed by his PCP and his psychopharmacologist.

SUMMARY AND CONCLUSION

For those individuals where cost is less of a factor in determining decision-making, consultation with a qualified sex therapist offers a potentially more elegant solution, than merely experiencing a trial of sexual pharmaceuticals, when confronted with SD. Yet, it would be unnecessary to subject everyone to a complex evaluation by a sex therapist in advance of a sexual pharmaceutical prescription and brief counseling by a PCP. In part, patients will seek the treatment they want and prefer. Some will seek herbal supplements purchased on the Internet, whereas others will choose a consultation with a MHP specializing in sex therapy. However, if only due to pharmaceutical advertising, most patients will first consult with a physician who will hopefully possess sex counseling expertise, as well as a prescription pad. This physician would adjust treatment according to the individual and couple’s history, sexual script, and intra and interpersonal dynamics.

All clinicians want to optimize the patient’s response to appropriate medical intervention. However, it is equally important to not collude with the patient’s unrealistic expectations of either his or her own idealized capacities, or an idealization of the treating clinician’s abilities. These fantasies are based on ignorance and may reflect unresolved psychological concerns. There are situations when it is appropriate to either make a referral within a team approach or to decline to treat a patient. Significant, process based, developmental predisposing factors, usually speak to the need for resolution of psychic wounds prior to the introduction of the sexual pharmaceutical. A man with ED or RE who avoids sex with his intrusive, domineering spouse, is even less likely to successfully utilize a sexual pharmaceutical; if his idiosyncratic and hidden masturbation pattern, emerged in response to a critical intrusive mother (35). The more determinants of SD are driven by developmental processes, the more likely the patient will benefit from sex therapy in addition to pharmacotherapy. There are situations when it is appropriate to postpone treating the patient for the SD, until psychotherapeutic consultation is able to assist the individual in developing a more reality-based view. Although sometimes this can be done simultaneously, other times, treatment for SD must be postponed.

Sexuality is a complex interaction of biology, culture, developmental, and current intra and interpersonal psychology. A bio-psychosocial model of SD provides a compelling argument for CT integrating sex therapy and sexual pharmaceuticals. Restoration of lasting and satisfying sexual function requires a multidimensional understanding of all of the forces that created the problem, whether a solo physician or multidisciplinary team approach is used. Each clinician needs to carefully evaluate their own competence and interests when considering the treatment of a person’s SD, so that regardless of the modality used, the patient receives optimized care. For the most part, neither sex therapy nor
medical/surgical interventions alone are sufficient to facilitate lasting improvement and satisfaction for a patient or partner suffering from SD. There will be new medical and surgical treatments in the future. Sex therapists and sex therapy will complement all of these approaches. This author is optimistic, for a future, which uses CT, integrating sexual pharmaceuticals and sex therapy, for the resolution of SD and the restoration of sexual function and satisfaction.

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