PRINCIPLES AND PRACTICE OF SEX THERAPY

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Fourth Edition

Edited by
SANDRA R. LEIBLUM

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An internationally recognized authority in sex therapy, Dr. Leiblum has received numerous awards for her professional contributions, including the Masters and Johnson Award from the Society for Sex Therapy and Research and the Professional Standard of Excellence Award from the American Association of Sexuality Educators, Counselors, and Therapists. She is the author or editor of over 125 journal articles, chapters, and books on various aspects of male and female sexuality, and is widely recognized for her teaching and clinical activities.

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Preface

It is nearly three decades since the publication of the first edition of *Principles and Practice of Sex Therapy* (1980). Much has changed since then, but much remains the same.

In 1980 there was both excitement and enthusiasm about time-limited, problem-focused learning approaches to overcoming sexual dysfunction. This was the method advocated by Masters and Johnson in their groundbreaking volume *Human Sexual Inadequacy* (1970). The promise of a rapid resolution to long-standing sexual problems was alluring. Sex counseling came to be practiced by a wide variety of health providers, including professionals, clergy, educators, social workers, and clinical psychologists. Expectations for treatment outcome were high, since almost all sexual problems were believed to stem from faulty learning, sex-negative family histories, guilt, and anxiety. The tools available for intervention were modest, but seemingly quite effective—behavioral therapy, sensate focus, imagery and paradoxical intention, the challenging of erroneous cognitive beliefs, the teaching of effective communication and enhancement of social skills, couple therapy, and masturbation training. And, in fact, in the initial period following the publication of *Human Sexual Inadequacy,* treatment outcome was impressive, particularly with the most common presenting complaints of the time, lack of orgasm in women and early ejaculation in men.

Already, though, even by 1980, when *Principles and Practice of Sex Therapy* was first published, it was becoming apparent that the high expectations for success needed to be tempered. As we wrote back then, "We realize that short-term approaches work well for some patients, with

some problems, and only some of the time." That realization prompted the writing of our book. We knew there was a significant disparity between theory and practice, that some problems were more modifiable than others, that some interventions might work well for some patients, but the same intervention with a different client or couple would have little impact. We wanted to explore the factors that contributed to treatment success or failure through the medium of in-depth case studies. By inviting the most prominent experts practicing in the field to contribute chapters highlighting their particular areas of expertise and favored theoretical approaches, including clinical illustrations, we believed it would be possible to identify both the best treatment approach for a particular problem and the psychological and interpersonal factors contributing to treatment success or failure.

Now, nearly 30 years later, we are somewhat more sophisticated in our understanding of sexual difficulties. We have a far greater appreciation of the role of biological and hormonal factors in the genesis and maintenance of sexual problems. We have a new respect for the contribution that drugs and hormones can make in both causing and ameliorating sexual complaints. We are grateful for the availability of safe and effective oral medications to treat erectile dysfunction. But we realize, too, that even with our considerably more advanced understanding of the anatomy and physiology of sexual response, our appreciation of the role of neurotransmitters and sexual pharmacology, and our investigations of brain functioning during sexual arousal, we must still rely on our clinical and psychological skills and sophistication in order to be effective. Above all, we must appreciate the psychological and relationship realities of our patients' lives and their complicated, often ambivalent, feelings about sex.

This fourth edition of *Principles and Practice of Sex Therapy* brings together the most current, evidence-based, clinically sophisticated, integrated and interdisciplinary approaches to the assessment and resolution of sexual complaints. Every chapter is written by a nationally or internationally recognized expert in sex therapy, one who is cognizant of both the research and practice in this fascinating field. Chapters focusing on heretofore neglected areas are included—such as cultural and ethnic contributions to sexual function and dysfunction, the treatment of men and women who have experienced sexual coercion, and persistent genital arousal in women—as well as a new and comprehensive overview of treating sexual problems associated with chronic medical illness. In recognition of the challenge and complexity of desire problems and the differing presentations by women and men, we have invited two experts to contribute chapters on sexual interest and desire disorders. We believe this volume will prove to be a useful and trusted guide to the principles and practice of sex therapy as it is practiced in the 21st century.

I am indebted to the enormous contributions of scores of exceptional therapists and colleagues who have provided inspiration and feedback over

several decades. In particular, I must acknowledge my appreciation and affection for Raymond C. Rosen, with whom I have talked, taught, learned, argued, and written for more than 30 years. As coeditor with me of the last two editions of *Principles and Practice of Sex Therapy,* his stamp on this book is indelible. He is indeed a giant in our field.

The truth is that there are many outstanding clinicians and physicians currently practicing in the field of sex therapy and sexual medicine. Some deserve special recognition for having influenced my thinking and my therapy: Bernard Apfelbaum, John Bancroft, Lonnie Barbach, Rosemary Basson, Eli Coleman, Judith Daniluk, Lorraine Dennerstein, Marion Dunn, David Goldmeier, Irwin Goldstein, Julia Heiman, Marty Klein, Jean Koehler, Arnold Lazarus, Stephen Levine, Joseph LoPiccolo, Marita McCabe, Barry McCarthy, Michael Metz, Michael Perelman, Derek Polonsky, Candace Risen, Bonnie Saks, David Schnarch, Pepper Schwartz, Leslie Schover, Patricia Shreiner-Engel, William Stayton, Kevan Wylie, Beverly Whipple, and, of course, the deeply missed Bernie Zilbergeld.

As well, I could not have edited this book without the help of three very special individuals: my much-loved husband, Frank Brickle; my secretary, Susan Connolly; and my research assistant and treasured helper, Rachael Fite. Finally, I must acknowledge my most heartfelt and warmest thanks to Seymour Weingarten, Editor-in-Chief of The Guilford Press, who helped launch me at the same time that he was first launching Guilford in 1978. He has stood by me for nearly 30 years, and I am grateful for his encouragement and friendship.

Contents

PART III. MALE SEXUAL DISORDERS

PART IV. SPECIAL ISSUES

PART I

INTRODUCTION

CHAPTER 1

Sex Therapy Today

Current Issues and Future Perspectives

SANDRA R. LEIBLUM

Over the past half century interest in sexual medicine generally and sex therapy in particular has truly flourished. Sexual problems are no longer regarded as symptoms of hidden psychological defects in maturity or development. Rather they are understood as perennial themes in the human drama. In the 19th century the focus was on sexual behaviors that were considered deviant or pathological. In the last century the focus was on destigmatizing and demystifying sexuality with surveys and laboratory research. In the present century the focus is more on fully understanding normative sexual function—what most people do and experience as they grow older and live longer. We want to understand such things as the physical and psychological factors contributing to changes in sexual interest and response in different contextual and interpersonal circumstances; the sexual concomitants of acute or chronic illness; the possibilities and development of new medications to enhance and/or improve sexual function, and the long-term sexual side effects of existing medications; and, critically, the challenge of maintaining sexual desire and a satisfying sexual life over the course of a long life and long relationship.

In some respects, there has never been a better time to be or to become a sex therapist. We live in an aging population, among increasingly lively

older adults who believe that an active sexual life offers great pleasure but also contributes materially to overall emotional and physical health. There is real interest in ameliorating sexual problems and enhancing sexual satisfaction. This reflects the current high sexual expectations of individuals of all ages and stages of life, and the expectations have never been greater. Most aging men and postmenopausal women want to enjoy active sexual lives every bit as much as young singles or couples. Survivors of all sorts of trauma, whether surgical, neurological, domestic, or sexual, want to recapture or experience sexual satisfaction, where in the past they might have written off this part of their lives. Not a day goes by without some publicity about sexuality—a new film or book highlighting relations between the sexes, or advertisements promoting new medications and the promise of relief from sexual problems or restoration of sexual function. A huge selection of sex toys and gadgets, lubricants, and condoms of every variety and description is now easily available over the Internet. Most clinicians would agree that the current *cultural* climate encourages an active interest in sex, even if the *societal* and *political* trends (at least in the United States) would imply the circumscription or suppression of sexual freedom. Despite ambivalence or even active attempts among religious fundamentalists or social conservatives to suppress sexual education and sexual freedom, the majority of women and men hope and expect to enjoy their sexuality, and they are often willing to seek treatment when things go awry. The practice of sex therapy is thriving as is the importance of sexual medicine.

At the same time, however, there continue to be many controversial or unresolved issues in the theory and practice of sex therapy. We mention but a few: What constitutes a sexual disorder? Which sexual complaints are legitimate disease states, warranting primarily "medical" interventions as opposed to quality-of-life issues? How important is the degree or existence of personal distress as a diagnostic consideration? What treatments are the most effective? Drug therapies? Relationship or sexual counseling? Which treatments work best for which problems? What are the upsides and downsides of medical versus psychological versus combined treatments? Cost? Outcome? Side effects? Must partners be included in treatment in order to achieve successful or long-lasting therapeutic outcomes? Indeed, what are reasonable expectations for any treatment? Who determines treatment success: the clinician or the patient? How do we evaluate treatment success? Greater sexual frequency? Increased feelings of satisfaction? Intimacy? Pleasure? How should these outcomes be assessed? With diaries? With self-report questionnaires? With clinician/physician ratings? These and other questions are critical to both research and clinical practice in the field of sexual medicine.

This *completely revised fourth edition* of *Principles and Practice of Sex Therapy* addresses some of these issues and controversies. It includes the most timely and comprehensive approaches to the diagnosis, assess-

ment, and treatment of the major sexual complaints and concerns of men, women, and couples. What is unique about this volume is the inclusion of a truly *international and interdisciplinary* group of authors. There is a balance between male and female contributors as well as physicians and clinicians. We highlight biopsychosocial treatment—in other words, we emphasize the interaction among psychological, biological, and interpersonal factors in problem etiology and treatment. Each chapter is written by a prominent authority in the field and is illustrated by one or more actual case examples. We believe that you will find the collection of chapters that follow to be an accurate, enlightening, and provocative reflection of the current practice and principles of sex therapy.

A PARADIGM SHIFT: MALE SEXUALITY AND FEMALE SEXUALITY ARE DIFFERENT!

Perhaps one of the most important changes in the conceptual and theoretical approaches to sex therapy in the recent past is the increasing recognition that male sexuality and female sexuality are actually quite different. Sexual desire in men and women tends to be piqued by different stimuli, maintained by different motivations, and, often, valued for different reasons (Hill & Preston, 1996; Leigh, 1989). It is well known that women tend to masturbate at a later age and with less frequency than men (Oliver & Hyde, 1993), to desire less sexual variety (Schmitt, 2003), and to report a greater number of sexual complaints and concerns (Laumann, Michael, & Gagnon, 1994). Their reasons for initiating a first consultation differ as well. Men are typically motivated to seek treatment for *problems with sexual performance*, such as an inability to obtain or maintain an erection or to delay ejaculation. In contrast, women often enter treatment expressing *concerns about sexual feelings*, such as an absence of sexual interest or sexual pleasure. While there is a veritable pharmacopoeia of drugs for male performance problems, there are none for women's sexual complaints. These observations may come as no surprise, but they signify an important shift from the theoretical foundations on which sex therapy originally rested.

Historically, Masters and Johnson's pioneering work in human sexual response (1966) provided the impetus for much of what followed in terms of early theorizing about sexual problems and their treatment (Leiblum & Pervin, 1980). Masters and Johnson maintained that male and female sexual responses were essentially analogous. They argued that similar physiological changes occurred in both men and women during each of the four phases of the sexual response cycle (excitement, arousal, plateau, and resolution). For instance, erection in the male and lubrication in the female were viewed as parallel ways of expressing sexual arousal, whether to in-

ternal (fantasy) or external (tactile) stimulation. Male ejaculation corresponded to female orgasm. In both genders, sexual problems were ascribed largely to anxiety, specifically performance anxiety. Masters and Johnson (1970) believed that removing the anxiety would result in the "natural" unfolding of satisfactory sexual response.

Now, nearly four decades later, we know that sexual interest, motivation, arousal, and pleasure are triggered and experienced quite differently by men and women. While there are diverse motivations for being sexually interested and willing (Hill & Preston, 1996; Regan & Berscheid, 1996), more of women's *conscious* sexual motivation appears to be related to a wish for emotional connection (or the avoidance of negative consequences) than by pressing internal feelings of genital tension, or by sexual thoughts or fantasies. This appears to be especially true for older women or women in long-standing relationships (Basson, 2002). On the other hand, sexual desire appears to be more readily and more reliably accessed in men than in women. For men, sexual craving or desire is usually palpable and there is often a direct association between the sight or experience of erection and a report of subjective arousal. This is not true of women, where there is a notable lack of congruence between subjective arousal and genital vasocongestion (Chivers & Bailey, 2005). As Basson describes in Chapter 2 on sexual desire and arousal disorders in women, the sexual response cycle of women tends to be circular and interactive, with arousal and desire triggering and being triggered by each other. For many women, in fact, sexual arousal precedes conscious feelings of sexual desire whereas for most men, sexual desire precedes arousal. In fact, without sexual desire, most men find it difficult to achieve or maintain an erection.

Recent research suggests that there are even more intriguing differences in the arousal responses of men and women. Although it has been understood for some time that there is poor correlation between women's genital and subjective arousal (Laan & Everaerd, 1995), it has only recently been demonstrated that women's genital response seems to be less specific than men's (Chivers, Rieger, Latty, & Bailey, 2004; Chivers, 2005). For instance, genital arousal in women does not necessarily reflect their *stated sexual interests* in the same way that it does for men. In studies in which women were shown films featuring both their preferred and nonpreferred sexual partners (e.g., female–female, female–male, and male–male), women reacted with some genital arousal to all three films. Heterosexual men only became aroused when shown films involving their *preferred sexual partners* (Chivers, 2005; Chivers, et al., 2004). The implication is that women's genital arousal is more *nonspecific* than men's arousal. In one study, women displayed genital vasocongestion (measured psychophysiologically) to nonhuman stimuli (the sound of female and male bonobos engaging in penile–vaginal activity) whereas the male subjects did not. Significantly, women did not report subjective arousal to the film se-

quences showing the animals whereas the men's report of subjective arousal mirrored their genital response.

Chivers (2005) believes that women's rapid and relatively nonspecific vasocongestive response to both preferred and nonpreferred stimuli is adaptive from an evolutionary point of view. Historically (and even currently) women are vulnerable to rape and other forms of coercive sexuality. Chivers suggests that a rapid vasocongestive response that results in both lubrication and engorgement of sensitive genital tissue protects women's genital organs from ripping or tearing with penetration and prevents long-term damage. While this is very speculative, it is intriguing to consider that women's sexuality has evolved in an adaptive fashion: that cultural constraints, social expectations, and interpersonal dissatisfactions—not biological, hormonal, or anatomical deficits—are the major factors accounting for the high incidence of women's sexual problems, as compared to those in men.

These new research findings highlight both the nonspecificity of female sexual arousal and the fact that little can be inferred about a woman's sexual preference based on genital response alone. The findings also provide support for Baumeister's (2001) assertion that women's sexuality is more plastic and flexible than men's, in that women can be both turned on (and turned off!) more readily than men. So while Masters and Johnson in 1966 emphasized the similarities between the sexes in terms of sexual physiology, Chivers and Bailey (2005) have highlighted the differences in male and female sexual arousal propensities and patterns.

INTEGRATIVE TREATMENT

Another major trend in sex therapy has been increasing recognition of the importance of an integrated approach to the treatment of sexual disorders and complaints. Sex therapists have always made token acknowledgment of the importance of a biopsychosocial approach to treatment. However, with the advent of oral medications for erectile dysfunction, it has become increasingly apparent that treating the genitals alone is unlikely to lead to long-term success. The relationship must be treated along with the individual. In the third edition of *Principles and Practice of Sex Therapy*, we discussed the watershed event that introduced the era of sexual pharmacology: the approval of sildenafil citrate (Viagra) in 1998 as the first orally active agent for the treatment of erectile dysfunction. There was concern in the years that followed that sex therapy was doomed, that pharmacotherapy would prevail for the remediation of both male and female sexual problems.

These predictions and forecasts have proved thoroughly unfounded. In fact, there is increasing recognition that sex therapy must be a truly inte-

grative specialty with attention paid to *all* of the contributors—psychological, biological, pharmacological, relational, and contextual—to sexual problems.

The Role of Assessment

Comprehensive assessment of both the patient and his or her partner is regrettably given short shrift in most medical practices. Nevertheless it is a critical component of sex therapy. To formulate a case effectively and plan its treatment it is necessary to interview the couple both together and individually. Unfortunately this does not always happen in actual practice. Physicians often fail to interview partners, citing too little time or reimbursement for conducting such assessments. Regardless, most of the contributors to this volume would agree that sex therapy is fundamentally *couple therapy*—without including the partner, crucial information is lost and therapeutic outcome is compromised.

The Role of Physical Examination and Laboratory Assessment in Sex Therapy

The current practice of sex therapy assigns an important place to physical examination and laboratory assessment. By general consensus it is mandatory for some complaints (e.g., sexual pain disorders—see Binik, Bergeron, & Khalifé, Chapter 5, on dyspareunia and vaginismus; Rosenbaum, Chapter 6, on physical therapy and treatment of sexual pain disorders; and Rosen, Chapter 10, on erectile disorders). It can be an important and useful adjunct for almost all sexual difficulties (Lue et al., 2004; Basson et al., 2004). For example, atrophic genitalia in the woman may be an indication of estrogen deficiency or connective tissue disorder. Similarly, erectile dysfunction in men may be the first sign of vascular disease or an indication of coexisting diabetes or LUTS (lower urinary tract symptoms) (Montorsi et al., 2003). Important information is often communicated involuntarily via the body in terms of physical tension or emotional response to genital examination. A comprehensive physical examination can be reassuring to the patient and illuminating for the physician.

When there is a question of neurological disorder, a pertinent genital exam may be indicated. The response to light touch, pain, pressure, heat or cold, as well as anal and vaginal tone and bulbocavernosal reflexes can provide important diagnostic information (Basson et al., 2004). However, for some sexual complaints, particularly those involving situational but not generalized problems, physical examination may be less important, although perhaps still helpful and even reassuring to a client.

Similar considerations apply to hormonal treatment. While the relationship between gonadal hormones and sexual function is the subject of

ongoing research, some facts are clear. Testosterone is an important ingredient in the hormonal brew that facilitates sexual desire and arousal, but it is by no means the most important ingredient. In fact, several recent research studies have failed to find a significant correlation between circulating androgen levels and self-reported sexual function in women (Davis, Davison, Donath, & Bell, 2005; Dennerstein, Lehert, & Burger, 2005). In their community-based study of 1,021 Australian women between the ages of 18 and 75, Davis et al. (2005) reported an absence of any significant relationship between scores on a sexuality questionnaire and low serum total, or free testosterone or androstenedione levels. Sexual desire is often suppressed in women who have had bilateral oophorectomies, premature ovarian failure, or pituitary or adrenal disease. There are many women with these conditions who do not report compromised sexual interest or function, however. Dennerstein and her colleagues (2005) have shown that partner relationship issues are far more important than levels of circulating hormones in predicting sexual desire and satisfaction in postmenopausal women.

Estrogen levels affect vaginal lubrication and elasticity. Estrogen depletion is often associated with complaints of sexual discomfort or frank pain (Bachmann & Leiblum, 2004). Estrogen replacement after menopause can improve sexual and emotional well-being. It may also enhance sleep quality and skin sensitivity (Bachmann & Leiblum, 2004). Supplemental testosterone in women who have undergone surgical menopause can be helpful in increasing sexual desire and arousal (Braunstein et al., 2005; Simon et al., 2005). Some authors believe that the benefit of androgen administration is related to increased estrogen availability to estrogen receptors, where testosterone is converted to estradiol within brain cells, and testosterone administration may lower levels of sex hormone-binding globulin (SHBG) (Basson, Brotto, Laan, Redmond, & Utian, 2005). Despite the fact that hormones do affect sexual and general physical well-being, there is little agreement concerning the necessity of routine laboratory assessment of gonadal hormones.

The role of hormones in either etiology or treatment will be a recurring theme in almost all the chapters to follow.

SEXUAL DIAGNOSIS: UPDATES AND CONTROVERSIES

Diagnosis has changed a lot since the first publication of *Principles and Practice of Sex Therapy* in 1980. Historically the nomenclature of common male and female disorders tended to be value-laden or pejorative (impotence, inhibited female orgasm, nymphomania, etc.). More recently there have been major efforts to update and revise sexual terminology and descriptions of dysfunctions (Leiblum, 2005a).

At present DSM-IV-TR is one of the ubiquitous tools for the diagnosis of both male and female sexual disorders. There has been dissatisfaction with its coverage of this topic for decades (Leiblum, 2005a), however. Our last edition recounted how the first consensus conference to review and revisit the diagnosis of female sexual disorders was held in 1998. While certain improvements were made in the description of each female disorder, the basic theory underlying the revisions remained based on the traditional Masters and Johnson (1966) model of sexual response. Many clinicians felt that the revisions did not go far enough. In fact an entire issue of the *Journal of Sex and Marital Therapy* (2001) was devoted to rebuttals and commentaries.

In 2003 a second consensus conference was convened in order to reconsider the diagnosis of women's sexual disorders. As with the first consensus conference, an international and interdisciplinary group of clinical and research experts in female sexuality was recruited to review the empirical and published literature and to suggest revisions. The recommendations from the 2003 consensus conference were published the following year (Basson et al., 2003). By far, the biggest change was in the greater specificity evident in the diagnosis of female sexual arousal disorders. Whereas DSM-IV-TR lists only a single term for female sexual arousal disorder, the new recommended nomenclature suggests that there are four distinct variants of arousal difficulties in women: those that are primarily physical; those that are primarily subjective; combined physical and subjective arousal disorder; and a newly defined arousal problem, that of persistent genital arousal in the absence of sexual desire (Leiblum, 2001; Leiblum & Nathan, 2002). Basson discusses the rationale and basis for these modifications in Chapter 2, this volume, on desire and arousal disorders. Leiblum focuses on the intriguing but mystifying problem of persistent genital arousal in Chapter 3.

Although neither set of recommendations has been formally endorsed by any "official" group at this time, they do reveal the need for greater sophistication and respect for complexity in assessing the medical, psychological, interpersonal, and contextual contributions to women's (and, by extension, to men's) sexual complaints.

The diagnosis of male sexual disorders has not been formally reassessed, but the likelihood is that it too needs revision. Most prominently, the diagnosis of premature ejaculation has undergone reevaluation as new pharmacological treatments are being investigated. In Chapter 8, Althof raises many pertinent questions about ejaculatory complaints and their diagnosis. What criteria should be used to define rapid or premature ejaculation? Number of minutes of intravaginal stimulation? Number of thrusts before ejaculation? He asks whether rapid ejaculation constitutes a bona fide problem for a man, or for his partner. There is certainly an absence of consensus on what constitutes "normal" ejaculatory latency (Montorsi, 2005).

Of some interest is the finding of considerable variability across countries as to what constitutes rapid ejaculation. For example, in one study, the perceived average latency in German men was 7 minutes while it was over 13 minutes in the United States. (For completeness, we should mention that the perceived averages for men in the Britain, France, and Italy were similar, at around 9.6 minutes [Montorsi, 2005]). Althof reviews many of the current issues concerning the diagnosis of rapid ejaculation and presents the latest recommendations for treating this most prevalent of male sexual concerns.

Another source of current controversy is the question of whether sexual problems should be considered "disease states" or even dysfunctions at all. Perhaps they should be thought of as normal variations in human sexual response and interest. For example, just a few years ago, Moynihan, Health, Henry, and Gotzsche (2002), in an article written for the *British Medical Journal*, asserted that hypoactive sexual desire disorder was a manufactured "disease" promulgated by pharmaceutical companies to create new disorders in order to justify the use of medications to treat them. This article sparked media controversy and letters to the editor, with physicians, patients, and sex therapists supporting or refuting these allegations (Basson & Leiblum, 2003). A full discussion of that controversy is beyond the scope of this chapter, and I confine myself here to the observation that there is some cynicism or dissatisfaction with current sexual classification and nomenclature.

The case studies presented in this volume attest to the fact that sexual problems, however diagnosed (or by whom), do cause or contribute to personal and relationship distress, dissatisfaction, and even, in some cases, despair. Whether the distress associated with sexual problems is related to the individual's own concern about sexual competency, or whether it is related to the impact sexual difficulties have (or will have) on relationships, it is undeniably the case that sexual problems deserve recognition as a significant impediment to overall health and well-being.

TREATMENT ISSUES: WHAT IS UNIQUE ABOUT SEX THERAPY?

While there have been significant advances in the pharmacological and medical treatment of sexual disorders since the publication of the last edition, the actual interventions that "uniquely" characterize sex therapy have not changed substantially in the last decade. Most therapists practice some admixture of cognitive-behavioral and systemic interventions including (but not limited to) sexual education, sexual permission, communication training, assertiveness practice, couple counseling, nondemand pleasuring, physical awareness and sensuality exercises, exploration of past traumatic or negative events that may be contributing to, or maintaining, current sex-

ual problems, and treatment of concomitant psychiatric conditions such as depression or anxiety disorders (Leiblum & Wiegel, 2002). What is more significant, and highlighted in this volume, is the creative and flexible way sex therapy interventions are integrated into individual or couple therapy, when and how they are introduced, the facility with which resistances and anxieties about sexual exploration and experimentation are overcome, and the skill with which particular interventions are used to enhance couple communication, cooperation, and emotional intimacy. The practice of sex therapy requires familiarity with a variety of psychological and pharmacological approaches and reflects the varieties and subtleties of the sexual problems seen today.

PHARMACOLOGICAL INNOVATIONS AND TREATMENTS

In the last several decades, the treatment of male sexual problems has undergone revolutionary changes. Whereas formerly male erectile disorders were greeted with dismay and treated with variable success by psychotherapists, nowadays the use of oral medications, such as the three major PDE5 inhibitors (sildenafil, tadalafil, and vardenafil), represent first-line interventions for many men who go to their family physicians or urologists. These patients request their drugs by name. Sometimes they order them via the Internet without much difficulty. On a regular basis, a host of new medications for the relief of erection problems become available in nasal sprays, gels, or injections. As Rosen indicates in Chapter 10, these drugs are largely efficacious and safe, particularly when there are no coexisting relationship or psychological problems.

There are some pharmacological interventions for treating rapid ejaculation, but currently there is no medication designed specifically for the delay of ejaculation that is approved by the U.S. Food and Drug Administration (FDA). Rather, as Althof (Chapter 8), Ashton (Chapter 17), and Stevenson and Elliott (Chapter 11) note, selective serotonin reuptake inhibitors (SSRIs) are often prescribed as off-label treatments.

It is rare that any medication completely resolves sexual problems as a "stand-alone" intervention (Leiblum, 2002). In fact, without concomitant psychological treatment, the dropout rate for pharmacotherapy generally, and erection problems in particular, is quite high, perhaps as great as 40–80% (Brock et al., 2002). Failure to assess or treat the patient's sexual desire, self-esteem, relationship dissatisfaction, or erroneous expectations contributes materially to disuse and treatment failure, as does a neglect of follow-up and counseling. The otherwise tangible physiological benefits of drug therapy are often undermined by high anxiety, inadequate stimulation, psychological inhibitions, or simple anger.

Virag (2005), a physician himself, is critical of how many physicians

oversimplify the treatment of erectile dysfunction. He stresses the importance of multidisciplinary assessment and treatment, noting that oral medications will not work if there is excessive anxiety, inadequate sexual stimulation, a too-low testosterone level, or excessive venous outflow. Moreover when medication treatment for erectile failure does not work, men typically experience increases in performance anxiety and despondency about their sexual adequacy. As Rosen (Chapter 10) emphasizes, integrated and multidisciplinary treatment is essential. The advent of oral medication only increases the need for effective sexual counseling of the man and his partner.

While many patients ask for pills as a "quick fix" for their sexual difficulties, others are less receptive to pharmacological treatment. In Chapter 17, Ashton discusses the conditions that limit the appeal of such treatment. If a couple engages in sex infrequently, they are reluctant to take a drug on a daily basis, especially one that has significant side effects. Many patients these days express concern about the negative consequences of long-term medication use. Recent media reports link a rare kind of blindness, retinitis pigmentosa, or nonarteritic ischemic neuropathy (NAION), with sildenafil. This has fueled anxiety about reliance on any "sex" drug. Similarly, many patients do not like the idea of taking medications that have been or are prescribed for psychiatric conditions like depression or anxiety. This is why bupropion (Wellbutrin), an antidepressant, was rechristened Zyban when it was newly targeted for the treatment of nicotine addiction. Fluoxetine (Prozac), another antidepressant, was rechristened Sarafem when prescribed for the treatment of premenstrual disorder. Most men and women want to feel that they, rather than their medication, are responsible for their sexual behavior and performance. Relying on a drug challenges feelings of self-efficacy. On the other hand, this may not be an issue for others who are indifferent to exploring psychological or interpersonal issues. Once again, it is important to match treatments and patients.

There is a relative scarcity of drugs available for the treatment of sexual problems in women, compared with men—at the present time there is not a single U.S. FDA–approved medication. Although initially there were high hopes that sildenafil citrate would do for women what it had for men, controlled clinical trials proved disappointing (Basson, McInnes, Smith, Hodgson, & Koppiker, 2002). Similarly, although testosterone in various delivery forms seem to be helpful for some percentage of women with hypoactive sexual desire disorder after oophorectomy (Simon et al., 2005; Braunstein et al., 2005), the U.S. FDA has rejected all applications that have been presented for review. What is perhaps most interesting and telling is the controversy surrounding even the search for a "female Viagra." Feminists and others have been vocal and vociferous opponents of all attempts to "medicalize" female sexuality or to suggest that medications may be helpful adjuncts to the treatment of women's sexual problems (Tiefer, 2000).

To highlight some of the issues surrounding the controversy concerning the search for, or use of, drugs for enhancing or ameliorating women's sexual problems, I recently published the following editorial (Leiblum, 2005b): "Pharmacotherapy for Women: Will We, Won't We, Should We?"

> Suppose somebody offered you a bag of Magic Beans that promised to solve all sexual problems. Would you believe it? Would you trade your best cow for them? Would you eat the beans? Or, perhaps most importantly, do you believe enough in Magic Beans to go searching for them yourself?
>
> Despite the best scientific and marketing efforts by Proctor and Gamble, their moderately magical bean—a testosterone patch for oophorectomized women with hypoactive sexual desire disorder (HSDD)—was recently rejected by the U.S. Food and Drug Administration. The demurral was ostensibly based on concerns about safety and efficacy alone. But we would submit that, perhaps, the outcome arose in part from a disbelief in magic beans, or an unwillingness to make them available to women. This is odd, since men are so well supplied with magic beans these days.
>
> Obviously we're talking about the possibility of pharmacotherapy for women's sexuality, whether for treatment of sexual dysfunction or enhancement of sexual pleasure. There appears to be a considerable degree of ambivalence, overt and covert, conscious and unconscious, and even hostility towards those advocating research and development of such medications.
>
> It's important to remember that there have always been aids, supplements, nostrums, spells, and formulas intended to enhance the sexual appetites and satisfaction of women and men both. Is there something particularly objectionable about creating medications whose chemical properties will be precisely known, to be marketed and marked up (for a profit)? Obviously there is a problem here, for purists, moralists, some feminists, social conservatives, and potentially countless others. As sex therapists, though, what do we think, even assuming there are or could be magic beans?
>
> Whether we view HSDD—or indeed any unwanted change in a woman's typical sexual response—as a complaint, a dysfunction, an adaptation to circumstances, or a transient phase of life, as sex therapists we know how hard it is to stoke up sexual interest when it has vanished or was never there. Some might argue, so what? Lack of sexual interest isn't life threatening. How then does it qualify as a medical condition?
>
> Perhaps the problem is that, regardless, it may be treatable by medical means. The purist will complain that the lack of symmetry—no medical condition, so no medical intervention—disqualifies women's sexual response issues from such pharmacological relief as might eventually be available. This point of view raises two objections. First, why should HSDD be any different from, say, headaches? In both cases the etiology can be either obscure or complex: they both can be attributed to an admixture of psychological and physiological components. We don't path-

ologize headaches, however. We merely take the aspirin and get on with it. How is HSDD different, exactly?

The answer, and our second objection to the purists' slant, is that women's sexual problems are overwhelmingly dyadic. They occur in a particular context with a particular partner. The idea of treating the woman alone carries the implication that she is the problem: it is her pathology, not that of the relationship. As clinicians we know unequivocally that this is not the case. So how could we, as clinicians, be behind magic beans?

Above all we're pragmatists. We know that a single magic bean is not going to solve the entire problem. You need a whole bag. We admit we're willing to exploit whatever will help us help the relationship. Just as we would not hesitate to prescribe antidepressants for one partner alone, we would not hesitate to prescribe testosterone if one partner might benefit from it. Obviously, there are safety concerns about the long-term use of any pharmaceutical or hormonal intervention. But this concern speaks to a need for more research in this area, rather than less.

The larger concern in this discourse is the fear that our field is in danger of being co-opted by "big pharma" and commercial interests. We agree that this is a genuine and realistic concern. However, to simply express righteous indignation seems to us to be of limited utility. Rather, if the needed research is to occur, we must work with, rather than in isolation from or opposition to, the pharmacological industry. Obviously, as sex therapists, we cannot command the resources to engage in crucial research. And it is clear that, regarding the pharmaceutical companies, they need us as much as we need them—whether it be to educate them about the complexity of sexual dissatisfaction or disorders, to design the most meaningful outcome studies or to interpret the resulting data.

In summary, we find no advantage in taking a principled stand against pharmacological research and treatment for women's sexual complaints. We are simply in the process of working out a necessary modus vivendi among all of the players—patients, clinicians, researchers, pharmaceutical companies. At this stage it is counterproductive to raise objections based on hypothetical problems. The fact is, we need the whole bag of magic beans. That said, at this moment, we are not sure that any magic bean at all will be forthcoming any time soon.[1]

Finally, we should make note in passing of the ever-increasing array of over-the-counter preparations that are currently available via the Internet and in drugstores promising relief of every conceivable sexual complaint. Typically these products contain a variety of ingredients such as l-arginine, menthol, glycerine, aloe vera, ginkgo biloba, peppermint leaf, niacina, and other botanicals or herbs. Some induce warmth; others induce tingling. Despite their stated claims, few have been subjected to randomized con-

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trolled clinical trials and almost none have been compared to placebo (Rowland & Tai, 2003). This is not to say that they are ineffective since many may be beneficial in enhancing general physical health. The problem is that they are advertised as promoting overall sexual enhancement and health. The data are lacking to support such promises. The claims for their efficacy are usually anecdotal, glowing but nonspecific, unsupported by evidence. Perhaps in the future we will see better-controlled studies of the prosexual effects of over-the-counter preparations, especially as U.S. FDA approval becomes more difficult to obtain. Western Europe and South America show more enthusiasm for herbal or "natural" remedies. Regrettably the broadly aggressive marketing of over-the-counter remedies can obscure the genuine contributions of FDA-approved medications.

OUTCOME

Inevitably the question arises as to the efficacy of sex therapy. The many case studies in this volume illustrate how treatment outcome is quite variable. Success is sometimes dramatic and the individual or couple completes treatment with all of their problems resolved: arousal increases, erections return, ejaculatory control is achieved, sexual pleasure and spontaneity become possible or even experienced for the first time. More often, though, outcome is ambivalent. Some but not all of the initial goals for therapy are realized. As Maurice indicates in Chapter 7 on desire disorders in men, therapy can be arduous and treatment expectations need to be modest.

We are still left with the issue of characterizing what counts as successful outcome in sex therapy. Several authors address this question in their chapters. Hartmann and Waldinger (Chapter 9) offer a complicated case in which the presenting problem, delayed ejaculation (DE), obscures the long-standing sexual and psychological issues of both partners. Basson and Heiman, in Chapters 2 and 4, illustrate how women's arousal and orgasmic problems may or may not be overcome when they coexist with complicated relationship or contextual issues. Treatment can be lengthy. It certainly may challenge the stereotype of sex therapy as a brief intervention. In Chapter 12 on the aftermath of sexual abuse, Hall discusses the fact that some patients leave treatment long before any significant benefit has been achieved. So then: imperfect as it is, what constitutes successful outcome in sex therapy? Is it the restoration of sexual desire and response to some earlier level of interest or performance? Can a 50-year-old man realistically experience the erections of a 20-year-old? Is this even a reasonable or desirable goal? Should treatment outcome be assessed in terms of objective performance criteria, such as the achievement of coital orgasms in 75% of sexual encounters? Should success in sex therapy be a predetermined score on a standardized assessment instrument? Do qualitative assessments of improvement and satisfaction count as much as quantitative

outcomes? Should patient reports of increased comfort and pleasure rather than changes in sexual frequency, number of orgasms, or rigid erections be considered the most salient indices of treatment success?

Metz and McCarthy (2004) have suggested that treatment should involve the realization of "good-enough sex," that is, sex that realistically acknowledges that performance is variable and is vulnerable to the vagaries of both one's own and one's partner's current emotional and physical state. These authors suggest that good-enough sex is playful rather than perfect and that sexuality is an integral part of one's daily life. They emphasize that treatment must be individualized to suit the particular client—that there is no "one size fits all" treatment. Few would argue to the contrary, and this is a constant, indeed fundamental, theme throughout this book.

It can be argued that the most important goal of sex therapy is *helping our patients achieve a more satisfying relationship and quality of life using the most effective and least costly means rather than any predetermined set of objective sexual criteria.*

From a practical point of view the evaluation of success in sex therapy is quite different from success in clinical trials. In sex therapy we are not so concerned about the frequency of sexual contact or about changes in ejaculatory latency or coital orgasms. What concerns us is our client's report of enhanced sexual confidence, pleasure, or intimacy. Numerical scores on questionnaire instruments often fail to capture a client's phenomenological experience or personal but unspoken hopes for treatment. Sometimes ending or leaving a destructive relationship signifies personal growth and treatment success. Research demands more stringent and quantitative evaluation of treatment outcome. Even here, though, there is controversy as to what constitutes meaningful outcome data (Althof et al., 2005).

The case discussions that follow clearly illustrate the variability of outcome. In some instances the individual or couple concludes therapy with complete restoration of sexual function and renewed emotional intimacy. In other cases, the achievements are firmer erections, more reliable orgasms, or pain-free sex, but they are accompanied by only a modest improvement in relationship satisfaction. The factors contributing to treatment outcome are discussed in each chapter. What will be evident to the reader is that sex therapy is not a "cookbook" exercise of interventions for each specific disorder. Instead it represents a unique alchemy of patient, couple, and therapist, influenced by "chance events," client motivation, contextual components, and favorable timing. In short, it's important to be lucky as well as good.

CULTURAL FACTORS, ALTERNATIVE LIFESTYLES

While nearly all of the case examples presented in this volume feature middle-class heterosexual Caucasian clients, sex therapists are seeing an increasing

number of clients who come from varied ethnic, cultural, and socioeconomic backgrounds, or who see themselves as belonging to some sexual minority. Thirty years ago sex therapy was the province of the so-called YAVIS patient (young, attractive, verbal, intelligent, and socioeconomically privileged). Nowadays clinicians are more likely to see older, culturally diverse individuals with varying levels of income, education, or health.

In Chapter 13, Nichols and Shernoff describe what they term "queering practice," that is, sex therapy with "LGBTQ"—gay, lesbian, bisexual, transgendered, or "queer"—individuals. They use the term "queer" to describe people who embrace multiple sexual orientations or identities, or lifestyles like polyamory. Nichols and Shernoff urge therapists to appreciate, rather than pathologize, individuals who practice diverse forms of sexual expression and who differ from therapists themselves in terms of sexual values and behaviors. Similarly, in Chapter 16, Carroll describes the unique challenge of treating individuals presenting with gender orientation concerns or blended gender identities. Such individuals are becoming increasingly visible in mainstream culture. In Chapter 15, Kafka describes thoughtful, respectful, and effective options for assisting individuals who struggle with nonconventional or compulsive sexual behaviors.

McGoldrick, Loonan, and Wohlsifer (Chapter 14) highlight the vast differences in upbringing, expectations, beliefs, and goals of individuals from diverse cultural and ethnic backgrounds and discuss some of the ways sex therapy with members of these different groups can differ significantly. One of the paramount "take-home" messages of this book is this: the current practice of sex therapy requires a genuine appreciation of diversity and an ability to adapt treatment interventions to varied client populations. For therapists to be effective they must be willing to explore their own cultural beliefs, assumptions, and stereotypes, as well as those held by the culture in which they practice.

CONCLUDING THOUGHTS

The first edition of *Principles and Practice of Sex Therapy* was published in 1980. It represented the first attempt to highlight the revolutionary changes in the treatment of sexual problems following the publication of Masters and Johnson's pioneering work on human sexual response and human sexual "inadequacy" (1966 and 1970). At that time it was believed that *all* sexual problems could be traced to unfortunate learning histories and that "natural" and problem-free sexual response would emerge by altering faulty conditioning, and by intensively working with couples in a 2-week therapy format. The vast majority of sexual problems were ascribed to psychological rather than physical causes. Now, in this fourth edition, my fellow contributors and I emphasize that it is impossible to separate

psyche from soma—most, if not all, sexual problems involve some combination of physical and psychological factors—and that treatment should, ideally, be a skillful blend of integrated interventions: psychological, interpersonal, and medical. As sex therapists, we must focus not only on the genitals of our patients, but the genital owners—the men and women who come to treatment with a rich, varied, and complex history of beliefs, experiences, and hopes.

This edition contains chapters by the most talented, productive, and knowledgeable therapists practicing today, and includes the most timely observations and recommendations concerning diagnosis, assessment, and treatment. There are chapters on new disorders (e.g., persistent genital arousal), perplexing disorders (e.g., delayed ejaculation), and potentially self- or partner-destructive disorders (e.g., paraphilic and nonparaphilic hypersexuality). There is a new chapter dealing with the aftermath of childhood sexual abuse (Hall, Chapter 12). There are updates on sexual pharmacology and recommendations for dealing with the side effects of psychiatric medications (Ashton, Chapter 17). There is a comprehensive chapter describing sex therapy with individuals coping with acute or chronic illnesses (Stevenson & Elliott, Chapter 11) and a new chapter on treating individuals and couples from diverse cultural and ethnic backgrounds (McGoldrick, Loonan, & Wohlsifer, Chapter 14). Embracing diversity is a theme of many of the chapters, particularly those on sexual minorities (Nichols & Shernoff, Chapter 13) and gender dysphoria (Carroll, Chapter 16).

We hope the reader will find this completely revised fourth edition of *Principles and Practice of Sex Therapy* entertaining, edifying, and practical. It offers a window into the fascinating, challenging, and immensely satisfying practice of sex therapy in the 21st century.

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PART II

FEMALE SEXUAL DISORDERS

CHAPTER 2

Sexual Desire/Arousal Disorders in Women

ROSEMARY BASSON

Without a doubt, the most common sexual complaint—by women of all ages—is absent or low sexual desire. In recent years, hypoactive sexual desire disorder has received considerable attention by the media, by pharmaceutical companies, and by women themselves—all seeking a magic elixir to rev up the engines of desire.

In this chapter, Basson questions the host of assumptions that have characterized recent discussions of women's sexuality generally, and sexual desire in particular. She suggests that the wellsprings of desire in women are quite different from those in men and arise not so much from hormonal or genital stirrings as from feelings that are not specifically sexual. Moreover, incentives other than the wish for genital tension relief (or even the expectation of sexual pleasure) seem to motivate sexual receptivity in women. There are diverse motives for being sexual, from the wish to enjoy greater emotional intimacy to the attempt to avoid a partner's displeasure. Furthermore, Basson believes that it is a woman's level of *subjective sexual arousal* that is the key player in the sexual cycle, rather than overt genital arousal or internal feelings of desire, and that lubrication and vasocongestion are not reliable indices of this critical ingredient.

Assessment and treatment in cases involving the complaint of low sexual interest are complex and involve attention to the woman's mental health generally (e.g., her energy, self-esteem, body image, feelings of attractiveness, and stress levels), physical health and medication use, emotional intimacy, and most important, the current sexual context. This includes assessing the adequacy of a couple's sexual and nonsexual communication (and satisfaction with it!), sexual techniques, feelings of pri-

vacy and safety, sexual script, and reasons for being sexual. There are no shortcuts in either assessment or treatment since so many factors typically contribute to the problem—psychological, biological, interpersonal, and contextual.

Basson emphasizes the importance of evaluating and attending to both biological and psychosocial factors in treatment. While supplemental testosterone may prove beneficial for some few women, Basson is concerned about the lack of long-term safety data with the use of androgens. Other biological factors need to be addressed as well, such as a possible change in medication, treatment of a mood disorder, or correction of hypo- or hyperthyroid states. Most important, therapy focuses on enhancing the couple's relationship and correcting misconceptions about what is "normal" sexually.

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The most common sexual concern among women is rarely or never sensing a desire to engage in sex. The typical remark we frequently hear is "if it were up to me, if I never had sex again, it would be okay." Although the sexual symptoms are so frequently presented in these terms, we shall see that the underlying difficulties and dysfunctions are varied and usually complex. Concern about low sexual desire may be present in some 30–40% of women. Exactly when such concern constitutes sexual disorder/dysfunction is a matter of ongoing debate. A clearer understanding of women's sexuality is emerging as increasing data on sexually content women are acquired, especially in relation to life cycle, age, and particular society and culture.

Empirical, qualitative, and clinical evidence makes it clear that sexual desire as manifest in sexual fantasizing, yearning and looking forward to sexual experiences, and "spontaneously" thinking about sex in a positive manner has a broad spectrum of frequency among women, and that overt desire is infrequent in many sexually functional and satisfied women—especially those in established relationships (Cain, Johannes, & Avis, 2003; Graham, Sanders, Milhausen, & McBride, 2004; Galyer, Conaglen, Hare, & Conaglen, 1999; Laumann, Paik, & Rosen, 1999). Moreover, studies confirm that women mostly accept or initiate sexual interaction with their partner for reasons other than desire. Qualitative research confirms clinical experience showing that reasons given for engaging in sex focus on increasing emotional bonding, as a response to romantic settings, as well as more specifically erotic cues (Graham et al., 2004).

None of this is in keeping with the traditional model of human sexual response emerging from the work of William Masters and Virginia John-

son and later expanded by Helen Singer Kaplan, whereby desire precedes arousal, orgasm, and resolution. Although Helen Kaplan wrote about the existence of both "spontaneous" (or initial) desire and a "responsive desire," the latter was never incorporated into the frequently cited linear model of desire, arousal, and orgasm. Indeed, this linear model underlies the text revision of the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) definition of hypoactive sexual desire disorder as an absence of sexual fantasies and of desire for (imminent or future) sexual activity (American Psychiatric Association, 2000). Prior authors of this publication similarly confirmed that an "absence of spontaneously occurring proceptive (sexual) activities, private (sexual) thoughts and emotional events is fundamental to the diagnosis of desire disorder" (Pridal & LoPiccolo, 2000).

The traditional linear model has been used as the foundation for teaching about human sexuality, for diagnosing dysfunctions and disorders, and for treatment planning with either pharmacological or nonpharmacological methods. When both responsive desire and the many aspects of sexual motivation (namely, the reasons and incentives for initiating and agreeing to sexual activity) are reflected together in a model of sexual response, the structure is circular rather than linear, and reflects the overlapping of the desire and arousal phases reported by women (see Figure 2.1). Also included in this circular model are the entities of sexual stimuli and

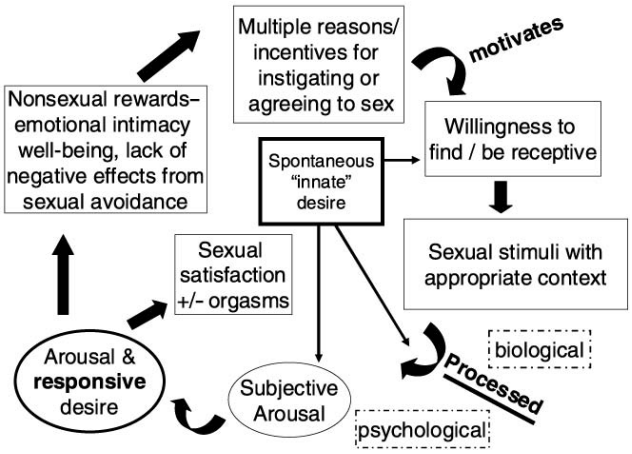

FIGURE 2.1. Sexual response cycle reflecting the many incentives for sex, the psychological and biological influences on arousability, and the fact that arousal may precede and then accompany sexual desire. Adapted from Basson, R. J. (2001). Female sexual response: The role of drugs in the management of sexual dysfunction. *Obstetrics and Gynecology, 98*, 350–353. Copyright 2001 by the American College of Obstetricians and Gynecologists. Adapted by permission of Lippincott Williams & Wilkins.

sexual context—essential components of a response that begins with feelings that are often not specifically sexual. The concept of arousability, that is, the ease with which the sexual stimuli arouse the woman, is reflected in the model. This is important given clinical and research evidence that many factors modulate arousal, including feeling desired rather than feeling used, feeling accepted by the partner, the partner's behavior, and the woman's body image and mood (Galyer et al., 1999; Graham et al., 2004). The importance of outcome (reward) in modulating subsequent motivation creates the circular structure.

A further important evidence-based change to the conceptualization of women's response is recognition of the importance of subjective arousal rather than genital congestion per se. Sexual arousal has been traditionally equated to vaginal lubrication/vulval swelling. Women, however, view lubrication rather as an epiphenomenon (Graham et al., 2004). Lubrication is necessary if intravaginal stimulation is part of the couple's interaction. Lubrication and genital swelling and the underlying genital vasocongestion do not correlate particularly well with subjective arousal (van Lunsen & Laan, 2004), nor do they robustly reinforce sexual excitement (Basson, 2001)—unlike penile swelling/erection in men (Cranston-Cuebas & Barlow, 1990).

This research has called into question the DSM-IV-TR definitions of sexual disorder and the figures for the prevalence of women's sexual desire and arousal disorders. The DSM-IV-TR definition of low desire underlies the majority of tools used in epidemiological studies of sexual problems (Althof, Dean, Derogatis, Rosen, & Sisson, 2005). Recently recommended revisions to the definitions of women's sexual dysfunctions have been published (Basson et al., 2003).

SEXUAL DESIRE/INTEREST DISORDER

The revised definition for women's sexual desire/interest disorders is:

> Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies and a lack of responsive desire. Motivations (here defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration. (Basson et al., 2003)

Currently, few questionnaires or structured interviews clarify that lack of initial/spontaneous desire per se is fundamentally normal. Rather, it is the lack of any "triggered" or "responsive" desire typically associated with a lack of subjective arousal and pleasure when engaged in sex and in response to other erotic stimuli that constitutes disorder. Thus the true preva-

lence of low desire/interest disorder in women is unknown. The 30–35% of women having difficulties with low desire (Avis et al., 2005; Fugl-Meyer & Sjögren Fugl-Meyer, 1999; Laumann, Paik, & Rosen, 1999) may well reflect a large number of women perceiving they have problematic desire because of the standard to which they compare themselves. Essentially this is a standard of male sexuality that is also depicted in movies and books as being the norm for women. Understanding that spontaneous desire is a reality for only some women, most notably when there is a new partner (Avis et al., 2005; Avis, Stellato, Crawford, Johannes, & Longcope, 2000; Dennerstein & Lehert, 2004) would cause an unknown percentage of women concerned about their lack of spontaneous desire to perceive their experience as normal. Moreover, much-quoted epidemiological studies tend to reflect self-reported symptoms rather than carefully diagnosed dysfunctions and disorders (Laumann et al., 1999). That one-third of women perceive themselves as "not up to standard" demands reassessment of that standard.

Similarly, there are few accurate figures for the prevalence of low subjective arousal, the focus of epidemiology usually being on just one component of arousal, namely, vaginal lubrication. One study of 979 women between ages 18 and 70 years in a nationally representative British sample found that 17% identified problems with arousal as distinct from vaginal dryness (Dunn, Croft, & Hackett, 1998), as did 5% in the Study of Women's Health Across the Nation (SWAN) (Avis et al., 2005). Lubrication difficulties are frequently a focus of investigation with a prevalence of 10–30% of women in nationally representative samples (Fugl-Meyer & Sjögren Fugl-Meyer, 1999; Laumann et al., 1999). However, without knowing if women with low lubrication are or are not subjectively aroused, these figures are of limited usefulness.

COMPLEXITIES OF AROUSAL AND ITS LACK

The evidence is that a *reflexive* vasocongestive response occurs within seconds of viewing an erotic stimulus in the vast majority of women studied over the past 25 years (van Lunsen & Laan, 2004). The response occurs even if the woman does not report that she finds the erotic video subjectively arousing. Interestingly, women who complain of chronic low arousal, including even those with arousal disorder by DSM-IV-TR criteria who report a "lack of lubrication/swelling," objectively show an increase in vaginal congestion comparable to those of control women (van Lunsen & Laan, 2004). These studies are done using a tampon-like device called a vaginal photoplethysmograph, which records increases in congestion of blood around the vagina while simultaneously the woman rates her subjective arousal.

Subjective arousal would appear to be a slower response involving different brain circuits to allow appraisal of the stimulus through conscious and unconscious mechanisms. The response of the autonomic nervous system leading to genital congestion appears to be highly automated and even "programmed." It probably involves the sensory thalamus and the amygdala, where conscious and unconscious processing of highly emotional stimuli occurs, with subsequent input into the supraspinal centers that organize genital autonomic nerve activity. The slower response of subjective arousal probably involves the sensory thalamus, the cortical centers, the hippocampus (thought to be important for relating sensory stimuli to past memories of emotional experiences), and finally the amygdala for further processing toward the experience of subjective arousal (see Figure 2.2).

If subjective arousal is experienced, it too will give rise to thoughts and emotions that may be positive or negative (Trudel, Ravart, & Matte, 1993). If they are positive, the arousal is reinforced, but if negative, subjective arousal may quickly dissipate. Interestingly, there is evidence that the vaginal congestion in women complaining of long-term low arousal may correlate with negative emotions (Laan, Everaerd, van der Velde, & Geer, 1995). Recent functional magnetic resonance imaging (MRI) studies identify various areas of the brain activated in sexual arousal, including areas subserving the genital vasocongestive response, such as the posterior hypothalamus. Activation in these areas correlates well with the subjective experience of arousal in men but not in women (Karama et al., 2002).

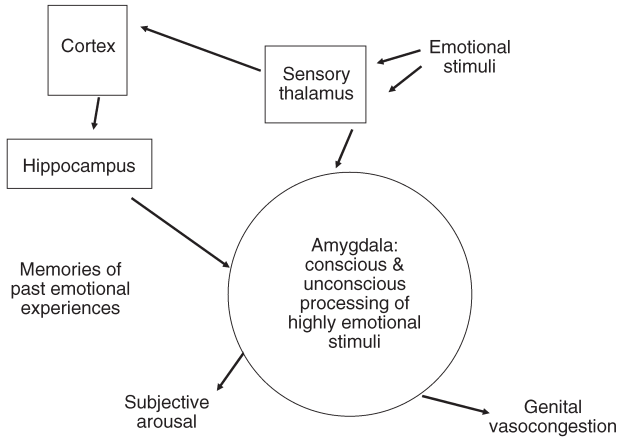

FIGURE 2.2. Schematic of possible pathways involved in subjective arousal and reflexive genital sexual vasocongestion. Adapted from Basson, R. J. (2002). A model of women's sexual arousal. *Journal of Sex and Marital Therapy*, *28*, 1–10. Copyright 2002 by Taylor & Francis Group. Adapted by permission.

Arousal involves many physiological changes. There is swelling of extensive vulval structures (located around the urethra, around the anterior distal vagina under the superficial perineal muscles, and including the shaft, head, and rami of the clitoris). There is also increased blood flow in the plexus of blood vessels just under the vaginal epithelium, causing more fluid to move across the vaginal epithelium into the vaginal lumen, thus increasing the volume and changing the composition of lubrication fluid. Increases also occur in muscle tone, body temperature, respiration, heart rate, blood pressure, and skin sensitivity, as well as breast engorgement, nipple engorgement, and nipple erection. There is little or no scientific research on any correlation between any of these nongenital physiological responses and the subjective experience.

The importance of women's subjective arousal persuaded the international committee convened by the American Foundation of Urologic Disease in 2003 to recommend changes to the DSM-IV-TR definitions of arousal disorder. Note that the entity of subjective arousal is lacking entirely from the DSM-IV-TR definition. Subtypes of arousal disorder are now recommended. These revised definitions are based entirely on the clinical history, in other words, there are no measurements made of genital congestion in response to stimulation. The diagnostic subtypes rest on the woman's perception of any genital changes and on her recognition of any subjective arousal. When neither is recognized in response to any kind of sexual stimulation, the disorder is one of combined arousal disorder, defined as "absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure), from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication)" (Basson et al., 2003). Some women deny any subjective arousal excitement but recognize there is some reflex lubrication and genital swelling. Their diagnosis is one of subjective arousal disorder: "absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure), from any type of sexual stimulation. Vaginal lubrication or other signs of physical response still occur" (Basson et al., 2003). There is also a clinical subgroup of women, usually in midlife, who report "genital deadness." They remain able to be aroused by nongenital stimuli. These would typically include breast stimulation, kissing, stimulating the partner, and reading or viewing erotica. Again, to restate, this is a clinical diagnosis and, in fact, the small amount of research on women with this disorder of genital sexual arousal suggests that only some of these women have demonstrably reduced vasocongestion in response to a stimulus that does nevertheless subjectively excite them (Basson & Brotto, 2003). Others appear to have lost sexual sensitivity of apparently normally congesting genital tissues. The proposed definition of genital sexual arousal disorder is as follows:

> Complaints of absent or impaired genital sexual arousal. Self-report may include minimal vulval swelling or vaginal lubrication from any type of sexual stimulation and reduced sexual sensations from caressing genitalia. Subjective sexual excitement still occurs from nongenital sexual stimuli. (Basson et al., 2003)

One more evidence-based change to the traditional conceptualization of women's sexual response is a recognition of its highly contextual nature (Avis et al., 2005; Bancroft, Loftus, & Long, 2003; Barber, Visco, Wyman, Fantl, & Bump, 2002; Cawood & Bancroft, 1996; Hill & Preston, 1996, Laumann et al., 2005; Öberg & Sröjens Fugl-Meyer, 2005). Of major interest is a corollary in animal research. Female rodents are not simply "driven" by a biological neuroendocrine mechanism to be sexually proceptive or receptive but rather have complex biological neuroendocrine mechanisms to assess the context (Pfaus, Kippin, & Centeno, 2001). Moreover, both contextual factors (e.g., male animal in adjacent cage) or administration of a neurotransmitter (dopamine) can replicate the same changes in sexual behavior afforded by administering progesterone to estrogen replete oophorectomized female rodents (Blaustein, 2003; Mani, Blaustein, & O'Malley, 1997). Additionally, conditioned responses (with memory of past reward) can invoke changes in the animal's sexual behavior similar to those afforded by administering sex hormones (Pfaus et al., 2001). Thus even in animals, we see the artificiality of the traditional split between physical/organic and psychological/nonorganic factors modulating sexual response.

The mandatory blending of mind and body is highly apparent in the areas of women's sexual desire and arousal. A very interesting study shows marked synergy between cancer of the cervix and sexual abuse in causing lack of sexual satisfaction, arousal, desire, and vaginal lubrication. Physiological impairment of the vasocongestive genital response is likely in women with cancer of the cervix who undergo radical hysterectomy with or without postoperative radiotherapy. The percentage with lack of sexual satisfaction who had both radical treatment and a history of abuse was 45%—whereas the percentage for women with cancer of the cervix but no abuse was 28%, and for control women without abuse 25%, and with abuse 31%. (Bergmark, Åvall-Lundqvist, Dickman, Steineck, & Henningsohn, 2005). Of 3,000 North American women of different ethnicities close to and entering perimenopause, the frequency of feeling desire was not associated with menopause status, night sweats, or hot flashes but with negative attitudes toward aging and higher levels of perceived stress—these being negatively related to feelings of desire. By contrast, starting a new relationship and perceiving sex as important were positively related. Ethnicity was also strongly associated with desire in that African American, Chinese, and Japanese women reported less desire than Caucasian women

(Avis et al., 2005; Cain et al., 2003). The consistent theme is that biological insults (radical hysterectomies, hormonal changes of perimenopause) create a vulnerability to sexual dysfunction but contextual, personal, past experiential, and cultural factors determine presence or absence of problems.

That women's sexuality is contextual is also endorsed in a study of lesbian and bisexual women, more than half of whom, when followed over a course of 8 years, changed their sexual identity labels at least once after first coming out as nonheterosexual. Often this was because they found themselves in unexpected relationships and circumstances that contradicted their perceptions of typical lesbian or bisexual behavior. Some even preferred eventually to assume an unlabeled identity. Some of these women explained that no one label could fully represent the diversity of sexual feelings they experienced with different female and male partners under different circumstances (Diamond, 2005).

COMORBIDITY OF DYSFUNCTION

In view of the overlap in the phases of sex response, especially those of arousal and desire, it is not surprising to find high levels of comorbidity of dysfunction (Hartmann, Philippsohn, Heiser, & Rüffer-Hesse, 2004; Leiblum, Koochaki, Rodenberg, Barton, & Rosen, 2006; Trudel et al., 1993; Dennerstein, Koochaki, Barton, & Graziottin, 2006). Thus rather than a discrete entity of "hypoactive sexual desire disorder" in women, the reality is a more pervasive gradual blunting of sexual response such that typically women complaining of lack of desire have little in the way of intense feelings of arousal and usually do not experience orgasm (Hartmann et al., 2004, Leiblum et al., 2006; Dennerstein et al., 2006). Of note, recent randomized controlled trials (RCTs) investigating the benefit of supplemental transdermal testosterone, although recruiting women diagnosed with "hypoactive sexual desire disorder," showed improvements in orgasm, arousal, and pleasure (Buster et al., 2005; Shifren et al., 2000; Braunstein et al., 2005; Davis et al., 2006; Simon et al., 2005; Shifren et al., in press). Problematic response was clearly present despite the diagnostic focus on "hypoactive sexual desire disorder."

DISTRESS REGARDING SEXUAL DYSFUNCTION

Not all women with sexual concerns are particularly distressed about them. Although a number of large studies failed to show an increase in prevalence of desire concerns with age (Laumann et al., 1999, 2005), smaller studies have shown that low desire increases with age but distress about that low desire decreases (Hayes & Dennerstein, 2005). Women

with a history of both radical hysterectomy for cancer of the cervix and past abuse are more distressed about subsequent dysfunction than those without abuse (Bergmark et al., 2005).

APPROACHES TO ASSESSMENT AND TREATMENT

The recognition that "desire" has a broad spectrum across women and is only one of many sexual motivations has far-reaching repercussions regarding assessment and management of arousal and desire difficulties. It could be said that in clinical practice, the focus is more accurately on the assessment of sexual motivations and sexual arousability. Rather than waiting for a possibly infrequent innate sexual need or hunger, a woman is particularly dependent on the acceptability of the context of a given possible sexual interaction. This would include feelings for the partner at the time of sexual interaction, as well as the larger interpersonal relationship, the woman's mental, psychological, and medical health, and the sexual and cultural contexts (Bancroft et al., 2003; Barber et al., 2002; Dennerstein & Lehert, 2004; Hartmann et al., 2004; Avis et al., 2005). It is this multifaceted assessment that guides therapy.

Emotional Intimacy

Assessment of the couple's emotional intimacy typically includes questioning about their ability to trust, to be vulnerable and not judgmental or highly critical, and to have a balance of power and assertiveness in the relationship that is sexually attractive to the woman. Noting the repeated finding of increased desire and response with a new partner (Avis et al, 2005; Dennerstein & Lehert, 2004), the challenge is to recall the behaviors and interpersonal atmosphere that triggered desire for one another when they first met. If relationship therapy is needed, it should precede recommendations regarding sexual interaction.

Mental Health

Assessment and subsequent management of overall mental health is vital, as well as assessment of the woman's own well-being at the time of sexual interaction. This would include her energy, self-esteem, sense of attractiveness, and body image, as well as freedom from stressful distractions and preoccupations. Interestingly, women who complain about their low levels of desire but are free from clinical mood disorder tend to show lower self-esteem, mood instability, and tendency to worry and be anxious compared to control women (Hartmann et al., 2004). Depression is strongly associated with reduced sexual function. Of 79 women with major depression,

prior to medication 50% reported decreased desire—similar numbers reporting far less sexual arousal when engaging in sex (Kennedy, Dickens, Eisfeld, & Bagby, 1999). Of 914 middle-aged women in the SWAN study, those with a history of major depressive illness reported less frequent arousal, less physical pleasure, and less emotional satisfaction in their present relationship. These findings remained significant after controlling for current depressive symptoms, marital status, and psychotropic medication use (Cyranowsky et al., 2004).

Antidepressants, especially those that are more highly serotonergic, may lessen women's sexual desire and arousal. This is especially true for those with less sexual enjoyment prior to the depression (Clayton et al., 2002). When women are specifically asked regarding sexual side effects, they may be detected in up to 70% of subjects (Montejo-Gonzalez, Llorca, Izquierdo, & Rico-Villademoros, 1997). Factors predisposing to antidepressant-associated sexual dysfunction include age, being married (as opposed to single, separated, or divorced), being without college or other higher education, being without full-time work, taking concomitant medications of all types, having a comorbid illness that might affect sexual functioning, and a past history of antidepressant-associated sexual dysfunction. Also, statistically the odds of dysfunction were significantly higher when sexual function was deemed unimportant and previous sexual engagement had afforded little pleasure. Management of mood disorder or change of psychotropic medication should precede specific sexual interventions. Pharmacological amelioration of antidepressant-induced sexual dysfunction is difficult. A recent Cochrane Review was unable to make any recommendation, but noted bupropion was promising in that one of two randomized controlled trials showed a benefit (Rudkin, Taylor, & Hawton, 2004).

Sexual Context

A detailed assessment of the couple's usual sexual context may lead to recommended changes. Time of day, time since last sexual activity, what has gone on in the hours preceding the sexual opportunity, and what needs to be done subsequent to possible sexual activity are assessed. Similarly, the sexual cues and means of communicating either partner's sexual intent are assessed. Specific sexual kisses, embraces, and skills in nongenital and genital stimulation are all relevant details that may largely influence expected outcome (reward), and therefore the woman's motivation and arousability. Do the partners take turns in pleasuring each other and guiding each other as to the most optimal ways of giving and receiving pleasure, or are they under the impression that giving and receiving must be done simultaneously, which is difficult for very many women? Is their flexibility such that low-key arousal and pleasure without necessarily having orgasms or

intercourse is satisfactory sometimes? Or is there a sense of obligation that once started, sexual interaction must include certain goals? Such questionable goals include orgasms for both partners (whether the partner is male or female), intercourse, or intercourse plus man's orgasm, or intercourse plus both partners' orgasms during that act, or even intercourse plus the man's orgasm and multiple orgasms for the woman.

Thoughts during Sexual Interaction

The woman's ability to focus on the sexual stimuli requires assessment and may need assistance. What are her thoughts? Frequently they are distracting in women with desire and arousal concerns. Distractions regarding day-to-day stressors are common—the degree of perceived stress being one of the factors more robustly correlating with women's sexual function in a large 29-country study recently published (Laumann et al., 2005). Other distracting feelings include resentment or obligation regarding imposed sexual frequency or type of sexual interaction that is not truly the woman's choice, prediction of a negative outcome such as unwanted pregnancy, further proof of infertility, or lack of sexual satisfaction. This latter aspect of dissatisfaction is very relevant for many women with minimal innate desire, particularly if they have been accustomed to more innate or initial desire in earlier years or early on in serial relationships. With their lessened innate desire, they may well go ahead and agree or instigate sexual interaction out of duty or guilt, or maybe generally wanting to improve the emotional intimacy. However, verbally and nonverbally they communicate that "their heart is not in it," but they will go along with what happens. However, whatever does happen, is that in time, despite initial misgivings, there is some pleasure or there is some arousal, but in keeping with her stance that she is not really desirous, such a woman fails to guide her partner toward her (suddenly discovered) sexual needs—and so, the sexual engagement ends and the other partner alone is satisfied. So, lack of sexual satisfaction becomes the rule. It is easy to see that in time, the expectation of this negative outcome (lack of sexual reward) will preclude any arousal at all.

Advice regarding more intensely erotic contexts and stimuli may improve the woman's ability to stay focused. Practicing recognizing and focusing on nonsexual feelings throughout the day may help. Encouragement that a person can deliberately change thoughts and behaviors such that emotions subsequently change is often necessary.

Biological Factors

Biological factors can also influence arousability. Included are depression, medications including serotonergic antidepressants, chronic debilitating ill-

nesses such as chronic renal failure, and fluctuations in blood sugar with diabetes and, less commonly, hyperprolactinemia or hypo- or hyperthyroid states. Loss of androgen activity from surgical removal of both ovaries, premature ovarian failure from chemotherapy, adrenal disease, hypothalamic or pituitary disease, and prolonged high-dose cortisol administration may all negatively influence arousability. How frequently loss of ovarian androgen production is associated with sexual dysfunction is unknown. A recent study of 106 perimenopausal women requiring hysterectomy for benign pathology who chose hysterectomy and bilateral salpingo oophorectomy over hysterectomy alone showed no change in sexual function assessed one year postoperatively compared to preoperative assessment (Aziz, Brännström, & Bergquist, 2005). Aging may be associated with marked loss of adrenal production of prohormones (dehydroepiandrosterone [DHEA] and DHEAsulfate [DHEAS], and others) that can be converted into either androgens or estrogens in the various organs of the body, including the brain and genitalia. However, clearly many women, despite reduced adrenal prohormone production, retain sufficient ovarian and adrenal androgen and androgen precursor production to preclude sexual symptoms. It is most unfortunate that we have so little knowledge of how frequent markedly low androgen activity is relevant as an etiological factor. This is because most androgen activity in older women is from testosterone formed within cells from adrenal precursors. The testosterone acts within the cells where it is produced and is metabolized within those cells. Very little spills back into the bloodstream to be measured. Thus serum levels of testosterone are of questionable relevance as they do not measure this intracellular production and activity (Labrie et al., 2003).

Recently published were conflicting small studies attempting to correlate serum levels of androgens in pre- and postmenopausal women with normal and abnormal sexual function (Nyunt et al., 2005; Turna et al., 2005). The recent SWAN study of 3,000 multiethnic North American women found minimal correlation of measures of arousal and desire with serum androgen levels (Santoro, 2005). Similarly no correlation was found between sexual function and serum androgen levels in 1,021 Australian women (Davis, Davis, Donath, & Bell, 2005). No studies have yet included measures of total testosterone activity, that is, metabolites such as glucuronides (Labrie et al., 2003). Older, smaller studies (Bancroft et al., 2003; Burger, Dudley, Cui, Dennerstein, & Hooper, 2000; Galyer et al., 1999) that included peri- and postmenopausal women also failed to correlate sexual dysfunction with androgen levels.

Assessment of "innate" or "spontaneous" desire is also necessary. Inquiry regarding sexual dreams or masturbation for reasons of genital release or sexual need may be helpful. As mentioned, there is a broad spectrum of this type of desire across women, but it may decrease with age and with menopause, as shown in both cross-sectional (Avis et al., 2000) and

longitudinal studies (Dennerstein & Lehert, 2004). However this was not reflected in the largest study, of 13,882 women from 29 countries, where it was shown that older age per se did not increase the likelihood of sexual problems in women, the only exception being lubrication difficulties (Laumann et al., 2005).

The clinical impression is that women with little recognition of this innate desire, and long-term appreciation of their own responsive desire (see Figure 2.1), are less likely to voice sexual complaints as they age and pass through menopause. However, the women who are more aware of innate desire (sometimes related to their menstrual cycle) are distressed at its loss, and they may react negatively with concerns about aging or fears that something must be very wrong with their bodies and minds, and they refrain from sexual activity. Thus they are denied the opportunity to discover that focusing on sexual stimuli in an appropriate context can still arouse them, and that arousal triggers desire. This was shown in the following case example:

> Caroline, age 55 and 6 years postmenopause, was referred because of low sexual desire—for some 8–10 years in her estimation, and for some 20 years according to her husband, George. George recalled how Caroline's sexual interest decreased with each of her three pregnancies, recovering only partially in between, and then plummeted some 8 years ago around menopause. There had been minimal sexual activity since that time. Caroline recalled how her work as a full-time teacher and the care of the children took all her emotional and physical energy such that she was only aware of sexual desire just prior to her menses. When the latter ceased, so more or less did sex. On the one level, Caroline felt very abnormal, but on another level somewhat resentful given that she personally was content with no sex and her menopause was not of her doing.
>
> Tracing Caroline's background, it was clear she had learned to be independent from an early age. Her single-parent mother had transferred her care to a distant aunt who was a strong, intelligent, and capable woman who, at varying times, brought up some 8 to 10 children—some related to her and others not. She provided structure and stability for them as well as love and a sense of belonging. However, there was just one mother to some 10 children, and Caroline learned to make do with the best that was possible from any given situation. She recalled how even by the age of 8, she was determined she would go to university and be a teacher. She successfully resisted the attempts of her biological mother to take her into her home with a new partner when Caroline was age 14. Only boyfriends who would be willing to avoid penetrative sex would be chosen until such time as Caroline felt she had found the person to whom she would like to commit the rest of her life. Caroline was able to follow through with all these resolves.

After hearing that many women have close to zero spontaneous desire but go ahead anyway and engage in sex, having previously ensured their partner's knowledge and skill in giving them sexual pleasure and satisfaction, Caroline totally changed her situation around between the first and second visit. We had suggested the couple might begin to discuss bringing back into their lives some nonintercourse sexual caressing and some "date like" contexts. However, apparently no discussion occurred—just action. Caroline went ahead and instigated two sexual episodes with her husband, inclusive of intercourse, during the 7 days between the visits. The origins of George's stance of being totally accepting of the situation, able to accommodate an absence of partnered sex, and immediately able to enjoy reinstituted sex with his wife, stemming almost certainly from situations in his childhood, we chose not to make a focus of discussion. Rather, we simply congratulated the couple and were pleased to find that their progress continued when they were seen some 6 months later. This truly appears to be an example of therapy that consisted solely of giving information.

When the loss of innate desire is very gradual, women adapt to these changes and become more gradually aware of their responsive desire and accept it as normal for them now. Why some women more suddenly lose innate desire and others lose it more gradually is unclear. Again, careful study of total androgen activity, as measured by testosterone metabolites, is awaited. Medication can compound this normative lessening of spontaneous desire. For instance, oral systemic estrogen will reduce bioavailable testosterone due to the estrogen-invoked increase in sex hormone-binding globulin (which will bind much of the testosterone).

Some biological factors are amenable to correction, for example, medication change, treatment of mood disorder or correction of hypo- or hyperthyroid states. Others, such as debility from chronic illness, require adaptations such as arranging sexual interaction at the time of day when energy is greatest, changing a focus from intercourse and orgasms for each partner to more low-key sexual pleasuring to lower levels of arousal and, possibly, orgasms reserved on a regular basis for the partner without debility.

Testosterone supplementation is investigational and associated with many difficulties. These include the unavailability of accepted measures of total androgen activity, as well as current lack of formulations of systemic androgen for women. Importantly, if it is suspected that the dysfunction is from hormonal lack, this lack is considered permanent, and there is absence of long-term safety data on administering systemic testosterone and also on long-term administration of systemic estrogen to accompany the testosterone. The Women's Health Initiative Study (Rossouw et al., 2002) involved asymptomatic women of average age 63 who were given oral

estrogens and medroxyprogesterone or placebo. No sexual benefit was noted in the limited assessment made of sexual function. Long-term safety of systemic estrogen for women with sexual problems who initiate estrogen therapy at menopause, long before the age of 60, is urgently needed. Prescribing testosterone without estrogen would be unsound physiologically as it would increase the ratio of androgen to estrogen even beyond the proportions that naturally occur postmenopausally. Additionally, there are no safety data on testosterone supplementation in estrogen-depleted women. Moreover, sensitive, accurate assays to monitor testosterone supplementation are not clinically available (the assays are designed for the higher male range). In the United States methyl testosterone in combination with oral estrogens is available. Concerns remain regarding the reduction of HDL cholesterol with this preparation and the inability to biochemically monitor testosterone effect since methyl testosterone is not picked up by testosterone assays. Reducing sex hormone-binding globulin and increasing endogenous free (unbound) testosterone is only part of the action of methyl testosterone.

If investigational testosterone therapy is to be prescribed, the possibility of increasing androgen availability by changing from oral to transdermal estrogen, thereby lowering sex hormone-binding globulin, should first be explored. For all women who complain of loss of sexual arousability and desire, whether they are naturally or surgically menopausal, careful assessment of interpersonal and intrapersonal factors must first be done and any difficulties addressed before investigational testosterone therapy is discussed. Limitations in the availability of longer-term outcome data must be explained if systemic estrogen and androgen are prescribed. The investigational nature of this therapy must be explained and consent obtained. In view of absent but required safety data, professional societies such as the Endocrine Society are not currently able to recommend testosterone therapy (Wierman et al., in press). Those embarking on investigational testosterone therapy must avoid supraphysiological levels of testosterone. Ongoing clinical trials involve the use of testosterone patches delivering 300 μg of testosterone daily; the patches are changed twice a week. Unfortunately, achieving a high premenopausal level of testosterone (the aim of current RCTs) is not necessarily desirable physiologically. This is because compared to when she was in her 30s, an older woman has a relative intracellular testosterone deficiency owing to markedly reduced adrenal precursors and the aforementioned phenomena of intracellular testosterone production. However, supplementing exogenous testosterone exposes all of her cells to higher concentrations. As well as using the best biochemical assay available for monitoring investigational therapy, interval measurements of lipids and hematocrit are recommended, as well as interval examination for hypertension, upper abdominal obesity, hirsutism, acne, scalp hair loss, clitoromegaly, and breast changes. The association of meta-

bolic syndrome with higher endogenous androgen levels is of major concern given the increase in investigational use of testosterone in women (Santoro et al., 2005).

Outcome

Assessing the outcome of sexual experiences will involve asking about emotional and sexual satisfaction. Details of the partner's sexual function or dysfunction are relevant. The consequences of a partner's erectile dysfunction on the woman are numerous and complex. Erectile dysfunction is understood to be a problem that affects both partners in terms of their interpersonal issues plus involving the interplay between the man's personal psychological factors and a variable degree of biological deficit, most notably endothelial dysfunction in the specialized vasculature of the penis. Recently, with the advent of effective and generally safe medical therapies, there is an increasing tendency for clinicians to consider only the man, assessing only him, prescribing him a medication, and subsequently measuring the outcome in terms of penile firmness and physical ability to have intercourse. Sometimes the man's overall sexual satisfaction is assessed, but there are reasons to question whether women's sexual enjoyment and satisfaction necessarily follows. There is some evidence that it may do so. One recent study showed improvement in women's sexual dysfunction when their male partner's erectile dysfunction was successfully treated (Cayan et al., 2004). However, another study found almost a third of female partners of men with erectile dysfunction were actually dissatisfied with the sexual outcome (Salonia et al., 1999). Of note, when asked what their most enjoyable part of sexual activity was, the majority of women whose partners had erectile dysfunction cited foreplay as opposed to sexual intercourse (Carroll & Bagley, 1990).

Similarly, women in sexually healthy and generally healthy marriages report foreplay as the most satisfying component of partnered sexual activity (Hurlbert, Apt, & Rabehl, 1993). Whether men's enthusiasm for caressing and pleasuring their partners using various forms of nonpenetrative sex increases with their renewed sexual self-confidence and increased sexual excitement associated with their enhanced erections has not been studied. Both the phosphodiesterase inhibitors and investigational dopaminergic drugs can only be effective when the man is subjectively sexually excited. For many men, such subjective sexual excitement in the longer term is dependent on their partner's sexual excitement and enjoyment. It is hoped that in the foreseeable future, erectile dysfunction will again be seen as a couple entity such that the woman's sexual concerns predating or associated with the man's prior erectile dysfunction can also be addressed. It is interesting that some studies have shown that when the partner's physical difficulties have limited but not prevented sexual interaction such that the

frequency of sexual experiences is somewhat lowered, women's desire actually increases (Avis et al., 2000; Dennerstein, Lehert, Burger, & Dudley, 1999).

CASE OF SARAH AND CARL

Sarah, age 27, was referred by an endocrinologist for consideration of testosterone supplementation as she was complaining of low sexual desire and had no ovarian tissue. One ovary had been removed, along with a large ovarian cyst, when she was age 13 and her second ovary had undergone torsion (twisting such that its blood supply was cut off) at age 16 and had to be removed. Estrogen and progesterone replacement had been instituted immediately such that menses never stopped and menopausal symptoms were avoided. Various formulations of oral contraception had been used, but currently Sarah felt well and free from mood changes on her current regime of 2 mg of oral estradiol and 5 mg of medroxyprogesterone.

Sarah initially was seen alone. She explained that sex with her partner, Carl, was enjoyable. They had been together 4 years and were sexual approximately weekly. However, Carl would have liked to be sexual every day but Sarah resisted. She added that even though sex was enjoyable and satisfying, she felt that "if she were never to have sex again, it would be fine by her." She told us that Carl thought she was very abnormal and so did her endocrinologist.

Sarah had very few sexual thoughts associated with arousal or enjoyable anticipation of being sexual or imagining being sexual. Rather, her sexual thoughts were troubling and had to do with guilt that their sexual interaction was infrequent and the feeling that there was something abnormal about her sexuality. Sarah rarely self-stimulated. Movies or novels with sexual material could arouse her but she did not deliberately read or view such material. When with Carl sexually, she was aroused, she enjoyed the experience, she was orgasmic, and there was no pain. Sarah found arousing Carl pleasurable and arousing for her.

We explained to Sarah that her experience was "within normal limits." Using the revised definitions of women's sexual dysfunction and disorder, she had no diagnosis. We also saw Carl and discussed the range of women's sexual experiences. The next question was whether there were factors causing Sarah's experiences to be at one end of the spectrum. We thought there were both biological and psychological reasons. Sarah was totally dependent on adrenal testosterone precursors. At age 27, it is not surprising that there were sufficient testosterone precursors to allow the target cells sufficient substrate to manufacture the testosterone needed for arousal, orgasm, and enjoyment. Possibly, higher levels of testosterone (were she to have functioning ovarian tissue) would have allowed more in

the way of spontaneous or innate desire. Similarly, Sarah's background gave clues of more psychological factors affecting her sexuality. Sarah grew up with an alcoholic father who was given to shouting, arguing, and resorting to emotional abuse such that Sarah would usually retreat to her bedroom. She suppressed her feelings of disappointment and anger, and did not rebel even as a teenager. These coping mechanisms served her very well then. However, it was highly possible now that she still was in the habit of suppressing emotions generally. Sarah readily agreed to this and could understand that sexual emotions were probably also suppressed.

So "therapy" did not include investigational testosterone supplementation. Rather, it focused on Sarah deliberately attempting to feel more in the way of nonsexual emotion throughout the day. Coupled with this, she was to deliberately allow more sexual stimuli in her life. Music, literature, movies, dancing, more erotic conversations—all of these possibilities were discussed.

The third component of assessment and therapy was to see Carl and explain the situation, as well as discuss his own background, assessing how that may be affecting the present. Carl's parents had a bitter divorce when he was just 10. He also felt that neither parent had really loved him but preferred the older brother. For Carl having sex with his partner was extremely important as a sign that he was loved. Carl was able to realize his pressuring Sarah did not help the situation and he desisted. Sarah very much appreciated this. Moreover, realizing the origins and the extent of Carl's need to feel loved strongly motivated her to find the triggers that were able to make her feel more sexual. Salsa dancing proved to be one of those triggers, coupled with wearing more feminine clothes and allowing Carl to flirt with her more often. We watched as Sarah's sexual self-image markedly increased, along with her sexual desire.

Discussion of the Case

The blending of biological and psychosocial factors is illustrated in Sarah and Carl's story. Although currently we hesitate to embark on long-term testosterone supplementation with only short-term safety data, it may well be that by the time Sarah's adrenal androgen precursors reduce as she ages, we will have more safety information such that supplemental testosterone will then be advised. An interim measure would certainly be to change from oral estrogen to transdermal, thereby reducing sex hormone-binding globulin and freeing up more of her endogenous testosterone, the small amount of testosterone released from target cells into the bloodstream, plus adrenal testosterone.

The importance of seeing the partner was also illustrated in this case. Carl's insistence on a certain frequency of sexual interaction was not really about sex but about his need to finally feel loved. Knowing this, Sarah

suggested it was sufficient motivation in itself to cause her to make the effort to trigger her own arousal and desire more frequently.

CASE OF VALERIE AND PAUL

Valerie and Paul were referred first in 1999. Valerie, then age 52, reported loss of sexual desire for 2 years. The couple described a strong friendship as a prelude to their sexual involvement. Valerie's former marriage ended in divorce and she recalled how supportive Paul and his wife had been to her then. Subsequently 8 years ago, Paul's first wife died from a particularly aggressive form of bone cancer. While both grieved her death, Valerie was then a source of support for Paul. Approximately 2 years later, their relationship became sexual and has been so for the past 6½ years.

Sex was described as very rewarding for the first 4 to 5 years. When seen alone, Valerie explained how attentive Paul was to her sexual needs such that their experiences were varied, and intercourse was not necessarily the focus. Each partner was always orgasmic. Then Valerie experienced a fairly abrupt change in her sexual interest, no longer looking forward to sex or enjoying the sexual experience when it occurred. Indeed, there was no longer sexual excitement or subjective arousal or pleasure and she became anorgasmic. Valerie agreed to be sexual anyway despite her disinterest. Nongenital or genital physical stimulation with or without penetration was no longer rewarding and now only led to frustration, annoyance, and on a few occasions, even mild physical irritation.

The couple was largely avoidant of sexual interaction when they were first seen. Paul was sad, disappointed, perplexed but strongly supportive, noncritical and nonblaming. Valerie was disappointed, frustrated, guilty, and similarly, perplexed.

When the interpersonal context was explored, both partners claimed they were still very affectionate, respectful, and considerate to each other and had very few differences of opinion. However, the general context environment was somewhat troubled mainly due to both partners' anxiety over Paul's daughter's unhappy marriage. Two years previously, Valerie had retired from her secretarial/administrative work and had started a small home-based business, which unfortunately allowed her time to dwell on the difficulties of the daughter and two granddaughters. Paul, then 62 years old, had 2 years previously reduced his work from full time to part time as a registered nurse caring for physically and mentally challenged individuals.

Valerie's past medical history included her menopause at age 50, minimal vasomotor symptoms, and a weight gain of some 25 pounds over the past 4 to 5 years. She had received medications for depression in her late

20s and again in an ongoing manner since her marital breakup. No change in antidepressant prescription was made prior to onset of her sexual difficulties—fluvoxamine 50 mg/day had been prescribed for the last 4 years. Previously, fluoxetene, paroxetine, and bupropion had each been tried but the former two were without benefit and the latter caused agitation in the dose taken (300 mg/day). Currently, Valerie had some symptoms of depression with a tendency to awaken too early in the mornings, to eat "for comfort," was lacking in energy, and sometimes experienced hopelessness—especially about her sexual life and the predicaments of Paul's daughter and granddaughters. She admitted to somewhat less enjoyment of life generally—her home-based business was neither exciting nor satisfying, which somewhat surprised her, given that this had been her dream. She denied any suicidal thoughts. Paul's medical past was uneventful. For the past year, he had taken a small dose of an angiotensin-converting enzyme (ACE) inhibitor for hypertension.

The couple had to travel to Vancouver from their home in Northern British Columbia, so two somewhat extended visits to the Vancouver clinic had been planned. After the second visit, the diagnosis given to Valerie, using DSM-IV-TR definitions, was hypoactive sexual desire disorder. Lack of lubrication or lack of awareness of genital swelling were not particular concerns for Valerie, so no DSM-IV-TR diagnosis of arousal disorder was made. Using the recently recommended expanded and revised DSM-IV-TR definitions, Valerie would have been diagnosed with sexual desire/interest disorder and subjective arousal disorder. Also diagnosed was ongoing clinical depression despite medication.

Recommendations included more effective treatment of the depression, initially suggesting that the fluvoxamine be increased to 100 mg/day. The possibility of adding bupropion 100 mg/day was mentioned with a caveat that the previous agitation from this drug might reoccur even though the dose was only one-third of that previously described. It was hoped that fluvoxamine activation of 5-HT_2 and 5-HT_3 receptors tending to suppress sexual desire and arousability would thus be somewhat countered by the increased dopaminergic and noradrenergic activity afforded by bupropion.

Secondly, the role of androgen decline during a woman's 40s and 50s due to reduced adrenal precursors of testosterone—DHEA, DHEAS, and androstenedione—was discussed. It was explained that this might account for the finding of Valerie's reduced "spontaneous" or "initial" desire. Nevertheless, most women are still able to be aroused by external stimuli if they can focus on them and if the context is appropriate. That there may be a subgroup of women for whom androgen activity is particularly low, was mentioned—but the fact that accurate tests for androgen activity in women were not available was also mentioned. The strong suggestion given was that knowing the experience could ultimately be rewarding sexually and emotionally, many women simply go ahead with a willingness to

become aroused and desirous during the experience rather than having those feelings initially. The need for Valerie to focus on suitable erotic stimuli but not become distracted was emphasized.

A recommendation to gradually lose the 25 pounds by permanent dietary changes was made, with a view to improving Valerie's self-image and sexual self-confidence, which are often closely linked with desire and arousability.

The question of prescribing any investigational androgen, along with estrogen and progesterone, was discussed. Valerie, however, had a long history of painful breasts and breast swelling generally with her menstrual cycles and was pleased all of this had ceased since menopause. Beginning systemic estrogen was not an attractive proposition to her on this basis. Additionally, beginning estrogen some years postmenopause, especially in heavier women, is not recommended due to increase in cardiovascular morbidity (Rossouw et al., 2002). Prescribing systemic testosterone without systemic estrogen has not been studied.

In 2002, the couple returned. They had moved nearer to Vancouver. Valerie described how the increase in fluvoxamine had been helpful and the dose was maintained. Focusing on the moment had been possible and arousal, pleasure, and some orgasms had returned, but only partially and, unfortunately, only temporarily. Valerie explained that for the past 9 months or so, not only had the ability to be aroused and have some pleasure disappeared, but she had become frankly aversive to any type of sexual touch or initiation. The circumstances within the extended family had deteriorated. The daughter had gone through a bitter divorce, and there was fierce fighting over the custody of the two granddaughters. Valerie and Paul had been completely unable to set any boundaries, with the result that phone calls from the daughter occurred more than daily. Despite the stressors, Valerie's depression was under reasonable control.

Seeing Valerie alone, some of her past was discussed. Her parents divorced when she was 8 and she had never felt loved by either parent. Thus she had become very independent and, indeed, left her mother's house at the age of 16 to finish her education. She lived in cramped quarters with an older sister who had troubles of her own. The theme she mentioned from that time onward was her determination never to be dependant on anyone. Her first sexual experiences as an older teen were not memorable but were not coercive or abusive. Sexual experiences in the first marriage were somewhat mechanical, fairly quickly becoming a matter of rather perfunctory intercourse once or twice on weekends. However, her body and mind had been responsive, at least until the marriage became troubled and sex ceased. Self-stimulation had never been an important aspect of Valerie's sexuality. Currently, Valerie admitted that she was extremely angry regarding the battles over the custody of the grandchildren and seeing them suffer. This brought back the anger she had toward her own parents. Valerie

also accepted that in order to control a very strong emotion, such as anger, one sometimes has to suppress other emotions, including sexual emotions. Valerie also spoke of the only guidance about sex that she had ever received from her mother—namely "sex is the only thing men want." The rather unrewarding sex in her first marriage had done little to dispel this theme and currently, although clearly Paul was a far more considerate, supportive, and affectionate man than her first husband, he was now nevertheless wanting sex when she was aversive—and the old theme was back in her mind.

When seen alone, Paul recalled desire discrepancy in his own first marriage. The couple had been very close in many ways and when his first wife died he had felt guilty and sad that their one area of discontent had been his greater sexual appetite, feeling he could have made her happier if he had asked less often. Now he was alarmed to find that Valerie was not simply less interested than he, but that she was speaking of no desire at all and she was not aroused on the infrequent occasions that they were sexual.

Valerie wanted Paul to understand her situation, so she shared with Paul some feedback. He learned that the current situation with the granddaughters and the desire discrepancy between her and Paul both echoed themes from her past. As a result, both partners agreed that only affectionate hugging would occur for the next few months while Valerie received a few sessions of psychotherapy focusing on her childhood, on the "loss" of both parents at age 8, the lack of reliability of other people, including relatives, and messages from her mother about men and sex. Both partners received advice about setting boundaries to limit intrusive calls from Paul's daughter. Valerie was able to work through many of her negative feelings for her parents, and after that she found that gentle sexual play without any goal was positive and comforting. Valerie was encouraged to take the lead in any increase in intensity of sexual experiences that might include orgasms or intercourse. Some months later, these activities were again enjoyed. When Valerie became aroused, this triggered desire.

The couple returned in 2005. Valerie again did not want sexual interaction, and she feared some of the old feelings of aversion were returning. Neither exacerbation of her depression nor the problems within the extended family were obvious as a cause. Paul said very little during the interview. A second visit was planned to see each partner separately.

Seeing Paul, I was saddened to note subtle but definite cognitive changes. He went on to tell me that he was being tested for dementia. He was extremely worried about what this would mean in terms of his work and, of course, in terms of his own and his and Valerie's future. Sex for him was even more important now. He saw it as a potential source of solace, comfort, and reassurance about himself.

When seen alone, Valerie was once more haunted by "that's all men want" as she faced Paul's sexual neediness amidst his forgetfulness and

lack of confidence and the role change in their marriage. Valerie felt that her taking control of their sexual interaction might again help her feel less aversive. She was very motivated to help Paul have at least one area of his life that was rewarding. We discussed again how there are many reasons and incentives for being sexual, and Valerie genuinely wanted to please her partner. However, it was again necessary to discover what would be necessary to make the experience positive for Valerie. Valerie spoke of her awareness that becoming subjectively aroused or not in some ways was under her control. She knew she could deliberately think positive or think negative as arousal began. Paul was very aware that his sexual engagement with Valerie without her enjoyment was not something he wanted. He said he was more than willing to allow her to take the lead again. This, again, removed Valerie's feelings of aversion and enabled her to have positive thoughts while the couple engaged in low-key sexual play, appreciating that they had learned many ways to pleasure each other when times were easier.

Clearly, the fear was that with future potential loss of insight, Paul's attitude might change such that he would request sex at times when Valerie was coping less well with his cognitive loss and with the return of her old feelings of aversion. The prognosis was therefore extremely guarded.

Discussion of the Case

Their first 5 years together provided rewarding experiences for Valerie in keeping with contemporary knowledge of women's sexuality: the newness of their relationship, their marked emotional closeness, good mental and physical health, Paul's sexual health, and positive expectations of their relationship. As is commonly the case, desire and arousal diminished with recurrence of a mood disorder. At this time also, the relationship was no longer new. Biological factors, namely depression and reduced adrenal prohormone production, were reducing her arousability, such that Valerie was vulnerable to the sexually negative effects of preoccupying distractions regarding the extended family.

Mood disorder was one risk factor but others were present in Valerie's developmental history. Temporarily dispelled by Valerie's own enjoyable experiences with Paul, the edict "sex is all men want" may have at least in part caused her lack of desire to be experienced as aversion. Valerie had never directed her anger to her parents for their lack of love and their emotional neglect. Those memories were revived as the situation was repeated with Paul's granddaughters. It seemed that the more strongly Valerie needed to suppress this anger, the more strongly other (sexual) emotions were suppressed.

Valerie and Paul's case illustrates the compounding of biological and psychological factors including depression, serotonergic medications, dis-

tractions, feeling used, and lowered sexual self-image from weight gain. Interestingly, reducing her weight was associated with improved sexual response although it would have been associated with reduction of bioavailable testosterone. This is partly because sex hormone-binding globulin, which binds testosterone, making it unavailable to the tissues, is abnormally low in obesity and increases with weight reduction.

Also illustrated is the current clinical dilemma regarding hormonal therapy in older women. If dysfunction is diagnosed as being based on estrogen and/or testosterone deficiency, then therapy is presumably long term. However, we lack sufficient safety data on long-term therapy for women's sexual dysfunction initiated around menopause. The Women's Health Initiative study was not focused on women with sexual dysfunction but rather on normative women recruited into the trial at average age 63. No sexual benefits were recorded in that study. There are essentially no long-term safety data on testosterone supplementation but there is growing concern about repeated findings of an association between high endogenous androgen and risk, both of metabolic syndrome (Santoro et al., 2005) and increased incidence of breast cancer (Hankinson et al., 1999; Key et al., 2002).

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CHAPTER 3

Persistent Genital Arousal Disorder

Perplexing, Distressing, and Underrecognized

SANDRA R. LEIBLUM

Persistent genital arousal disorder (PGAD) is an unusual, perplexing, and troubling condition that has only recently been recognized, described, and diagnosed. It refers to a condition of unsolicited genital arousal that perseveres for hours or days despite the absence of sexual desire or sexual stimulation. It may lead to one or multiple orgasms (whether self-, partner-, or even spontaneously induced), which provide only temporary relief. The feelings of genital arousal persist, often without sexual thoughts or fantasies, without warning and without being provoked in any obvious way. The sensations of arousal are usually experienced as extremely distressing and worrisome.

There is a dearth of research and few references about persistent genital arousal. In the past, women were reluctant or embarrassed to even describe the condition to their physicians. However, as a result of more openness about sexuality generally, and greater media attention, more women are acknowledging this troubling problem. Prevalence rates are unknown.

Although we now refer to the condition as persistent genital arousal disorder (PGAD), the condition was originally named persistent sexual arousal syndrome (PSAS) (Leiblum & Nathan, 2001). We now recognize that although the troubling sensations are experienced genitally, they are qualitatively different from the sensations associated with the gradual build-up of feelings that occur with genuine sexual arousal. However, throughout this chapter, both terms, PSAS and PGAD, are at times used interchangeably.

This chapter provides an overview of the various presentations of PGAD, theo-

ries of etiology, descriptive features, the role of medications in triggering or ameliorating the condition, and three case examples. Since there is such uncertainty about etiology, no single treatment can be recommended and evidence-based research about all aspects of the condition is much needed. The chapter concludes with a plea for caution since women experiencing PGAD are desperate for relief and are vulnerable to any intervention that sounds reasonable. While new interventions must be explored, it is important to have a clear rationale and follow-up since placebo effects are quite likely. PGAD is a problem that clearly demands an integrated, interdisciplinary, and collaborative treatment approach.

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Most female sexual complaints involve a deficiency or absence of some sexual response—a lack of sexual desire, too little vaginal moistness or lubrication, too few genital sensations, an inability to experience orgasm or too muted orgasms, too little sexual pleasure. But there also exists a perplexing condition in which the woman's major complaint centers on "too much" response, and the response is unremitting genital arousal in the absence of conscious feelings of sexual desire. As noted in the introductory section, this condition has been called persistent sexual arousal syndrome (PSAS), although it may more accurately be termed *persistent genital arousal disorder* (PGAD).

Women who complain of PGAD are quite diverse in presentation—they may be young or old, heterosexual or homosexual, married or single, premenopausal, perimenopausal, or postmenopausal. However, they are alike in that their major complaint centers on the sensations of insistent and persistent feelings of vaginal vasocongestion and other physical signs of sexual arousal in the absence of any initial or deliberate attempt to invoke either desire or arousal. Their sensations of genital arousal usually lead to attempts to satisfy or quell the arousal—either alone or via partner stimulation. However, despite deliberate genital stimulation and the experience of one or multiple orgasms, the feelings of arousal persist—sometimes for hours, sometimes for days, sometimes for years. It is this aspect of the condition that makes it so mysterious, distracting and, ultimately, distressing.

For some few women, the sensations of unexpected but intermittent or even mildly persistent genital arousal are a diversion and occasionally,

even reassuring. For instance, one woman writes, "I live happily with this state of being. It's rather like tinnitus to me . . . while initially, I found it so distracting, it drove me mad, I had medical help in refocusing because it is not curable and I have learned to live with it." However, for the vast majority of women, the feelings of unremitting and insistent genital sensations are worrisome and extremely distressing. In some cases, women describe feeling suicidal because of the lack of relief. For instance, one 71-year-old woman said, "It's just a horror; it bothers me more than breast cancer because it never stops, it never lets up, and it ruins everything, including riding in a car, seeing friends, or simply sitting still. It colors your whole life." Another younger woman said, "This is an unimaginably miserable affliction and the total lack of success in treatments despite time, effort, money, and misery only adds to the feelings of fear, anger, and frustration." These sentiments are echoed by many of the women who experience the sensations.

Compounding the injury is the anticipation of embarrassment or humiliation that women feel about admitting or describing their condition to physicians or even to partners. These fears are not unjustified since many women do hear dismissive or insulting comments when they consult their physicians. One woman's gynecologist cavalierly commented, "Don't worry . . . you're every man's dream," an insensitive comment that completely ignored the physically and psychologically distressing nature of her complaint. A psychiatrist suggested to another woman who reported these feelings, "You're sexually repressed. You should try homosexuality." Other doctors simply dismiss or bypass the complaint entirely because they have never heard of the condition and have no idea what to recommend.

The embarrassment and fear of ridicule that women feel or anticipate feeling about disclosing this problem to their physicians is, perhaps, one of the major reasons that the existence of this condition has gone unrecognized for so long and very likely, continues to remain underreported. There are no figures available on the actual prevalence of PGAD as a worrisome condition since it was not even identified until recently. However, in the last several years it has been described and discussed in magazine articles, television programs, and Internet support groups with the result that more women are admitting that they have or once had this complaint.

DISTINGUISHING FEATURES OF PGAD

Leiblum and Nathan (2001, 2002) first named and described the condition after having encountered several women presenting with bothersome persistent and unprovoked genital sensations that appeared mysteriously and felt distressing.

When conferring about their cases, Leiblum and Nathan were sur-

prised to find a similar set of descriptive features. They named the condition "persistent sexual arousal syndrome" since, at first glance, the complaint appeared to be *sexual*, although the condition was primarily one of *genital* arousal, in the absence of desire. A priori, they identified five descriptive features based on presenting complaints of the women whom they had seen (Leiblum & Nathan, 2001):

- The physiological responses characteristic of sexual arousal (genital and breast vasocongestion and sensitivity) persist for an extended period (hours to days), and do not subside completely on their own.
- The signs of physiological arousal do not resolve with ordinary orgasmic experience, and may require multiple orgasms over hours or days to remit.
- These physiological signs of arousal are usually experienced as unrelated to any subjective sense of sexual excitement or desire.
- The persistent sexual arousal may be triggered not only by sexual activity, but also by seemingly nonsexual stimuli or no apparent stimulus at all.
- The physiological signs of persistent arousal are experienced as uninvited, intrusive, and unwanted.

Since the original description of PGAD in 2001, several women have identified yet another characteristic of the disorder—intense, spontaneous orgasms that occur without any apparent provocation or deliberate stimulation. These orgasms can be surprising and disturbing for the women who experience them.

DIFFERENCE BETWEEN HYPERSEXUALITY AND PERSISTENT SEXUAL AROUSAL

While persistent genital arousal may seem to resemble what is sometimes termed "hypersexuality" (Montaldi, 2002) or sexual compulsivity, it is actually quite different. Although not a common complaint in women, there are some individuals who describe strong, insistent, and frequent feelings of sexual desire that are accompanied by, or lead to, insistent and/or intrusive sexual fantasies/thoughts and high frequencies of masturbation and/or other sexual behaviors (see Kafka, Chapter 15, this volume, on nonparaphilic hypersexuality). Usually, the sexual experiences that result are perceived as pleasurable even though they may be followed by guilt or recrimination. Hypersexuality has been noted as an occasional symptom associated with various psychiatric or pathological neurological conditions or as a side effect of some of the drugs used to treat such disorders (e.g.,

levodopa). However, hypersexuality differs from persistent genital arousal in that hypersexuality refers to *excessive feelings of sexual desire with or without persistent genital arousal* while persistent genital arousal refers to *physiological genital sensations in the absence of conscious sexual desire*. Women complaining of persistent genital arousal cannot readily identify any obvious trigger for their feelings of genital vasocongestion or tingling sensations and worry that there might be a worrisome or dangerous physical condition responsible for their genital sensations such as a brain tumor or some neural pathology. Moreover, women with hypersexual feelings generally feel satisfied once they have experienced an orgasm, whereas women with PGAD typically do not. Finally, hypersexual women, if they complain at all to their physician, complain of mental preoccupation with sex, while women with PGAD complain of disturbing, intrusive genital sensations that will not abate.

TRIGGERS FOR PGAD

The woman with PGAD is typically unable to identify any precipitant with absolute certainty although many women have hypotheses as to the original cause of their sensations. Some sufferers attribute the onset of persistent genital arousal to the initiation, increase, or discontinuation of a particular type of medication such as norepinephrine/dopamine reuptake inhibitors (NRI/DRIs) and/or selective serotonin reuptake inhibitors (SSRIs), hormone replacement therapies, various surgical procedures (e.g., cesarean sections), or having engaged in an activity that placed insistent pressure on their genitals, such as cycling (Leiblum, Brown, & Wan, 2005). One woman described her persistent sexual arousal as a kind of "hormonal rape." She said that she knew "exactly" when it started—"when I had to increase my dosage of synthroid from .05 to .75, which, while still a small dose, is a very big jump all at once . . . I think it probably has to do with various systemic hormonal floods, triggered by the sudden increase of synthroid which might well have overstimulated my pituitary or adrenal glands."

Some women wonder if the sensations might be due to past sexual abuse or sexual excess (e.g., a belief that they engaged in excessive masturbation as a child or young adult). One woman commented:

> "As far back as I can remember, I had this problem but I always believed it came from my early and excessive masturbation. To be honest, I don't know which came first—my arousal or my masturbation. As years have passed, I have been able to cut back on the masturbation to about twice a day during a good period. This still just seems to

> take the edge off. During bad periods I don't know what triggers it, but I don't think it is anything physical. I can masturbate five times that day and still have intercourse to try to take the pressure away. Over the years, I have fractured or chipped my pubic bone in efforts to get relief."

Other women are convinced that their PGAD initially developed as a result of a pelvic injury or a physical insult such as neurological damage. For example, one woman said, "I have the sense that a nerve or nerves have been damaged or are being compressed as a result of surgery. I have read about pudendal neuropathy and most of my symptoms seem to point in that direction." Other women feel that irrespective of the original trigger, their symptoms seem to wax and wane with psychological stress or heightened anxiety. A few women have commented that feeling sexually thwarted or deprived leads to strong genital feelings of arousal. With only a few exceptions, the etiology of PGAD has yet to be determined, although there are many theories, which will be discussed shortly. Moreover, it is likely that there are a variety of paths that lead to the symptom complex. It seems clear, as well, that there is a mind–body interaction and that the hypervigilance to genital sensations exacerbates the condition.

SIMILARITIES BETWEEN PERSISTENT SEXUAL AROUSAL AND VULVODYNIA

In many respects, PGAD is similar to vulvodynia. Both problems may be viewed as medical conditions characterized by a diverse spectrum of etiologies and presentations. Like vulvodynia, little is known with any certainty about the causes or risk factors for the sudden emergence of PGAD. As with vulvodynia, women suffer for weeks or even years before consulting a physician. When they do, their concerns are typically minimized or dismissed. Often, women are referred to a mental health clinician, suggesting that the physician considers the complaint to be "in their head" or psychologically based. While chronic vaginal infections, trauma, or irritation have been identified in some cases of vulvodynia, the majority of cases appear to be *idiopathic*, that is, of uncertain origin. A similar situation exists with PGAD. Like vulvar vestibulitis syndrome (VVS), PGAD is experienced as highly distressing and emotionally consuming. With both syndromes, there is no agreed-upon efficacious treatment. Rather, everything from dietary modifications to topical anesthetizing agents is prescribed along with every imaginable SSRI or dopaminergic medication. At this time, none have proven reliably effective for all women, although some are effective for some women. Finally, there is a genuine question as to whether either

vulvodynia or persistent genital arousal should be diagnosed as a sexual disorder. Binik and his colleagues (Chapter 5) regard dyspareunia and vulvodynia as pain disorders rather than sexual disorders, and there is a similar rationale for viewing PGAD as a neurological condition rather than as a sexual problem per se. Nevertheless, it is undeniable that both vulvodynia and PGAD often have a negative impact on a woman's sexual life and intimate relationships.

SIMILARITIES BETWEEN PGAD IN WOMEN AND PRIAPISM IN MEN

Goldstein, De, and Johnson (2006) have suggested that PGAD in women is reminiscent of priapism in men. In males, priapism refers to a pathological condition of peripheral genital arousal that persists beyond or is unrelated to sexual stimulation (Goldstein et al., 2006). "Clitoral priapism" may be the analogous condition in women. However, unlike clitoral priapism, persistent genital arousal is not acute and painful, but rather chronic and continuous or recurrent. Goldstein et al. (2006) suggest that PGAD is similar to two rare but identified forms of male priapism. One type is called *high flow, arterial priapism*, an inability to regulate physiologic arterial inflow to the corporal cavernosal bodies. In men, it has been associated with blunt or penetrating perineal trauma or pelvic arterial-venous malformations (Pryor et al., 2004). Goldstein et al. (2006) note that in the condition of high-flow priapism, the physical state of abnormally high arousal is persistent and unrelated to feelings of pain or sexual desire. The other form of priapism is termed "stuttering or recurrent" priapism. Goldstein et al. (2006) describe this condition as one of repeated episodes of unwanted genital arousal that may or may not result in ischemic, low-flow priapism. Stuttering priapism is typically associated with sickle cell disease and may occur in men who experience "recurrent idiopathic prolonged erections." The condition is one of unrelenting genital smooth muscle relaxation which eventually progresses to permanent erectile dysfunction. However, for some men, ischemic low-flow priapism has resulted in stuttering or recurrent priapism. According to Goldstein et al. (2006), "One hypothesis to explain this unusual sequela of tissue ischemia is that the damage interferes with the biochemistry of contraction, resulting in a tendency to recurrent genital arousal. Unfortunately, there is limited research on this topic" (p. 5).

To date, there is no published literature supporting these hypotheses. However, it is noteworthy that with the publication and dissemination of articles about PGAD in women, several men have come forward complaining that they, too, suffer from this problem. It is conceivable that they are experiencing what Goldstein and colleagues have described as high-flow arterial or stuttering priapism.

PHENOMENOLOGICAL EXPERIENCE OF PGAD

Women with PGAD state that although their genital vasocongestion appears without any obvious sexual precipitant and without conscious feelings of sexual desire or interest, it often leads to some type of sexual behavior in an effort to quell the arousal. Most often, the woman engages in repeated masturbatory attempts with the hope that one or more orgasms will dissipate the genital arousal. For some women, a specific number of orgasms are needed to provide even a temporary waning of arousal. For instance, one woman noted, "I masturbate once a week and have to have at least seven orgasms to feel relief." Over time, however, women report that it becomes more difficult to achieve orgasm and masturbation only heightens the feelings of genital arousal. As one 63-year-old noted, "At first it was relieved by easily achieved orgasm(s) for a few hours . . . now I know that if I try to relieve it, it just comes back and I might just make it worse!"

PROVISIONAL DIAGNOSIS OF PSAS

In 2003, PSAS was included as a provisional diagnosis by an international committee of experts convened to recommend revisions in the nomenclature of women's sexual dysfunctions (Basson et al., 2003). The disorder was defined as follows:

> Spontaneous, intrusive and unwanted genital arousal (e.g., tingling, throbbing, pulsating) in the absence of sexual interest and desire. Any awareness of subjective arousal is typically but not invariably unpleasant. The arousal is unrelieved by one or more orgasms and the feelings of arousal persist for hours or days.

Furthermore, as with the other female sexual dysfunctions, a diagnosis of PGAD should only be given if the woman reports subjective distress about the condition.

To date, there have been only a handful of research studies on persistent arousal. Recently, we undertook the first large-scale pilot Internet survey to determine whether the original descriptive features would be endorsed by women and to see whether any triggers or treatments could be identified (Leiblum et al., 2005). A 46-item questionnaire was posted on three Internet sites related to women's sexual health. The survey included demographic questions, medical and sexual history, questions related to the experience of persistent genial arousal, triggers of arousal, and treatment interventions and advice received from physicians. The original study was based on responses from 103 women (at this time, nearly 500 surveys

have been returned worldwide). The majority of respondents were all in relatively good health, well educated, and in long-term relationships. Some women describe their sexual orientation as heterosexual while a distinct minority self-identify as bisexual or homosexual.

The results supported several of the initial observations about the condition. For example, although the original description of five features identifying persistent sexual arousal was based on a small handful of cases, results from the Internet survey revealed that 98% of the women who took the survey endorsed at least one feature of the syndrome and 53% endorsed all five criteria, suggesting that the original description of the condition was recognized and replicable. Involuntary genital and clitoral arousal persisting for extended time periods, genital arousal unrelated to subjective feelings of sexual desire, and genital arousal not relieved with orgasms were the most frequently endorsed features.

When asked what stimulated the sensations of genital arousal, women described a host of varying triggers, some physical, some psychological:

- "Persistent sexual arousal began a few weeks after my cesarean section."
- "I alternated between bupropion (Zyban) and paroxetine (Paxil) and believe my PSAS started while on Zyban as a rebound effect."
- "Despite taking antidepressants, having had surgery to repair the clitoris, etc., there was no apparent trigger for the more bothersome symptoms I'm experiencing. I did have an increase in sexual interest following a discussion of sex in marriage in a class I was taking—however the actual PSAS symptoms seemed to come on without any trigger. They have been constant and there is no apparent trigger for them now—they just persist and orgasm does not relieve them for more than an hour (more often, not at all)."
- "Beginning of PSAS coincided with cessation of periods."
- "Originally started following ectopic pregnancy and subsequent pregnancy with second child."
- "Persistent yeast infections."
- "The original cause, I think, was the accident and injury to my pelvis that I suffered in the summer of 2002. The first time I experienced PSAS was after masturbation a couple of weeks after my injury, which was also the first time I had done anything sexual."
- "Switching to different antidepressants."
- "Possible original trigger—receiving many enemas as a child for years? Another possible cause—undiagnosed problem with calcium metabolism?"

Overall, the respondents identified the following as additional triggers: intense sexual stimulation by self or partner, terminating or beginning

a particular medication or hormonal regimen, emotional stress and anxiety.

Sixty-three percent of respondents reported at least moderate distress as a result of their persistent feelings of genital congestion while 19% reported extreme distress. The strongest predictors of distress were intrusive and unwanted feelings of genital arousal ($p < .0001$), continuous symptoms ($p <. 001$), feelings of unhappiness ($p < .03$), shame ($p = .0001$) and worry ($p = .01$), reduced sexual satisfaction ($p < .004$), enjoyment of symptoms some of the time ($p = .01$), and relationship status ($p < .004$).

While these results are of interest, they neither account for nor suggest ways of treating the condition. More research is clearly needed.

A recent investigation (Brown et al., 2005) explored the sexual functioning of 45 women with PSAS compared to 152 women with female sexual arousal disorder and 244 healthy control women using the Female Sexual Function Inventory (FSFI; Rosen et al., 2000). Women with PGAD scored significantly *lower* on the total FSFI scale and on the desire, arousal, lubrication, and orgasm subscales suggesting *reduced overall sexual functioning and less satisfaction than the normal controls*. They reported more desire, arousal, lubrication, and orgasm than women with female sexual arousal disorder.

CURRENT ETIOLOGICAL THEORIES

At present, there is no consensus regarding etiology. The following major etiological possibilities are currently under investigation: (1) central and/or peripheral neurological changes (e.g., head injuries, specific brain lesion anomalies, seizure disorders, pelvic or pudendal nerve hypersensitivity or entrapment); (2) medications (initiation or discontinuation of SSRIs or SNRIs or other pharmaceutical or over-the-counter products); (3) psychological vulnerabilities (e.g., past history of sexual abuse, major stress); or some combination of all three. Many cases appear to be idiopathic and no definite etiology can be determined even after a thorough and comprehensive history is taken. And sometimes, there is the assumption of etiology in the absence of definitive data. For example, a case study was recently published in which PGAD appeared to be associated with increased intake of soy products and symptom alleviation was presumed to be due to the effect of reducing dietary phytoestrogens (Amsterdam et al., 2005). While this example is suggestive, it seems unlikely that many cases of PGAD will be successfully treated with dietary modification.

In some instances, an identifiable physical cause has been determined. For instance, Goldstein et al. (2006) describe four women whose PSAS appeared secondary to central neurologic pathophysiology, for example, following neurosurgical intervention for arteriovenous malformation, fol-

lowing a cerebrovascular accident, after discontinuing estrogens, and after discontinuing a cholesterol-lowering agent. One case of PGAD resulted from a rare vascular condition, namely, a pelvic arteriovenous malformation with multiple branches feeding the clitoral corporal bodies. Following a series of embolizations, the PGAD was resolved.

It is likely that there are several subtypes of persistent genital arousal, some of which are more related to physical or neurological causes, and others to more psychological etiologies. For instance, certain sexually related words appeared to be a trigger for one 23-year-old woman. She reported that her arousal "operates at a subliminal level at times so that while there seems to be no cause, there actually is." She went on to say that once when she was listening to a lecture about the social behavior of monkeys, "a strong feeling of arousal intruded and interfered with my concentration. I realized on reflection that the arousal started when the lecturer made a passing remark about the sex of the monkeys. It was just that word that triggered it." She also noted that anxiety triggered her arousal and that the ensuing pelvic tension would become unbearable. For this young woman, the feelings of arousal were constant, and "waves of orgasm-like (without the contractions) feelings would flood me. . . . I would feel physically hot; my knees would sometimes go weak and it seemed to interfere with my consciousness of what was going on around me for the duration of the feeling."

For other women, the condition seems to be pharmacologically induced. Trazodone, for example, has been implicated for some women. In men, trazodone can lead to prolonged penile erections, especially nocturnal erections. While the exact mechanism is unknown, it is speculated that the genital arousal is due to trazodone's alpha-adrenergic and serotonin-blocking activity. In men, this can result in the persistence of smooth muscle relaxation, causing erection or, in women, perhaps a condition of clitoral priapism (Medina, 2004; Pescatori, Engelman, Davis, & Goldstein, 1993). If the trazodone is used for extended periods of time, it is conceivable that it may foster a condition of persistent genital arousal although there are few published studies on this phenomenon. Goldstein et al. (2006) noted that two women had symptomatic relief when the use of trazodone for sleep difficulties was discontinued.

SSRIs AND PGAD

Several physicians and PGAD sufferers have suggested that there might be a relationship between PGAD symptoms and the use of SSRIs such as paroxetine (Paxil), fluvoxamine (Zoloft), citalopram (Celexa), or fluoxetine (Prozac), or SNRIs such as venlafaxine (Effexor) or duloxetine (Cymbalata). There is speculation that associates PGAD with both the start and also

with the discontinuation of these drugs (see *Journal of Sexual Medicine*, 2005).

Sexual response is certainly influenced by serotonin although data are conflicting as to whether it serves primarily as an inhibitory, excitatory, or mixed agent. It may depend on which receptor subtype is stimulated. Although the incidence of sexual side effects associated with the use of SSRIs is quite high (30–40%), delayed rather than enhanced arousal and orgasms are typically reported. This is not surprising since SSRIs block nitric oxide (NO), decreasing smooth muscle relaxation and inhibiting genital blood flow (as opposed to a PDE5 inhibitor like sildenafil [Viagra], which increases NO levels by inhibiting phosphodiesterase type 5 enzyme [PDE5]), thereby enhancing arousal and the likelihood of orgasm. However, some psychiatrists have suggested that if pudendal nerve irritation is the cause of the persistent genital arousal, the use of SNRIs such as Effexor XR or Cymbalta or antiseizure medications such as valproic acid (Depakote) may be helpful (personal communication, Saks, 2005).

A few case reports have been published reporting clitoral engorgement and spontaneous orgasms with the use of Prozac (Modell, 1989). In one published case study, a 30-year-old woman described clitoral engorgement, multiple spontaneous orgasms, and yawning when she was started on fluoxetine for the treatment of depression. These reactions stopped when she discontinued the medication. Of special interest was the fact that her clitoral engorgement lasted several hours each day and her sexual sensations persisted in spite of masturbation or intercourse. Her symptoms sound quite similar to PGAD in that they were not associated with vaginal lubrication or feelings of sexual desire. It is possible that these sensations were secondary to the acute increase in central serotonin neuronal activity.

Many of the women in the Internet survey described earlier did associate the onset of PGAD with beginning a new medication. For example, one 48-year-old woman reported having taken Effexor XR for severe clinical depression and prior to that, Prozac. When her dose of Effexor was cut back to 150 mg/day and Wellbutrin XL (bupropion) 150 mg was added to her treatment, she reported feeling more energetic and less depressed. When she abruptly stopped taking the Effexor because she ran out of pills, she reported feeling extremely aroused—so much so that she could not sit still because she constantly felt on the verge of orgasm. In describing her sensations, she says, "This is a completely different feeling from 'being horny'. It's like my body turned on the orgasm switch and I can't turn it off."

On the other hand, many women report some relief of their PSAS with the use of SSRIs. For example, one woman wrote, "I have had PSAS for 9 years, but I have noticed significant improvement from antidepressants, the best two being Paxil and clomipramine. I am currently on clomipramine. When *not* on these medications, my PSAS is out of control, but when on

medications, it is better tamed." Another woman, too, reported relief from PGAD following brain injury, when she was placed on Paxil.

It is certainly conceivable that PSAS may result from a rebound discontinuation syndrome of SSRI use, although SSRIs usually have short half-lives and are totally eliminated from the body in anywhere from 24 hours (Paxil) to 2 months (Prozac).

Some prescription drugs do appear helpful in alleviating the symptoms of PSAS. One woman noted, "My condition responded to Depakote and I am grateful." Another woman wrote, "My PSAS is much less severe than it was originally; however I don't know if that's because I am taking Lexapro (an SSRI) or because I had pudendal nerve decompression surgery." Still another woman reported considerable relief when placed on Neurontin (gabapentin).

Given that medications have been implicated in both the genesis and treatment of persistent genital arousal, a careful drug history—both past and current—is essential. Careful specification of the order of events (e.g., did the sensations of genital arousal precede or follow the initiation or termination of a particular medication?) is obviously of critical importance.

PUDENDAL NERVE ENTRAPMENT AND PGAD

While medications may trigger genital arousal in some women, for others the condition appears related to pelvic muscular changes or pelvic nerve hypersensitivity. These conditions may cause blood to become "entrapped" in the pelvic region. The pudendal nerve as well as the other nerves innervating the female pelvis (the ilioinguinal nerve, the genitofemoral nerve, and the iliohypogastic nerve) may be implicated. When blood becomes trapped in the genital area and/or there is a resulting condition of hypertonicity of the pelvic muscles, tremors or feelings of pressure in the genital area may result which may contribute to, or cause, feelings of sexual arousal.

The feelings of arousal may not dissipate with masturbation or partner stimulation because the fascia surrounding the nerves trap the blood, thereby maintaining high levels of arousal despite one or many orgasms. *In fact, the more insistent the attempts to relieve the congestion either by oneself or with a partner, the more insistent or more continuous are the feelings of genital arousal.* This theory was proposed by Peters (personal communication, 2003).

Stein (personal communication, 2004) suggests that persistent engorgement of the pelvic erectile and vascular tissues may lead to chronic stimulation of the pelvic nerve endings and result in low-grade continuous symptoms of sexual arousal. He suggests that such a syndrome might be common in women who have sustained multiple childbirth experiences or

deliveries over 7 pounds or who have either a family or personal history of varicose veins; documented pelvic varicosities in the broad ligaments on laparoscopy; rapid or precipitous childbirth as a result of weak pelvic floor muscles; pelvic relaxation syndrome; cystocele or rectocele; urinary stress incontinence; or uterine prolapse. The resulting treatment recommendations include strengthening the pelvic floor muscles through isotonic exercises in order to strengthen the resting tone and mass of the pelvic floor, which might be compressing the adjacent venous structures. As yet, there is no empirical research supporting these speculations.

In summary, at this time, it appears that PGAD is a multifactorial disorder with varying etiologies. For different women, physical, pharmacological, and psychological contributions interact in different ways and exist to varying degrees so that the triggers for the condition are difficult to determine with any certainty. Moreover, it is possible that the factors currently maintaining the condition may be quite different from the factors initially giving rise to it.

What follow are descriptions of three cases, one unsuccessful, one with mixed outcome, and the third successful. In the first, the client underwent a variety of medical and psychotherapeutic interventions to eliminate her condition but was ultimately unsuccessful. In the second, the woman struggled with the condition for years and consulted one physician after another searching for a diagnosis. She explored every treatment avenue, eventually finding some relief with psychotherapy. The final case describes a situation in which the sufferer undertook a carefully researched and observed self-management program to investigate the likely causes of her condition. As a result of many and diverse interventions and by dint of careful observation, she was eventually successful in what she called "taming the dragon."

CASE ILLUSTRATION: UNSUCCESSFUL RESOLUTION OF PSAS

At a recent meeting of the Society of Sex Therapy and Research, Whitcup (2004) presented a case of PSAS with the subtitle "PSAS: Understanding the Mystery of a Body in Rebellion." The patient was a 46-year-old professional married woman with two children who reported that her symptoms of PSAS began with her first pregnancy 10 years earlier. She was the middle of three children who grew up in what she described as an overly sexualized household. She reported that her mother never wore underwear while her father walked around in suggestive briefs. Family life tended to center in the parents' bedroom, where the family bed became the dining table, the homework space, the recreational space, and so on, and where her mother, an overly intrusive and needy woman, dominated the family. The patient had an antagonistic relationship with her mother—she believed her mother

preferred her sisters to herself. As a child and adolescent, she recalls becoming "hypersensitive" to eating and sexual sounds, saying, "I would feel it in my genitals." The patient reported little privacy growing up and often feeling angry with her mother. She tended to hold in her feelings.

She attended college and graduate school, marrying in her 20s. Her sexual relationship with her husband is good. It was during her first pregnancy that she developed the symptoms of PSAS, which, once started, never completely resolved. While there were periods when her genital arousal was more or less intrusive, it never completely disappeared. The client reported that she typically required four to six orgasms to relieve the congestion and that this was necessary every 4–5 days (even if there was no obvious trigger for the arousal). Moreover, self-stimulation might occupy from 4 to 6 hours of private time. If she chose to relieve her feelings of genital arousal by engaging in intercourse with her husband, she often experienced a burning sensation when it was over.

The patient admitted that one of her triggers was the fantasy of her mother or actual telephone contact with her mother. Other "triggers" included the sound of chewing or her mother's voice (aural triggers), the sight of her mother's tongue or even her mother's phone number on her caller ID, and occasionally, speaking to, or hearing from, her sister.

Since the PSAS in this case clearly seemed to be of psychological origin (due to the mostly "mother" triggers that precipitated the arousal), the patient underwent several years of psychotherapy from two experienced clinicians as well as complete laboratory and medical evaluations. None of the hormonal data revealed anything anomalous. Collaboration with a psychopharmacologist suggested a perservative quality to her symptoms, indicative of anxiety. Consequently, an SSRI (Paxil) was prescribed, which reduced the number of orgasms required for relief but often lengthened the amount of time needed to achieve even one orgasm.

The psychotherapy she underwent was basically psychodynamic in orientation but included several behavioral interventions, such as, relaxation and visualization exercises, practicing kegel exercises as a means to relax an overactive pubococcygeus muscle, perhaps in spasm, visually constructing a "container" in which to imaginatively place her mother when she seemed to invade the intimate space (the image included a box at the bottom of the ocean with three padlocks to seal it off), and even two sessions of eye movement desensitization and reprocessing (EMDR) (Shapiro, 2001). This latter intervention was particularly difficult for the patient since she was so anxious and mistrustful that she was unable to allow herself to recall (and stay with) specific unpleasant memories from the past.

Given that the patient's symptoms began with pregnancy and the attendant hormonal changes and given the client's obsessive anxiety-driven personality, Whitcup (personal communication, 2005) postulated that the PSAS was the patient's response to early family-of-origin issues as well as exposure to a provocative, stimulating dynamic between the patient's par-

ents, including rage for having sexualized her early developmental years. Noting that there were many unresolved mother–daughter issues that conceivably might explain the PSAS, including extraordinary boundary violations and enmeshment, these were focused on in treatment. Whitcup (2004) wondered if the patient's anger at her mother might have unconsciously produced a symptom that necessitated keeping the mother at some distance although paradoxically keeping her mother "in bed with her" during sex, thereby maintaining her mother's loyalty. Moreover, it was speculated that the patient's sensitivity to sounds—her mother's voice or the sound of chewing—might be activating some kind of early (sexual) "trauma." However, despite two years of therapy, treatment did not really resolve the problem.

In describing this case, Whitcup (personal communication) now believes that the etiology is neurological rather than strictly psychological. She says, "I really think there is some kind of nerve damage that occurred when she was carrying her first child and was exacerbated with other pregnancies, almost like a pinched nerve. . . . Perhaps surgery is an option at some time in the future, although for now, the patient has stopped treatment, feeling discouraged."

This is not an atypical case. Often, despite thorough and careful medical and laboratory evaluations, even including MRIs, no precise physical cause for the PSAS can be determined. While there are often a host of psychological or dynamic factors that appear plausibly implicated in the genesis of the problem, psychological treatment alone has been found to have little or no efficacy (with the possible exception of stress reduction). Many women with persistent arousal report an onset with or following pregnancy. It is possible that the pressure exerted by the expanding uterus on the bladder or genital area might provoke a heightened awareness of genital tension, leading (unconsciously) to heightened muscle tension which then further exacerbates sexual sensations and the seeking of orgasmic relief in a recurring cycle.

CASE ILLUSTRATION: MIXED OUTCOME OF PGAD

Ms. J is a 52-year-old divorced woman, an effective and successful editor. She described the onset of symptoms as beginning 6 years earlier, describing her genital sensations as overpowering and completely distracting. She associated her condition with the following stressors, described as occurring at the same time as the onset of her genital arousal:

1. A compressed fifth cervical rib in my neck that caused *terrible* pain and multiple pressure points in the scapula shoulder area and at the base of my neck.
2. An employer who purposely became intimidating to try to get me to

quit because #1 above was work related. Work [had] always been my *safe refuge* from turmoil in my *personal life* and my employer threatening [me] caused more anxiety then I've ever known.

3. I went on an SSRI, Zoloft for the PTSD caused by the above. Within three months of starting the SSRI, PSAS began. Since Zoloft is currently in the throes of a class action law suit, I have a feeling that an adverse reaction to the chemical could also contribute to turning on a "switch" in the hypothalamus neurotransmitter of the brain that hasn't been turned back off, causing continuous sexual hyperactivity.
4. I believe the high anxiety and depression brought on by both #1 and #2 thrust me into menopause because PSAS started right at the same time as I went into menopause without warning.

While it is impossible to implicate any one of these stressors as the "cause" for the initial appearance of symptoms, this list highlights the fact that for many sufferers, there is often a multiplicity of events that appear to be implicated in the onset and maintenance of the condition.

Ms. J described being plagued by her sensations because she could not experience relief. She commented, "Whereas I had always been content with one orgasm, I now have a constant need for release. Immediately after an orgasm, [and] with no . . . thoughts of sex, my body begins pulsating intensely and persistently . . . my orgasms are far deeper and [more] exhilarating than usual. The constant need for release is relentless, with relief coming only while I sleep." She had come to believe that she was the only person in the world with this problem, and eventually resorted to the use of antidepressant medication. The problem made it difficult to get through the work day, and prevented her from leaving the house otherwise (personal communication, 2001).

Ms. J consulted a family physician, three gynecologists, a urologist, and a psychiatrist. None had ever heard such complaints. Her blood test results and hormone levels were within normal limits. A psychological history that was eventually undertaken did reveal early neglect, loss, and abandonment by her parents along with some suggestion of possible sexual abuse by an older male friend of the family. However, Ms. J. was initially disinclined to explore her early developmental history in any depth, and in fact reported relative amnesia regarding her early years. She sought medical explanations and treatments. In fact, during the previous 6 years, she was prescribed a variety of antianxiety and antidepressant drugs—including divalproex, sertraline, buspirone, and fluoxetine—without success. She even underwent an MRI, with normal results. She was totally disheartened by the failure to find a cause or cure and believed it was only her sense of humor and the support of her daughter and friends that kept her from succumbing to a genuine clinical depression.

Ms. J only recently began to experience relief from her PSAS, when

she discovered the writings of John Sarno and underwent mind–body therapy with an experienced clinician. This is what she says:

> "I recognized as soon as I read Sarno's books on TMS (Tension Myositis Syndrome; http://www.tmshelp.com/) that I hold an enormous amount of suppressed emotions and would need what he referred to as mind–body therapy. I have to admit that it really is helping. I have noticed that my PSAS is not as frequent or intense as it was before. It isn't gone, but I can sit, I can ride a train, and I can work all day without feeling the intense misery of throbbing in the clitoris or the need for release.
>
> "I also do not give myself relief every day as I used to before the therapy . . . partly because it is not as bad every day or night like it was, and partly because I try to abstain, either by staying up later and keeping busy so that when I go to bed I am too tired or when it flares up and is intense, if at home [by using], Soma muscle relaxers which calm it down and put me to sleep. I pay more attention as to what is going on when the flare-ups occur and it 'seems' to be due to some inner emotion I have suppressed but not always.
>
> "I've become aware that when something happens that increases my anxiety or anger or really has hurt my feelings PSAS flare-ups come on. I stop and figure out what the real deeper issue is and once I make that connection, I calm down and so does my PSAS. With the mind–body therapy the flare-ups are quite less frequent.
>
> "I *do* still have PSAS . . . but it is not nearly as intense as it was *most* of the time . . . but I have do have my moments."

This case suggests that (1) there are typically multiple triggers accounting for the initial PGAD "attack" and these are likely both medical and psychological (both recent and past history); and (2) treatment should ideally be directed at both the mind (stress reduction, psychological exploration) and body (interventions that diminish genital congestion or sensations, such as lidocaine, etc.).

The last case describes a successful outcome, due in large part to the diligence and determination of the woman experiencing the problem. She is an eloquent reporter and perceptive witness of her own condition.

CASE ILLUSTRATION: SUCCESSFUL OUTCOME OF PGAD

"I am a Caucasian woman, in my mid-50s; married with adult children. I experienced PGAD as a very distinct dynamic where seemingly unprovoked genital sensation leads to an uncontrollable process of physical

arousal, culminating in the irresistible urge to clear it by whatever means possible."

Background

"I came from a loving but unstable family which always seemed in a state of relational and geographic flux. My parents were always friends but were often separated; they divorced when I was in junior school and, at times, had other partners. They both moved location often and as an infant I had two significant periods of separation from them. Although I did not consider my childhood unhappy, it was not emotionally nurturing and, being introvert by nature, I chose to respond to it by being quiet, compliant, and desirous of pleasing. Good behavior was emphasized, freedom of thought was encouraged, but the emotional expression of it wasn't. Sex was never discussed, nor did it occur to me to seek to understand or experience it as I grew up.

"I married in my mid-20s and had no previous sexual experience, but my personal reactions to sexually provocative things led me to believe that I would not have any sexual difficulties. In practice, though, I found myself to be emotionally inhibited and lacking in physical sexual sensation including the ability to climax. Not knowing what could be done about this and, in a way typical of the manner I had come to handle life problems, I accommodated the difficulty and disappointment within myself. Not surprisingly this way of handling life problems took its toll. For months at a time I would experience emotionally and physically draining back and neck muscle tension that did not seem to be related to my generally pleasant life circumstances.

"By my early 30s the sense of harassment from this muscular distress had become intolerable and I finally decided to do something about it. The consequence of this decision was an ongoing commitment to a process of psychological discovery and recovery. This process also helped clear much of the stored distress about my sexual experience, so that sex was not emotionally unpleasant. Unfortunately, though, the recovery process did not remedy my paucity of sensory experience.

"In my late 40s, for reasons I mention below, I started taking an SSRI antidepressant (citalopram). I found great emotional benefit from this medication but it totally dampened what sexual interest and sensation I did have. This side effect of the medication, coupled with other serious work and family stressors on our relationship, resulted in a complete cessation of sexual activity with my husband.

"Eventually, increasing concern about the state of our marriage prompted me to discontinue the SSRI, which I had been taking by that time for almost 3 years. In trying to privately ascertain whether any 'feeling' was returning I discovered greatly heightened sensory responses including

the ability to climax. The emotional benefit from this new physical capability was enormous and I keenly embraced it. Unfortunately these newly discovered responses quickly became increasingly intrusive and would neither settle nor resolve. This heralded the beginning of my distressing experience of PGAD."

PGAD Triggers

"My PGAD symptoms began at the convergence of a number of potentially significant factors:

- Ceasing an antidepressant (citalopram)
- Beginning menopause (coincidental with the start of PGAD)
- Serious work-related burnout
- Sexual anxiety (motivating me to discontinue the antidepressant)
- Ongoing traumatic relational difficulties with one of our children
- Physical inactivity over a long period (especially sitting at the PC)

This makes it difficult to know if PGAD was triggered by one, some, or a blend of all.

"I have ADD [attention-deficit/hyperactivity disorder], a lifelong condition that was only recently diagnosed. The medication I started taking for it may possibly have been a factor in my PGAD. ADD is a condition associated with an imbalance in dopamine, a neurotransmitter that affects focus and attention. Six months after starting the SSRI, I started taking dexamphetamine, which works by boosting dopamine levels into the normal range.

"The potential connection between this and PGAD is that many factors in my own experience of PGAD are associated with dopamine levels and can be affected by fluctuations in them. Dopamine is associated with emotional pain-easing endorphin levels and physical levels of sexual responsiveness. It has a partnership with acetylcholine in affecting muscle tension and function (e.g., in Parkinson's disease) and a complementary relationship with serotonin.

"Perhaps the impact and interactions of both medications, coupled with significant levels of stress, facilitated a centrally mediated origin for PGAD. Nevertheless I attribute my current freedom from PGAD to a series of physical therapy processes that I undertook over a 6-month period and have since chosen to maintain."

My Experience of PGAD

"The first 10 months with PGAD were a nightmare. I was without medical knowledge or a physician that I could talk to—should I have known how

to express what was happening to me—but I was too embarrassed to discuss my situation with anyone at all. In my effort to clear the arousal it became clear that I had damaged an area near the clitoris. Ultimately, this led to a UTI [urinary tract infection] and forced me to seek medical help for that and the endless arousal.

"The doctors I saw were all considerate but unable to provide a diagnosis or satisfactory course of treatment. After I had poured out my story, one specialist tellingly said, 'Well, Mrs. D, I really don't know whether you need a gynecologist or a sex therapist.' Eventually I decided I would have to find my own answers and embarked on a course of study using texts from a medical library and articles from the Internet. It was searching the Net that led me to Dr. Leiblum's survey and associated article; this provided enormous encouragement to further pursue a solution.

"By this time I was already trying abstinence as a means of breaking what I supposed might be an 'addictive' dynamic operating in my physiology. Dr. Leiblum then suggested lidocaine and this provided my first significant symptom relief in 10 months of mostly unabated arousal. Shortly after, I experimented with a topical form of atropine after noticing for months that there was a secondary provocation of the arousal coming from motor nerves in the area I had damaged earlier. Atropine blocks the action of acetylcholine (ACh), the neurotransmitter triggering muscle contraction in 'mucosal' motor nerves and I hoped to stop my ones from continually 'firing.' This actually proved most effective and the area has since healed completely but the original arousal was still working its mischief.

"I had become aware that tension can cause a variety of problems in the pelvic floor but it was not until I started to take a proactive approach to freeing up this muscular environment that I began to notice significant reductions in symptoms. Again this relief was achieved by experimentally developing a routine of flexibility-enhancing exercise and localized massage, especially along the path of the pudendal nerve. I also began a magnesium supplement to try and quell a sense of tremor that I would often feel, not only in the pelvic muscles but also more broadly. After 6 or so months I was no longer experiencing what I earlier described as PGAD symptoms. Since that time, a year ago, I have maintained a level of physical therapy as a preventative measure and as a means to better general health."

The Types of Exercise I Found Helpful

"I spent some time studying the anatomy of the pelvic area and fundamental principles of physiology. In relating these to my own symptoms I came to the tentative conclusion that a contraction in the left ischiocavernous muscle may be triggering PSAS. As a first course of action I manually stretched this area with firmness and noted a lessening, but not cessation,

of symptoms. Pleased with this result I began walking and experimenting with various exercises aimed at producing flexibility and with massage, especially in areas that may have impacted on the pudendal nerve.

"Originally, I only considered the pudendal nerve, which I supposed was coming under pressure at a particular point; however, exercising areas not innervated by the pudendal system also produced either an increase or decrease in symptoms. I began to suspect a different dynamic, involving connective tissue (fascia), was putting a broad but mild pressure on a number of nerves (and possibly capillaries) that may influence arousal and its resolution.

"Utilizing a principle called thixotropy,[1] I exercised for periods of 5–10 minutes every few hours of my waking day, finding better results from slow, gentle stretching than from fast repetitions. I also massaged the pelvic environment regularly. I did this until I was confident that I was free from the core terror of PGAD: persistent, uncontrollable, and unwanted arousal that came when it chose and could not be properly cleared via orgasm. This was a gradual process over a 6-month period. I also found the massage to help in overcoming remaining vulvodynia-like symptoms."

My Own View of PGAD

"During this past PGAD-free year I have monitored myself very carefully. My self-observation is that there are certain times when I can feel a distinct 'neuro-physical' dynamic at work in me that seems to be a blend of mental tension and genital sensation. It is hard to know whether, at these times, the brain is sending a request to the genital apparatus to ease some mental discomfort or whether some local pressure on the genital equipment is provoking a reaction from the brain. These feelings have never led to a recurrence of PGAD but it confirms a thought that physical therapy may have removed an environment conducive to PGAD but is only one part of a multifaceted dynamic.

"Over time I have come to see PGAD as a multifactored condition that can potentially arise from a chemical shift in neural pathways affecting the way the body physically responds to psychological stressors placed upon it. The disturbance of these pathways appears to incite the mecha-

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[1] Collagen fibers are deposited in a substance that has the unique ability to change from a gel to a liquid state by the application of heat, mechanical force, or stretch. This process, called thixotropy, takes about 90 seconds to occur, so the stretch needs to be held for at least that period of time in order to loosen the connective tissue. Nevertheless, I found that stretch could still put pressure on the nerve while simultaneously freeing up its environment, creating the initally confusing experience of heightened nerve sensitivity with a parallel reduction in arousal levels.

nisms of genital arousal in a process that may be facilitated and perpetuated by a structural pathology in the pelvic environment."

Discussion

Mrs. D was aware that she would be unlikely to find a "quick fix" for her condition both because of the many factors involved in its etiology as well as because of the chronic nature of her pelvic nerve and muscular tension history. From the outset, she believed that breaking the persistent cycle of arousal would necessitate intervening on several levels simultaneously rather than successively. And that is what she did. It is impossible to determine just which factors have proven most helpful. Certainly having an optimistic, noncatastrophizing, and self-analytical attitude, coupled with both a scientific mind and a strong religious faith, helped her eventually gain control over her symptoms. At the same time, it must be noted that the operative word is control rather than elimination. There are times when she does feel unprovoked genital arousal but Mrs. D knows what to do should these unwanted sensations recur.

VARIETIES OF CASE PRESENTATIONS

Women differ greatly in both the ease and extent of genital arousal. On one end of the continuum are a group of women who describe what they consider to be a "pathological condition" of persistent arousal—these women tend to be postmenopausal or older and experience highly intense and very disturbing feelings of physical vasocongestion for which no precipitant can be determined. Despite extensive hormonal and neurological workups, there is no obvious evidence of abnormality. On the other end of the continuum are women whose genital arousal is either easily accessed or relatively constant but who find the sensations neither particularly distracting or bothersome. In fact, many of these report feeling pleased or pleasured by their awareness of arousal. It is conceivable that mild pressure on the pudendal nerve activates the awareness or sensations of genital tingling which then triggers sexual arousal and/or the likelihood of orgasm or, alternatively, that subconscious sexual fantasy activates a condition of arousal. These women tend not to report or seek medical or psychotherapeutic treatment since they enjoy their sensations. In between are some women who, upon thorough neurological workup and MRI testing, are found to have brain lesions responsible for genital arousal or medications triggering arousal.

Finally, there are some seemingly anomalous sexual reactions that women describe that do not fit "neatly" into any known diagnosis or cate-

gory. For example, there are some women who report repeated multiple orgasms (as many as hundreds) that are experienced as physiological (as opposed to pleasurable), occurring in rapid succession with little prior arousal (whether deliberate or spontaneous). There are case reports describing such spontaneous orgasms following the use of a particular SSRI, such as venlafaxine (Effexor) or citalopram (Celexa) (Yanik, 2004) or due to seizure activity in the brain (Crevenna et al., 2000; Reading & Will, 2000). In one reported instance of spontaneous orgasms, a computed tomography scan, magnetic resonance imaging, and an electroencephalogram (EEG) did not reveal structural lesions or focal signs, but a long-term EEG revealed a right temporal sharp-wave focus lasting five seconds, suggesting that the woman's symptoms were part of an epileptic aura pointing toward partial seizures in the right temporal lobe (Reading & Will, 2000). In this case, the authors noted that their seizure diagnosis was confirmed by the fact that all symptoms stopped once antiepileptic treatment was started.

One such unusual sequence of sexual reactions was recently described by a 63-year-old woman who wrote as follows:

> "I have been anorgasmic all of my life, having grown up in a sexually repressive and conflicted environment. I have no memories of actual sexual abuse although I experienced considerable emotional abuse and/or neglect. I probably had CFS (chronic fatigue syndrome) from puberty although this is only now being assessed. I also suffered from repeated bouts of clinical depression, undiagnosed from childhood, including suicidal ideation, never acted upon. I have not experienced significant depression for several years and am not on psychoactive drugs. I do however have a virally induced cardiomyopothy, diagnosed 8 years ago, and am prescribed Perindopril, Spironolactone, bendroflumethiazide and bisoprolol.
>
> "In October last year I began sex therapy and became orgasmic in the context of masturbation (my husband, who is 73, coincidentally was diagnosed with an enlarged benign prostate gland and erectile dysfunction). However, these orgasms were from the start 'odd.' They were always preceded by sudden very rapid bursts of intense energy which caused my knees to bend and my back to go into lordosis. This pattern had become established a few months before I actually became orgasmic. Once I was orgasmic these involuntary movements would be followed without a gap by orgasms that were themselves characterized by intense bearing down contractions as if in childbirth (although I have no children and no experience of actual childbirth by which to judge these experiences). Although not all of my 'preorgasmic energy bursts' resulted in orgasm, all orgasms were preceded by them. My or-

gasms were unresolved or incomplete, without resolution, leading to multiple orgasms (as many as 10 to 12 at a time). They seemed to have more of a physiologically rather than sexually intense character, and this tendency became more pronounced as time went on. Above all else, the whole phenomenon was characterized by an extreme rapidity both of onset and through to completion. There might, at first, be a longer period of arousal before the sudden energy burst, but there was no plateau period intervening between arousal and this almost reflexive activity.

"Once I became orgasmic . . . a progression set in whereby it required less and less stimulation to trigger the entire response. Indeed, physical stimulation seemed far less potent than mental stimulation. I began to need no genital manual stimulation, merely touching my nipple was enough to trigger the entire process. This soon progressed to merely a fantasy or even an erotic thought, such as thinking how arousal felt in a particular area of my body. Then, this 'progression' took a most bizarre turn. One night I awoke at around 3 A.M. for no apparent reason.

"I had no memory of dreaming. I was not aroused in the slightest. While I was deciding whether to get up to go to the bathroom I began to orgasm spontaneously, with no stimulation of any sort and with no sexual sensation or physical arousal. They felt more reflexive than anything and almost violent. My back muscles, which are somewhat weak anyhow, had already become tender from the frequency of orgasmic activity (as many as four, even five times in a day, but always with some degree or intent) and now I became very apprehensive that my back would go into spasm. I had 12 orgasms I think in fewer minutes. I couldn't go back to sleep and in the next roughly 3 hours I had several more episodes, but with fewer multiples. The following night the whole sequence repeated itself, even to the time that it started. A third night, with a 'night off' as I recall, the same thing but with fewer orgasms. Then it stopped. I continued to have more ordinary orgasms for a few days but then these too ceased. For a while I became more or less disinterested altogether. When desire did return it was often difficult or impossible to become aroused. I believe that the whole experience was so fraught with anxiety of one sort or another that this has put me off for fear that the sequence will repeat itself. So now I am back to being anorgasmic, but with the added feature that I fairly often (several times a day sometimes) find myself physically aroused with no or bizarre contexts. I have a good deal of vaginal/clitoral twitching (which I have actually observed in a mirror). The degree of arousal can be almost unnoticeable all the way to fairly intense, but I can't climax."

When questioned as to whether a conditioned reaction of arousal/orgasm had occurred as a result of her recent frequent masturbatory and orgasmic experiences, the woman replied as follows:

> "Possibly. CFS was requiring me to take frequent naps and/or rests and I was becoming conditioned to becoming aroused in association with lying down so often on my bed. I wonder also if the mere frequency of opportunities to engage in mental and physical self-stimulation created a momentum, perhaps also associated with a desire to 'make up for lost time.' Certainly my motivation to deal with my anorgasmia has been very high and the variety of endeavors related to this objective have been very broad.
>
> "With regard to muscle tension and on further reflection I should say that the considerable muscle tension experienced in my 'energy bursts' did not occur as a gradual buildup prior to them but rather as a consequence of them. They seemed to happen instantly as a result of a specific, identifiable thought or activity. The stimulus, energy burst, and ultimately the associated orgasmic activity all seemed to happen in a second or less and seemed to be an isolatable event superimposed on a backdrop of more generalized, less intense arousal. That in itself seems weird. But the most distressing experiences were the night awakening orgasms, which were totally devoid of sexual arousal or pleasure; indeed, they were unpleasant and more like a series of uncontrollable sneezes or kneejerk reflexes combined with the anxiety of whether they would ever end, and when."

Hormonal and neurological testing did not indicate any pathology.

This description is presented in its entirety because it highlights certain features that are characteristic of some women with PGAD, namely an emotionally deprived and repressive upbringing, early sexual inhibition and anxiety associated with sex in general, a history of anxiety or depression, and anorgasmia. These background factors along with a tendency toward *autonomic reactivity* may be contributory to the perplexing sensations of heightened genital arousal and even orgasm. If a woman is made anxious by sex in general, especially if she views certain sexual cues as unacceptable, she may be unaware of her subjective sexual arousal but be cognizant of seemingly unprovoked genital sensations. Because these genital sensations are unexpected and anxiety arousing, a woman may become overly vigilant and sensitized to them, which can lead to increased focus on the genitals, as well as greater anxiety, which may result in the physiological symptoms of sexual and generalized arousal and orgasm.

In summary, there are cases of persistent genital arousal that appear

mostly neurological, others that appear mostly psychological, and a vast number suggesting the complex interplay of psychological and physical factors. It is for this reason that treatment, ideally, should be multifactorial and interdisciplinary as described below.

TREATMENT

The most sensible approach to treatment is one that emphasizes self-management along with an initial use of anesthetizing agents to numb the area and provide some relaxation of the pelvic floor musculature. Treatment should focus on control rather than elimination of the complaint since it may recur. Social support and self-hypnosis, medication, physiotherapy and stretching exercises, and cognitive-behavioral interventions comprise aspects of this approach. Each component is discussed below:

Social Support

Women complaining of PGAD report extreme relief when they discover that they are not alone in having this condition—that the problem has a name and that there exists a support group that can provide sympathy and suggestions (www.psas_support.com/). Determining what may be contributing to or exacerbating the condition is important. Distraction is very important, either accomplished via self-hypnosis or through a determined focus on nonsexual activity.

Pelvic Massage

Pelvic massage or stretching exercises may reduce or eliminate pelvic floor tension and break up whatever connective tissue strictures contribute to the PGAD. Consultation with an experienced pelvic therapist may be helpful as well.

Medication

As we have seen, certain medications may alleviate (or paradoxically, worsen) feelings of genital tension. Mood-stabilizing, antiseizure medications such as valproic acid (Depakote) have helped some women, while others report relief with some of the SNRIs. Determining which, if any medication, may diminish the sensations of genital vasocongestion is often a question of trial and error.

Cognitive-Behavioral Interventions

Helping women identify and challenge their self-defeating, self-blaming, or pessimistic thoughts and replace them with more adaptive and positive cognitions may enhance "coping behaviors." This is especially crucial when women report feeling suicidal or despairing because of the chronic, incessant, and distracting nature of their genital sensations.

A PLEA FOR CAUTION

It must be emphasized that the majority of women who experience PGAD suffer considerably and hence are vulnerable to any treatment that promises relief. Regrettably, although many novel treatments have been described and discussed by women in a PSAS support group, none have provided long-lasting relief. One woman, for example, underwent ECT treatments at the suggestion of her physician because of its possible beneficial effect on mood regulation via its effect on serotonin and dopamine receptors. While ECT substantially helped one woman, another found that her symptoms soon returned. Another women underwent a novel form of "trauma uncovering" therapy. She experienced a cathartic reaction during her initial sessions but symptomatic relief proved temporary. While psychotherapy—from virtually any theoretical orientation—can be helpful in promoting insight, providing possible explanations, encouraging carthartic expression, contributing to stress reduction, and providing self-soothing exercises, it has not resulted in any "cure." At the same time, to be pragmatic, it must be emphasized that any treatment that helps reduce emotional stress or physical tension is to be encouraged.

At this time, it is unlikely that there is a single intervention that will work for all of the varied presentations of this condition. Rather, self-management strategies—both physical and psychological—are recommended along with the realization that for some sufferers, the condition may be chronic, but one that can be tamed and controlled.

SUMMARY

The recent identification and provisional diagnosis of the condition of persistent genital arousal in women is fascinating for several reasons. Although it is unlikely that it is a brand-new syndrome, it is noteworthy that it has come to light only recently as a "new" aspect of female sexuality. This highlights how little is still known about the range and diversity of women's sexual response. Isolated case reports of persistent genital arousal,

spontaneous orgasm, or clitoral "priapism" have only recently surfaced in the literature—there is no way of knowing how widespread these complaints are. Similarly, even with such a common gynecological condition as vulvodynia, little is known with any certainty about the most efficacious treatments. Clearly, there is a pressing need for epidemiological studies, basic research, and evidence-based treatments for these distressing problems. It is imperative that clinicians and researchers from a variety of disciplines work together in order to further our understanding of both the physiology and psychology of female sexuality.

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CHAPTER 4

Orgasmic Disorders in Women

JULIA R. HEIMAN

While not as common a presenting problem as in the early days of sex therapy, orgasmic complaints continue to be a significant issue for many women. While historically anorgasmia in women was somewhat normative, most women today expect and feel they deserve sexual pleasure, including reliable and satisfying orgasms.

Historically, there was concern about achieving the "right" kind of orgasm (e.g., vaginal vs. clitoral). While we no longer consider orgasms as either immature or mature, there remain uncertainties about many of the basic mechanisms of female sexual response. Technological advances, described by Heiman, make it possible to observe changes in the brain at the time of orgasm, yet the triggers for orgasm are incompletely understood, as are the reasons why some women are easily orgasmic and others find orgasm so elusive and time-consuming.

Moreover, although pharmacological advances have significantly altered the treatment approach to many of men's sexual problems, there are no drugs that overcome orgasmic dysfunction, although many interfere with sexual arousal and orgasmic ease.

In her thorough and thoughtful chapter, Julia Heiman notes that the ultimate causes of orgasmic dysfunction are uncertain in most cases, although there are a large number of contributing factors: Anatomic and physical, sociocultural and interpersonal, pharmacological and psychological determinants all appear to be implicated in the etiology and maintenance of orgasmic problems. Conceptual and therapeutic interventions are similarly varied and include a range of psychodynamic, cognitive-behavioral, and systems-interpersonal approaches.

Heiman favors a cognitive-behavioral and systemic orientation to the treatment of orgasmic problems with an emphasis on the exploration of interactional patterns within

the relationship. In this chapter, she focuses on the treatment of the more challenging orgasmic complaints, namely those that are situational or secondary to desire disorders. While behavioral exercises are sometimes recommended, the emphasis is more on the symbolic and systemic nature of the couple's relationship. This systems-interpersonal approach depathologizes the woman as the "patient" and keeps the focus on the couple.

Helping couples understand the function of the symptom at both the personal and interactional levels is a central focus of treatment. What does having an orgasm mean to the woman? To her partner? What does the orgasmic "problem" solve for the couple? Does the woman have a sense of ownership over her body Does she want to achieve orgasm for herself or to satisfy her partner? Can the couple communicate directly about sexual preferences? These and similar issues become the major treatment focus in this approach.

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HISTORICAL AND CULTURAL CONTEXT

Across the centuries, varied meanings and levels of importance have been attributed to women's orgasm. At different historical periods, orgasm has been believed to be either good or bad for the woman, for her partner, or for her marriage. Ambivalence about the value of orgasm for women still continues to the present. Currently a woman's orgasm is more likely to be valued and seen as positive for herself and her relationship. Thus this chapter appears in a book on sexual disorders, because the lack of female orgasm is seen as a problem that needs clinical attention.

If we look at the cultures of Western societies, we can notice some interesting patterns. Laqueur (1990) has illustrated an example, in parable form, of the meaning given to orgasm. In late-17th- to early-18th-century Western Europe, it was believed that women needed to feel the pleasure of orgasm to conceive. By the 1830s, beliefs had shifted; conception was believed possible without pleasure, orgasm, or even consciousness. This change emerged not from new scientific information but from a "radical reinterpretation" of the female body. For centuries prior to the 1700s, women's bodies were seen as being on a continuum with men's; by the late 18th century, writers insisted on fundamental differences between men and women. Laqueur (1990) uses this example to show how changes in epistemology and politics, rather than scientific progress per se (though all three interact dynamically), shape the meaning of sex.

From a clinical problem perspective, one of the core factors separating more traditional from more modern views of sexuality is the degree to which sexuality has been seen as needing control and inhibition as opposed to needing stimulation and facilitation. In the latter half of the 19th century, therapeutic and social control of sexual activity was of great importance whereas inhibited or lost sexual behaviors and feelings became the therapeutic and social concern of the more prosexual late 20th century (see Robinson, 1970, for further discussion of traditionalists vs. modernists). On the cusp of the turn of the prior century was Sigmund Freud's work. Freud presented a categorization of female orgasm based on personality maturity. His theory viewed clitoral orgasms as superficial and immature whereas vaginal orgasms were authentic and adult. Although controversial, this anatomically based distinction of different types of orgasms represented an important transition from Victorian values. It recognized the presence and power of female orgasm without abandoning the cultural paradigm of procreative sex as the more valued and correct expression.

Contemporaneous with Freud's work was that of Havelock Ellis. Ellis not only suggested that women's responses were equivalent to men's but that women were probably more sexual than men. He saw women's sexuality as more mysterious and more extensive given that women not only had a clitoris but also a womb, which gave them a large and diffuse sexual anatomy that could respond to sexual stimulation. Ellis said little specifically about female orgasm. He did see women as innately passive beings who required both courtship and the driving interest of men to elicit a sexual response.

A different perspective came from Alfred Kinsey, who prepared the way for a new conceptualization of female orgasms. Kinsey did not distinguish between anatomical types of orgasms in women. He did use orgasms as one of the several markers of human sexuality. An indirect outcome of his survey research was that orgasm frequency became one of the key variables that made up a person's, a group's, and a society's sexual demographics. It was also Kinsey who reported, much to the distress of readers in the 1950s, that a woman was more likely to be orgasmic during masturbation than during sex with a partner.

Masters and Johnson (1966) interpreted their data on sexual response to mean that all female orgasms were the result of the same neurophysiological process of response and that women's orgasms were more similar than dissimilar to male orgasms. They published their research in 1966, when advocates of sexual equality was more outspoken than in the previous decade. Women were claiming reproductive rights with the help of an easily available oral contraceptive method. The "right" to orgasm made sense in this context, and it was Masters and Johnson's (1970) *Human Sexual Inadequacy* that proposed a plan for making orgasms possible to women who never or rarely experienced them. Masters and Johnson

offered a nonpathological model for cure: Remove the anxiety and the "natural expression of sexual response" will appear. As modest and atheoretical as this model was, it probably would not have been accepted in 1900. Masters and Johnson required the data of Kinsey's work as well as a different cultural environment to be heard.

It becomes rather obvious as we look across these major contributors to the understanding of sexuality that the simple fact that we recognize and treat orgasmic problems in women is, in part, a cultural accident. One hundred years ago, at least in northern Europe and Victorian England and certainly in the United States, we would not have done so. Thus, we must be cautious about classifying orgasm problems as either purely physical or purely psychological. Although such purity may exist on occasion, such as medication-induced orgasmic dysfunction, a woman's experiences, including her history, her relationship, and her culture, continuously interact with her neurophysiology.

The purpose of this chapter is to examine the ways in which the complexity of physical, psychological, and sociocultural factors can interact. After reviewing the incidence of orgasmic problems, etiological factors, theoretical treatment approaches, and treatment efficacy, the chapter addresses how to assess psychological, sociocultural, interactional, and physiological factors. Currently, women's sexuality in general is being examined with a heavy emphasis on the physiological factors that affect functioning. The release of oral medications specifically for men's erections has prompted a new interest in understanding how physical factors may impact female sexuality. The interest in understanding the physiology of women's sexuality is a positive trend in my opinion, as the neurophysiological aspects of female sexual response have been minimally researched. However, if new research proceeds without a simultaneous examination of the subjective data on sexual response and satisfaction of women, it will ultimately not contribute to a broader understanding of sexuality. As shown in the discussion below, although we have some knowledge about female sexuality and have treatments for orgasmic dysfunction, in fact we know very little about mechanisms that might contribute to a complex model of female sexual response that encompasses biological and psychosocial factors.

DEFINITIONS AND PREVALENCE OF ORGASMIC PROBLEMS IN WOMEN

Orgasms are usually defined as a combination of both subjective experience and physiological changes in the vagina and pelvic area. Subjective descriptions women use include such words as "reaching a peak," feeling a building tension and then letting go, a feeling of contractions in the genital area, and/or a period of high excitement followed rather suddenly by a re-

lease into relaxation. There are no defined requirements for the subjective experience of orgasm; for example, some women report experiencing an orgasm with no accompanying muscular contractions (Levin, 1980, 1983; Levin & Wagner, 1987). Another subjective aspect of orgasm is a sense of the loss of the passage of time. Levin and Wagner (1985a) found that the women they studied in the laboratory setting underestimated the duration of their experience of orgasm by as much as 50% when compared with the physiological measures of the same experience.

Masters and Johnson (1966) were among the first researchers to study the physiological and behavioral indexes of orgasm in a laboratory setting. They documented that the entire body was involved in the orgasmic experience. Rhythmic contractions occur in the uterus, the vaginal barrel, and the rectal sphincter, beginning at 0.8-second intervals and then diminishing in intensity, regularity, and duration. Facial grimaces, generalized muscle myotonia, carpopedal spasms, and contractions of abdominal and gluteal muscles also occur, although they are not required for the experience of orgasm. There is scant physiological data on the stimulation necessary for orgasm. Masters and Johnson (1966, 1970) noted the clitoris is the source of stimulation for orgasmic response with the vagina playing a lesser role and they argued for the similarity of orgasms regardless of the source of stimulation. Though this may be accurate, controversy exists regarding the role of the vagina, cervix, uterus, and connecting ligaments to the clitoris, all of which may be impacted during coitus or even certain types of masturbation. What seems to be clear is that well-innervated clitoral tissue is important for orgasm, though some parts of the clitoral structure (which is quite extensive) may be missing or damaged with orgasm still possible (for anatomical information see O'Connell, Anderson, Plenter, & Hutson, 2004; Suh, Yang, Cao, Heiman, Garland, & Maravilla, 2004; Yang, Cold, Yilmaz, & Maravilla, 2006). We do not have physiological laboratory data to make a definitive statement on these differing opinions (see Meston, Levin, Sipski, Hull, & Heiman, 2004, for a detailed review).

Although there is a general impression that orgasmic problems are common in women, there are few well-controlled studies that have carefully examined the incidence of orgasm. An exception is the National Social and Health Life Survey done in the early 1990s (Laumann, Gagnon, Michael, & Michaels, 1994; Laumann, Paik, & Rosen, 1999). This study was a random probability sample of men and women that included 1,749 U.S. women between the ages of 18 and 59. The women were 75% Caucasian, 12% African American, and 7–9% Hispanic, with a range of educational, economic, and religious backgrounds. This study included heterosexual, lesbian, and bisexual individuals. Orgasmic problems were the second most commonly identified problem, with 24% of women reporting that in the past year, for at least several months or more, they had experi-

enced a lack of orgasm. A Massachusetts population-based, random sample of 349 women, ages 51–61, found a lower prevalence: 10.3% reported having difficulty reaching orgasm all or most of the time (Johannes & Avis, 1997). Of a random community sample of 521 British women ages 35–59, 16% reported infrequent orgasm (Osborn, Hawton, & Gath, 1988). Using the same sample but including only those women with partners (n = 436), 15.8% had no orgasms and 22.2% had orgasm on less than half the occasions of sexual activity with their partner in the last 3 months (Hawton, Gath, & Day, 1994).

Clinic-based data typically show higher frequencies of dysfunction. In an outpatient gynecological clinic, of a sample of 329 healthy, 18- to 73-year-old women followed for routine care, many reported orgasmic problems (29%), frequent intercourse pain (11%), and anxiety or inhibition during sex (38%) (Rosen, Taylor, Leiblum, & Bachmann, 1993). Of 104 patients attending a UK general practice clinic, 23% of women 18 to 65+ (mean age = 45) reported anorgasmia (Read, King, & Watson, 1997).

A common distinction is whether a woman has primary or secondary anorgasmia. Primary anorgasmia refers to never having had an orgasm; secondary anorgasmia refers to orgasmic infrequency or restricted conditions for being orgasmic (e.g., masturbation only). This chapter emphasizes secondary orgasmic problems because they are more common and typically more difficult to treat (Arentewicz & Schmidt, 1983; Heiman & LoPiccolo, 1983; Kaplan, 1974; Masters & Johnson, 1970). Clinical or epidemiological studies have not examined the distinction between primary and secondary anorgasmia. Kinsey's work, now over 50 years old, reported that 10% of women remain incapable of orgasm (Kinsey, Pomeroy, Martin, & Gebhard, 1953). In addition, there are no distinctions made between women with *both* orgasmic and arousal disorders versus women with *only* orgasmic disorder.

It is important to note that orgasmic problems do not always cause sexual distress or marital unhappiness for women. A nonrandom sample of couples found that 63% of the women reported arousal and orgasm problems although they were happily married, and 85% reported that they were satisfied with their sexual relationship (Frank, Anderson, & Rubinstein, 1978). More recently, a national probability sample of 987 women, ages 20–65, found that 9.3 % of the sample experienced no orgasm in the past 4 weeks (Bancroft, Loftus, & Long, 2003). Of those women experiencing no orgasm, between 30 and 50% (depending on age) experienced marked distress about their sexual relationships and 28–43% experienced marked distress about their own sexuality. So feelings of distress, about either one's own sexuality or one's sexual relationship, are not necessarily associated with orgasmic problems.

ETIOLOGICAL FACTORS INFLUENCING ORGASM IN WOMEN

A woman's capacity to experience orgasm appears to be influenced by a number of factors. These include neuroanatomic, physiological, psychological, sociocultural, and interactional factors. However, none of these contributions have been confirmed as being primary or absolute. Difficulties in studying orgasm include the lack of (1) an objective measure of documenting when orgasm is occurring for those who are studying the neurophysiological aspects of orgasm and (2) an agreed-upon subjective definition of orgasm. This latter point is extremely important for a therapist to keep in mind. If one listens carefully to patients with sexual problems, some of them will report experiencing orgasm though it later becomes apparent that they were not, and other women will not identify orgasms when they are in fact occurring.

Neurophysiological Factors

Several anatomical areas are important for the experience of orgasm. Those most frequently mentioned are the clitoris and the vagina. The areas of the body that seem to be most sensitive to touch are the labia, the introitus to the vagina, and the clitoris. These areas, particularly the clitoris, are highly innervated and also have vasocongestive capacity. The vagina is relatively insensitive to touch, though strong deep pressure may act as a sensory stimulus. This is believed to be true partly because of the pubococcygeal (PC) muscle located at the 4 and 8 o'clock positions of the vagina, which itself is well supplied with proprioceptive nerve endings and has been found to generate pleasurable feelings when stimulated by pressure stroking (Graber & Kline-Graber, 1979; Kegel, 1952). Thus the strength and tone of the PC muscle have been proposed as contributing to orgasmic capacity (Kline-Graber & Graber, 1978). However, correlations between PC muscle tone and orgasmicity are low and probably PC tone is idiosyncratically related to female orgasm. There is some evidence suggesting that vaginal stimulation can increase the threshold for pain in women (Whipple & Komisaruk, 1985, 1988).

A few centimeters from the vaginal introitus on the anterior vaginal wall, an area about 1 cm in diameter has been identified as the Grafenberg (1950) or "G" spot. The exact nature of this area has not been completely confirmed, but for some women, stimulation of this area results in fluid expulsion with orgasm. It remains controversial whether this substance is distinct from urine. Stimulation of this area has been found to consistently result in more sexual excitement than stimulation to the posterior wall (Levin, 1992). It has been theorized that G-spot stimulation helps women reach orgasm (Richards, 1982, 1983) although this has been documented in only a few clinical subjects.

The brain is also an important source of sexual arousal and orgasm in women. There is evidence that individuals can have orgasm with no direct stimulation to the genitals. This evidence comes from the phantom orgasms experienced by paraplegics (Money, 1960), from orgasms induced hypnotically, from orgasms stimulated by fantasy alone, and from orgasms experienced as a result of stimulation in certain areas of the brain. In addition, there have been reports of orgasm from women who have had clitoral and labial excision and vaginal reconstruction. Whipple, Ogden, & Komisaruk (1992) studied 10 volunteers who reportedly were able to experience orgasm from fantasy alone. Orgasm resulting from either self-induced imagery or genital self-stimulation was associated with the same physical correlates. This research suggests that the brain be considered as part of the anatomical requirements for orgasmic experience. Whipple and colleagues have proposed that several different nerve pathways are involved in sexual response: the pudendal nerve for clitoral stimulation, the hypogastric plexis and pelvic nerve for vaginal stimulation, and possibly the vagus nerve directly from the cervix to the brain (Whipple & Komisaruk, 1997).

Little is known about the pertinent neuroanatomy and neurophysiology required for female sexual response. Many assumptions are based on extrapolations from male neurophysiology. Innervation of the female genital tract appears to be mediated by the somatic and autonomic nervous system. The somatic innervation is conducted through the branches of the pudendal nerve, which is derived from sacral spinal segments 2 through 4 and travels laterally through the pelvis. Disruption, injury, or disease that affects this process may affect orgasmic ability. The autonomic innervation consists of fibers from both the sympathetic and parasympathetic nervous systems. The sympathetic fibers are derived from spinal segments T_{10}—L_2 and the parasympathetic fibers from S_2—S_4, though these data are based primarily on men. One controlled study found that 52% of women with spinal cord injury at or above T_{10} were orgasmic compared to 100% of able-bodied women (Sipski, Alexander, & Rosen, 1995).

There has been some preliminary work looking at brain activation during orgasm. Two women with spinal cord injuries above T_{10} as well as a noninjured woman were studied. Using PET (positron emission tomography) and fMRI (functional magnetic resonance imaging), it was found that with orgasms achieved during masturbation, a number of brain areas were activated including regions of the cortex, the cerebellum, the paraventricular nucleus (PVN) of the hypothalamus, the central gray area (PAG) of the midbrain, the amygdala, the hippocampus, and the anterior basal ganglia (striatum) (Komisaruk et al., 2002; Whipple & Komisaruk, 2002). If sexual arousal studies (e.g., Karmara et al., 2002) and orgasm studies are compared, the most important activation sites for orgasm appear to be the PVN, the PAG, the cerebellum, and the hippocampus. Although intriguing, this work currently has little direct applicability to treatment.

Sexual stimulation results in pelvic vasocongestion, vaginal lubrication, vaginal lengthening and tonic contractions, labial size increase, uterine elevation, and clitoral retraction (Masters & Johnson, 1966). Correlations between respiration rate, heart rate, or average pelvic contractions with reported subjective intensity or satisfaction with orgasm have not been found (Bohlen, Held, & Sanderson, 1983). Levin and Wagner (1985a) found no correlation between increases in vaginal blood flow, orgasm latency, or duration of orgasm with the intensity of orgasm. They did find a correlation between orgasm intensity and changes in heart rate (Levin & Wagner, 1985b).

Vasculogenic insufficiency of the genitals has been proposed as one possible cause of female sexual arousal disorder and potentially orgasmic disorder (Goldstein & Berman, 1998). To date there are few data supporting this position in women but research is currently exploring this possibility.

The innervation of female genitalia is known to include cholinergic and adrenergic nerves. In addition, a number of peptides have been found to be involved in neurotransmitter or neuromodulator roles and have been located in female genital tissue (Ottesen, Wagner, & Fahrenkrug, 1988). Orgasm is correlated with increased secretion of prolactin, ADH (vasopressin), oxytocin, and Vasoactive Intestinal Peptide (VIP) (Meston et al., 2004). It is clear from the impact of medications on female sexuality, especially the selective serotonin reuptake inhibitors (SSRIs), that serotonergic and dopaminergic factors play an important role in arousal, orgasm latency, and potentially in sexual desire (Rosen, Lane, & Menza, 1999). Typically increased availability of serotonin and decreased dopamine have a negative impact on sexual response, although the mechanisms are incompletely understood (Meston & Gorzalka, 1992; Steele & Howell, 1986). In addition, adrenergic blockade or anticholinergic activity peripherally may delay or inhibit orgasm.

Psychosocial Factors

In spite of assumptions about the impact of religion, education, age, social class, and other sociocultural factors, few supporting data are available. Laumann et al. (1999) found that the only significant demographic factors that were related to women's complaint of anorgasmia were education, marital status, and age. Women with orgasmic complaints were younger, unmarried, and had less education than women who did not report orgasmic difficulties. Risk factors associated with arousal and orgasmic complaints included a decrease in household income, infrequent sex, infrequent thoughts about sex, a history of sexual harassment, being sexually touched before puberty, and being sexually forced by a man. Health and lifestyle issues, including ever having a sexually transmitted disease, ever having had

urinary tract symptoms, poorer health, and having emotional problems or stress, were important predictors of arousal disorder. Women without religious affiliation were the least likely to report always having an orgasm with their primary partner (Laumann et al., 1994). Having a religious affiliation was associated with higher rates of orgasm for women.

In the randomly selected community sample of 436 British women with partners noted earlier, predictors of orgasm included younger age, better general marital adjustment, and a shorter duration of relationship (Hawton et al., 1994). Women's satisfaction with their sexual relationship was closely related to marital adjustment and bore no relationship to age.

Psychological factors that may affect orgasmic ease are difficult to confirm. Depression is often accompanied by hypoactive sexual desire and thus can contribute indirectly to orgasmic problems. Sexual abuse does not necessarily produce orgasm difficulties although such problems have been reported to be higher in abused than nonabused women (Tsai, Feldman-Summers, & Edgar, 1979; Norris & Feldman-Summers, 1981). Decreased sexual responsiveness (Walker et al., 1999) and decreased sexual arousal (Wenninger & Heiman, 1998) have also been reported in women with a sexual abuse history. One of the more extensive studies of personality and background variables and women's orgasm was Fisher's (1973). The most consistent finding was that anorgasmic women often had experienced their early love objects, especially fathers, as undependable and tended to experience later love objects similarly. These women felt an increased need to control situations involving high arousal and the potential for loss of control. There is clinical evidence of early abandonment by an important male figure for some, but certainly not for all, women with orgasmic problems.

Anxiety in various forms is often seen as interfering with satisfactory sexual function. However, there are different types of anxiety and distinctions are not always made as to the different ways researchers and clinicians use this term. Women who become aroused but cannot achieve orgasm with a partner who is loved (or conversely, unloved) may have different "anxiety" processes than do women who never become aroused or who are never orgasmic.

In the laboratory sympathetic nervous system activity (suggestive of anxiety) has been shown to enhance sexual arousal. When women are shown frightening films (Palace & Gorzalka, 1990), asked to exercise just before a sexual stimulus (Meston & Gorzalka, 1995), or given a drug such as ephedrine, which increases sympathetic nervous system activity (Meston & Heiman, 1998), vaginal response to sexually explicit films increases. Nonsexual arousal, such as a fear response, may have a negative impact on some women with orgasmic problems, especially those who report feeling uneasy with the experience of sexual arousal. Further exploration is needed regarding the role of physical or psychological general excitation and its impact on arousal and orgasm. For the present, we can say that sex-

ual arousal requires enough "relaxation" to take in sexual stimulation and enough "tension" to respond with arousal and orgasm.

Relationship factors do appear related to sexual response, although exactly which aspects of a relationship are important has not been determined. Certainly, women can be orgasmic with partners who treat them well or treat them badly, in situations that make them uncomfortable or comfortable, and with either a great deal of foreplay or almost none at all.

In summary, there are no consistent empirical findings that support a constellation of factors separating orgasmic from nonorgasmic women. One reason for this is that the labels "orgasmic," "nonorgasmic," and "situationally orgasmic" are themselves too global and unlikely to ever yield reliably discriminant factors. We might find more satisfying results if patterns of orgasmicity and nonorgasmicity were developed based on early history factors, personal (physiological and psychological) factors, and relationship factors.

TREATMENT APPROACHES: THEORY AND APPLICATIONS

The following section provides a brief overview of the salient features of three major theoretical treatment approaches to orgasmic problems: psychoanalytic, cognitive-behavioral, and systems theory. It should be noted that only cognitive-behavioral approaches have a substantial body of research support (see Heiman & Meston, 1997), though other approaches may assist in conceptualization and interpretation.

Psychoanalytic Approaches

In traditional psychoanalytic theory, sexual dysfunction has been viewed as a symptom that expresses a pathological process in personality development; a developmental arrest is thought to result from castration fantasies, guilt over wishes for gratification with father, and unconscious fears (e.g., Bergler and Fenichel, both cited in Faulk, 1973). The capability to experience orgasm and pleasure during sexual intercourse have been seen as intrinsically related to the woman's capacity to relate intimately to another person.

From the perspective of object relations theory, the ability to relate to another person is innate, begins at birth, and is partly influenced by the ability to develop an internal representation of the other. Later both negative and positive attributes of the caretaker are internalized, and these engender the capability for relatedness in later life. Tolerance of the ambivalence brought about by recognizing a loved one's faults contributes to a person's ability to maintain interest and intimacy with another. Later for-

mulations about female psychological development emphasized the relationship with the mother as critical to adult heterosexual functioning (Jordan, 1985; Stiver, 1984; Surrey, 1983). Rather than being a pathological dependent syndrome as it often has been labeled, the reliance of a woman on relationships is considered a normal part of self-definition (Stiver, 1984).

However, intimate relationships may be experienced as threatening because they recreate a feeling of merging with the mother similar to the preverbal, undifferentiated experience between the infant and mother. Sexually intimate relationships may recreate the demand of having to meet another's emotional needs, previously the mother's, currently the sexual partner's. Clear boundaries with an internal sense of separateness are necessary if one is to be able to tolerate intimacy; conflicts with closeness may result in hostility, anger, an inability to trust, and inhibited orgasm. A woman must feel secure enough in her self-identity to experience pleasure in the physical "taking in" of the other without fears of merging with a partner or losing herself.

Several defenses, the ego's unconscious means of coping with anxiety, are pertinent to orgasm dysfunction (Kernberg, 1987; Scharff & Scharff, 1987). Denial may be expressed in the minimization of physical sensation. Projective identification, unconsciously projecting one's feelings onto a significant other, represents a way of dealing with unacceptable feelings or impulses. For example, a nonorgasmic woman who feels uncomfortable with her own desire to control others may see and interact with her husband in a way that views whatever he does as controlling.

In psychoanalytic psychotherapy the emphasis is not on symptom removal but on working through conflicts that are believed to lead to the symptom. The symbolic content and functional utility of the symptom are explored (Cohen, 1978). Other common features include examining and reclaiming the memories of early childhood experience in relationships, interpreting and working through the resistance to change in therapy, and attending to the transference and countertransference aspects of the therapeutic relationship. Therapy focuses on the patient–therapist dyad and requires more frequent sessions than other approaches. Variations from traditional psychoanalytic treatment have combined individual and couple treatment with additional sex therapy (Kaplan, 1974; Levay, Weissberg, & Blaustein, 1976; Segraves, 1986). Outcome data on psychoanalytic therapy are extremely sparse and restricted primarily to clinical reports.

Cognitive-Behavioral Approaches

Cognitive-behavioral therapists depend on theories of learning and cognitive processing to help explain the origins and maintenance of orgasmic problems. Anxiety that has been associated with sexual experiences may

interfere with relaxation, prevent arousal, and inhibit orgasmic response (cf. Barlow, 1986).

The goals of cognitive-behavioral therapy are to promote cognitive change, attitude shifts, reduced anxiety, increased orgasmic frequency, and increased connections between positive feelings and sexual behavior (Ellis, 1975; Fichten, Libman, & Brender, 1986; LoPiccolo & LoPiccolo, 1978). The hallmark of cognitive-behavioral therapy is the prescription of privately enacted behavioral exercises, the "debriefing" of the results, and new exercises tailored to meet the client's needs. Treatment is generally brief, averaging 15 to 20 sessions, although with more complex cases it can take longer.

Directed masturbation (DM) is most frequently used with women who have primary anorgasmia (Andersen, 1983; Heiman & Meston, 1997). The procedures include a period of education and information followed by visual and kinesthetic self-exploration of the woman's body. Directed masturbation is most effective in treating primary anorgasmia, with a success rate of at least 80 to 90% (Riley & Riley, 1978; LoPiccolo & Stock, 1986). The success rate of secondary anorgasmia treatment ranges from 10 to 75% (Fichten et al., 1986; Kilmann, Boland, Sjortus, Davidson, & Caid, 1986; Kilmann, Mills, et al., 1986; Kuriansky, Sharp, & O'Connor, 1982; Mills & Kilmann, 1982). Younger, emotionally healthier, and more happily married women have a higher probability of success (Schneidman & McGuire, 1976; Libman et al., 1984; LoPiccolo & Stock, 1986). In some studies an increase in sexual and relationship satisfaction occurred without a significant improvement in the presenting sexual symptom (Everaerd & Dekker, 1982; DeAmicis, Goldberg, LoPiccolo, Friedman, & Davies, 1986; Heiman & LoPiccolo, 1983, LoPiccolo, Heiman, Hogan, & Roberts, 1985). Hurlbert and Apt (1995) showed the effectiveness of what they term the "coital alignment technique" for women with secondary anorgasmia. In this technique the woman is supine and the man lies across her, up and forward, so there is more clitoral contact. In this study 37% of women in the coital alignment group gained more than 50% improvement in orgasmic ability during intercourse compared with 18% improvement in the DM group. Tables 4.1 and 4.2 provide a summary of recommended exercises for the treatment of primary orgasmic dysfunction and for experiencing orgasm in partner sex. These may be integrated with other approaches to therapy and should be selected for and tailored to the individual woman and her interpersonal context.

A number of women are able to "transfer" their new knowledge learned in masturbation to partner sexual experiences, at least over time and with an interested partner. However other women who orgasm exclusively in masturbation, and have done so for years, may need to learn different additional stimulation techniques through partner sex interactions, especially to find it easier to orgasm during vaginal intercourse. This is because of all the interpersonal factors involved in the couple's sex, but it also

TABLE 4.1. An Outline of Basic Exercises Useful in the Directed Masturbation Treatment of Primary Orgasmic Disorder

Background, context, and meaning

- Review lifetime sexuality-related experiences. These include touching, sensual touching, and sexual activity, as well as thoughts, feelings, and desires or yearnings. Take some time to remember and write down where possible. Try to do this with an attitude of self-study and understanding, as if viewing and reporting, rather than judging yourself for what did or did not happen.
- On a separate occasion, take a look at your experiences so far and look at how your responses to them and to sex in general may have been influenced, positively and negatively, by family, friends, religion, politics, and popular culture (magazines, films, music, successful figures in the media).
- Challenge the assumption that the past determines the present and future. Instead how can the past inform the present and future of your sexuality?

The body and genitals

- Look at your body and come to terms with what you accept and like about it and what you wish were different. What is realistic to change in a healthy way and what is important to accept? What determines how you feel? How can you value your appearance as is?
- While sitting comfortably on your bed, use a small mirror to look at your genital area. Make sure you can identify your clitoris, labia majora, labia minora, vagina, and anus. These are important parts of your anatomy. Can you let yourself feel accepting and appreciative about this area?
- Explore your body and genitals for touch sensation and sensitivity. You are not trying to get yourself to feel any particular feeling; rather, notice how different types of touch trigger more or less pleasing sensations. Do this without lotion or oil at first, using them later if you wish. In touching your genitals, pay attention to sensations around the clitoral area and labia and around and inside of the vagina (omit oil-based lubricants inside the vagina). Notice differences in sensation and touch. What feels pleasant?
- Learn and try Kegel exercises to help build awareness and connection to this area of your body.
- Let yourself claim your body as your own.

Exploring sexual arousal

- If genital touching is difficult or unpleasant consider some cognitive techniques to examine where those feelings come from and what could be alternative ways of thinking that are more respectful and appreciative, even if you do not fully believe them yet.
- Try touching your genitals for pleasure.
- Depending on whether or not you have experienced arousal, you may be more or less aware of what is psychologically sexually arousing for you. Think about visual images and physical gestures or touches that enhance your sexual interest or desire to be physically close. Investigate feature films, videos, or written materials that contain sexual or romantic imagery—these may help identify your themes of sexual attraction.
- Knowledge about the sexual response "cycles," aging and hormonal effects, and sexual health in general may be helpful.
- Role-play orgasm; address fears about orgasm and orgasm triggers.
- Consider the pros and cons of using a vibrator to enhance stimulation.

Ways to include your partner

- List expectations and apprehensions about sharing changes with a partner.
- Consider physical and verbal approaches to use with a partner.
- Learn new aspects of initiating, accepting, or refusing a sexual invitation.

Note. For more details and additional exercises, see Heiman and LoPiccolo (1988). All of these exercises should be tailored to the individual woman's issues and experiences. Some will be more helpful than others as sexual growth experiences.

TABLE 4.2. Guidelines in Exercises and Techniques for Transferring Orgasmic Experiences to Partner Sex

- If you are orgasmic in masturbation, address expectations of partner's reaction to sharing your sexual knowledge with him or her. Be careful not to assume you know his or her response and give your partner a chance to think or feel differently.
- Whether or not you are orgasmic decide on how much to verbally or directly guide the partner's touch. Avoid constant chatter and directions. Let your partner know that initially you will need to set the pace of the touching.
- Reassure your partner that he or she isn't expected to know what you want but to begin to develop some general ideas about preferred rhythm of and pressure of touch. There will not be a formula.
- Both partners should try to be appreciative of all efforts, no matter how limited and far from what you eventually want to experience.
- If the partner's slow or fast speed of sexual response interferes with the process, see if different kinds of touch or positions can be helpful. See if you both can accept and use other differences to enhance the experience.
- Expect growth, not perfection. Avoid blame of self or other or try an alternative approach to deal with unappealing or uncomfortable experiences. See if you can believe in each other's good intentions as a starting point for changing patterns of touch between you.
- Appreciate what touches and interactions help you feel connected. Expect some attention to your partner and some just on yourself; you have to attend to your own experience to some extent or you will lose your sexual arousal.
- Nurture arousal and arousing interactions but do not demand or pressure each other for something specific. Focus on experiencing and expressing positive feelings if they occur.
- Find the appealing positions for different kinds of stimulation and start with one that is the most comfortable and least distracting so that the stimulation is easy to focus on. For sexual intercourse, consider the coital alignment technique that allows more clitoral stimulation for heterosexual couples. Others may like positions in which there is deeper stimulation vaginally. Combined vaginal and clitoral stimulation also requires a position adjustment, which differs by couples. Some include vibrator stimulation, which takes some adjustment for both partners. Finally, some women want orgasm without vaginal stimulation—preferences may vary from occasion to occasion.

is because the stimulation itself is often different (particularly depending on the partner; not all partners have the skill, interest, or wish to change a style of stimulation). The coital alignment technique is one stimulation option found to be effective, but there may be other approaches. Exploring orgasm in sexual intercourse, without demanding a specific response, can add to the couple's enjoyment of sexual interactions.

One controversy has been the effectiveness of Kegel exercises (contraction of the PC muscle) in producing orgasm. Roughan and Kunst (1981) found no difference in orgasmic frequency among those who practiced Kegel exercises, relaxation training, or attention control, although the PC group had increased muscle tone. These findings were supported by Trudel and Saint-Laurent (1983) and Chambless et al. (1984). Tensing the vaginal musculature has been found to be less arousing than using fantasy on both

physiological and subjective measures of arousal; however, tensing plus fantasy was most arousing (Messen & Geer, 1985). Kegel exercises may contribute to enhanced arousal as well as facilitate orgasm by increasing women's awareness of and comfort with their genitals.

Systems Theory Approaches

General systems theory claims to offer a paradigm to account for multifactorial phenomena. In psychotherapy, a systems approach has been primarily developed within family and marital therapy. Systems theory has been applied to general dysfunctions or inhibited sexual desire rather than orgasmic problems per se (Heiman, 1986; Verhulst & Heiman, 1979, 1988; Schnarch, 1991; Weeks, 1987).

There are several systems concepts that are important to sexuality. Living systems are composed of mutually interacting components. They have boundaries, yet they are open and constantly interchanging information with their environment (von Bertalanffy, 1968; Miller, 1978). Each person is a system and is a part of subsystems within a family; the family is embedded in a sociocultural context, yet another system.

The systems principle of *emergent qualities* states simply that a system, such as the couple, is more than the sum of its parts. Relationships therefore have properties of their own, beyond the properties that people bring to them. It is helpful to impart this information to couples early in order to get beyond the stance of "one against the other," to decrease the sense that there is one patient and one nonpatient, and to build a general nonjudgmental working alliance. For example, we might suggest to a woman, "Isn't it interesting that you are a competent, assertive person in your relationship with your coworkers, even your boss, but you feel inadequate and dependent around your husband." And to her husband we might suggest, "Others seem to experience you as easygoing and generous, and yet you feel resentful about sharing time with your wife."

Other important theoretical elements to consider include *homeostasis*, the system's self-regulating process that maintains stability; *morphogenesis*, the capacity to change and adapt; and *circularity* or circular causality, meaning that a change in one element influences the other elements.

These general principles can be incorporated into a systems perspective of sexual dysfunction. Following is a brief summary of a theoretical model presented in greater detail elsewhere (Verhulst & Heiman, 1988). Different levels of interactions are exchanged between the two people during sex. One level, *symbolic interactions*, refers to the exchange of words, ideas, symbolic gestures, and other representational cognitive features. A simple example is that two people must come from a similar enough cultural background for each to have a similar interpretation of such symbols as presenting flowers, making eye contact, and even use of the word "mar-

riage." These are not issues of agreement but issues of shared understanding of meaning.

A second level, *affect-regulated* interactions, describes the interacting expressions and perceptions of affect, exclusive of the symbolic level just discussed. Affect-regulated interactions are coordinated by the affective states of the participants and are expressed through autonomic responses, movements, postures, facial expressions, gestures, and the affective component of speech. Affect-regulated interactions predominate in sexual interactions because of sexuality's emphasis on desire, arousal, and nonverbal communication. In an earlier paper, Verhulst and Heiman (1979) described four different types of "affect-regulated interactions" that can steer a couple toward or away from a sexual context of meaning: attachment, exploratory, territorial, and ranking-order interactions. Attachment interactions focus on establishing, preserving, and intensifying the affiliative bond between individuals. Exploratory interactions focus on familiarity through sensory contact. Territorial interactions focus on the acquisition, management, and defense of ownership over material and psychological possessions. Ranking-order interactions focus on the acquisition and defense of social position and status, with dominance and submission issues often the visible evidence. Affect regulation patterns can both enhance and detract from sexual interactions.

A third level of interactions is *sensate exchanges*, referring to the sensory pattern, neurophysiological responses, and motor reflexes that each partner elicits from the other. Masters and Johnson's (1970) work was particularly aimed at coordinating the sensate stimulation while decreasing physiological anxiety and the influences of affective and symbolic interactions.

These three levels—symbolic, affective, and sensate—can function somewhat independently but are constantly interacting within each individual. In addition, they comprise subsystems. Each level requires some type of interactional fit between individuals or there will not be a connection on that level.

The lack of efficacy data on systems approaches to sex therapy means that its ultimate value remains to be tested. The reason for its placement here is that it provides the therapist with a framework that might assist the couple's understanding and can be integrated into cognitive-behavioral approaches.

Other Treatments

Pharmacotherapy, in spite of the significant success of PDE5 (phosphodiesterase type 5 inhibitor) agents for men's sexual dysfunction, has thus far been unpromising for women. To date there are no double-blind placebo-controlled studies of any medications on women with orgasmic dysfunction that is not caused by another medication (e.g., antidepressants).

Pharmacotherapy with bupropion hydrochloride has not proven effective in increasing specific sexual responses in women in general (Crenshaw, Goldberg, & Stern, 1987), with more recent exceptions in selected populations. For example, in one double-blind placebo-controlled study premenopausal women with acquired global hypoactive sexual desire disorder were treated with bupropion sustained release for 112 days and reported greater orgasmic response compared to placebo (Segraves et al., 2004).

Sildenafil citrate (Viagra) has had few placebo-controlled trials, with modest effects on limited variables. Women were not selected for orgasmic problems but for female sexual arousal disorder (FSAD). Nevertheless, there is some evidence that for this FSAD sample, orgasm significantly improved (along with arousal sensation and lubrication) only if there were no concomitant sexual desire problems (Berman, Berman, Toler, Gill, & Haughie, 2003). However, a more definitive randomized double-blind placebo-controlled study of 577 estrogenized and 204 estrogen-deficient women found that sildenafil did not help sexual symptoms (Basson, McInnes, Smith, Hodgson, & Koppiker, 2002). In sum, the use of sildenafil for orgasmic disorders per se is not indicated.

Sex education and bibliotherapy have shown positive results for amelioration of orgasmic disorders. For example, Kilmann et al. (1983) found significant increases in orgasmic frequency and decreases of sexual anxiety in secondary anorgasmia after 4 hours of sex education in 1 week. Jankovich and Miller (1978) reported that 7 of 17 women with primary anorgasmia had orgasm in the week following an audiovisual presentation designed to educate health care providers. The content included anatomy and physiology of sexual response and a film on intercourse. Minimal therapist contact appears to be effective in conjunction with self-help manuals (e.g., Barbach, 1975; Heiman & LoPiccolo, 1988) that outline exercises for women to try on their own (Tripet Dodge, Glasgow, & O'Neill, 1982; Morokoff & LoPiccolo, 1986). For a motivated woman with primary anorgasmia reading may be an adequate intervention.

INTEGRATED THEORY AND PRACTICE

When faced with the complaint of lack of orgasm, how does a therapist combine the theoretical and empirical information discussed above? Although no formula exists, there are important elements that require attention during assessment and treatment.

Assessment: Elements and Issues

It is revealing to track closely what happens in the first 15 to 30 minutes of the first visit. Both *content* and *context* are important. How does each

partner in a couple describe the problem? "I don't like sex," "I find sex humiliating," "My wife doesn't enjoy sex," "He thinks I should have an orgasm" provide useful initial clues as to how a lack of orgasm is experienced by each partner. Their views on the origin and maintenance of the problem and its connection to the rest of their lives are important. Having the partner present can be extremely helpful and efficient for the therapy: misconceptions, positive and negative, can be revealed. Often partners make assumptions about one another based on a brief comment or interaction, and retain that idea for years without questioning it. Sometimes a partner's apparent boredom is a reflection of feelings of inadequacy sexually or interpersonally; other times a partner feels the woman is controlling with stimulation "demands." Clarifying this can move the process to another more productive level.

The affect surrounding the expression of the problem is also important. Common affects are sadness, self-denigration, anger or irritability, anxiety, and depression. An apparent lack of affect or detachment is common in women with primary anorgasmia, who often seem somewhat removed from their search for this unknown entity. The therapist also develops an initial sense of the relationship's emotional climate: tension, frustration, and territorial and ranking-order interactions are common. Nonverbal expressions such as posture, mannerisms, eye contact, verbal–nonverbal contradictions, and the general energy level of the couple can help reveal unspoken conflicts and fears.

The therapist first needs a carefully detailed problem description documenting the level and frequency of desire, arousal, orgasm, and genital pain, and the degree of sexual satisfaction (for further details, see DSM-IV-TR, American Psychiatric Association, 2000; Basson et al., 2003), and of distress about the problem. A woman reporting arousal without orgasm will usually need a different therapeutic intervention than a woman who is never aroused. As a natural lead-in to more historical material, the therapist should ask whether the sexual symptoms are *global* or *situational* and whether they have been *lifelong* or intermittent (*acquired*).

Masters and Johnson's (1970) thorough sex histories lasted some 5 hours, a length that is impractical in today's brief therapy climate. Cognitive-behavioral and systems (e.g., strategic family) therapy may focus minimally on historical factors, in the belief that a current focus is essential if the past is not going to continue invading the present. Masters and Johnson's extensive, evocative history-taking session, culminating in a roundtable discussion with therapists and patients present, effectively drew a line between the past (acknowledging the contribution of historical factors) and the present (doing sex-therapy exercises). An alternative form of history taking is the sexual genogram (see McGoldrick, Loonan, and Wohlsifer, Chapter 14, this volume), in which couples are taught the basics of making a genogram and then sent home to construct one over three generations,

with an emphasis on sexual, gender, and intimacy issues across the different generations.

Thorough history taking, although not absolutely essential, has many valuable features, especially with women with anorgasmia. It is usually informative to do a woman's history in the presence of her partner—the reactions of both individuals to the material and process cannot be captured in individual interviews. We use assessment sessions to obtain content, develop an understanding of the symbolic, affective, and sensory aspects of the problem, and facilitate the development of a therapeutic relationship. Sexual history taking includes asking about overt and covert messages about sexuality and affection in the family of origin with special attention to the behavior of the parents toward each other and the children, early sexual experiences, adolescent development, sexual and physical abuse, losses, particularly of early male and female figures, affects associated with sexual ideas and experiences, and degree of enjoyment of sensual experiences. Information is obtained concerning the parent's attitude toward sex and the perception of the parental relationship. A straightforward and nonthreatening approach is "What did you learn about how men and women relate to each other from your parents' relationship?"

The therapist must assess whether the orgasm problem is secondary to a physical or biochemical disorder. As mentioned, all classes of antidepressants can impair sexual functioning (Aldridge, 1982; Gitlin, 1997; Segraves, 1985). The impact of SSRIs on delayed orgasm and desire range from a few percentage points to 80%, with more effects found for women (Rosen et al., 1999). Current use of prescribed and over-the-counter medications, as well as recreational drug and alcohol use, should be checked to see whether onset coincides with the sexual problem.

Other medical conditions may affect orgasmic response. Back problems or nerve damage should be considered in cases in which the woman has noticed an injury-related change, can tolerate long periods of intensive vibratory stimulation, or has a lack of sensation of any kind in her genital area. Sexual dysfunction has been reported in the early stages of multiple sclerosis, often in conjunction with bladder and bowel problems (Lundberg, 1980), as well as in diabetic women who have peripheral neuropathy (Jensen, 1985). Abdominal surgeries that cut vascular tissue and lymph nodes may interfere with autonomic nervous system functioning and inhibit orgasm (Wise, 1983). Hysterectomy with or without oophorectomy has been reported to inhibit orgasm in some women but data vary considerably across studies and most are poorly controlled (Farquahar et al., 2002; Roovers, van der Bom, van der Vaart, & Heintz, 2003; Thakar, Manyonda, Stanton, Clarkson, & Hiryonen, 1993). There is evidence that the retention of the cervix in hysterectomy protects against dyspareunia or loss of orgasmic ease of response (Kilkku, Gronroos, Hirvonen, & Raurumo, 1983).

An evaluation of current depression is important. Undiagnosed or subclinical levels of depression may be behind the presenting symptom of infrequent orgasm in a woman, especially if she reports low sexual desire as well. Seasonal depression may also require diagnosis, although sexual symptoms have rarely been reported with this disorder (Avery, 1997; Rosenthal & Wehr, 1987).

An important task of the clinician is to understand why the symptom makes sense and what functions it may serve. This step may be critical in determining the therapeutic interventions and managing therapeutic impasses. A natural place to begin is to ask the anorgasmic woman what having orgasms means to her: "What would it mean if you had no more orgasm difficulties?" Reactions to this question vary: "I would feel powerful," "I would be vulnerable," "I would be close to my partner," "Extremely sexual." Usually these meanings are conflicted—desired and feared, sought and avoided—by both the woman and her partner. A couple who believes that the woman's orgasms will make them feel closer may be singing silent praise to the symptom bearer who does them both the service of regulating closeness. A lesbian client responded to the question about her reaction to having the orgasm problem resolved with the comment, "Well, then Paula would be *the* relationship in my life." This was a telling remark from a 39-year-old single woman involved with a female lover 2,000 miles away and for whom being in a committed relationship signaled the beginning of the end of her life. From this woman's perspective, being orgasmic was connected to loss, dependency, or even death.

An assignment we frequently give after the first session, particularly when the problem seems entrenched, is to think about what the problem does for the couple. It is a good sign if the couple can come up with a response. The symptom then stops being the enemy and, instead, opens ideas toward solutions.

The therapist's role is to listen to what the person says, cannot remember, omits, glosses over, or emphasizes in order to help frame or reframe the picture into one that helps explain why the sexual problem exists and may have served a valuable function. To a woman who views orgasm as a loss of control and whose family background is explosively physically violent and alcoholic, we might begin the therapy by agreeing that it makes sense not to ever have orgasms, especially around others. This hypothesis would be proposed to the couple. A therapeutic issue then becomes whether orgasm can mean something besides loss of control.

The power of past patterns is sometimes more striking when each partner hears the other discuss earlier events. Interactional patterns and themes begin to surface, and therapists can begin to weave an initial systems understanding of the problem with the couple. Our clinic has seen a

number of couples in whom the partners experienced childhood and adult sexual abuse. A therapeutic dilemma in certain cases of abuse is whether to see each person individually, which might make it possible to obtain more information but could leave the therapist vulnerable to inclusion in the systemic proclivity to keep sexual secrets or repress them. One approach is to meet partners separately but to tell each person that the purpose of the sessions is to find another way besides secrets and forgetting to protect each of them. Standardized assessment can also be useful. We include formalized assessment routinely: the Spanier Dyadic Adjustment Scale (Spanier, 1976), which examines relationship factors including consensus, satisfaction, cohesion, and affectional expression; a medical history form; the Brief Symptom Inventory (BSI; Derogatis, 1977), which assesses psychiatric symptoms; the Life Experiences Survey—Abridged & Revised (adapted from Sarason, Johnson, & Siegel, 1978); and a sexual history form (modified from Heiman & LoPiccolo, 1983; LoPiccolo et al., 1985), which asks about specific sexual behaviors.

Treatment: Elements and Issues

Initially a decision of format is required: Would this woman or couple benefit most from an individual, couple, or group setting? The outcome data are not very helpful in making this decision. If the woman has an ongoing partner and no current affairs, it is likely she will benefit from couple therapy, especially if her desire is to have orgasms with that partner. Women in tentative relationships or hopeless marriages, or with a history of abusive relationships, may benefit from individual treatment, at least initially. Women-only treatment groups are valuable if the woman is anorgasmic and without a partner.

Symbolic Issues

The initial symbolic issue to explore is the meaning of the orgasm for the woman and her partner. The might say, "Our sexual relationship would be more complete if my orgasm were part of it," whereas her partner's response might be, "If she has orgasms, our marriage would be perfect." The woman in this situation may find it difficult to begin to change if it means that (1) she is the only obstacle between their current situation and a "perfect" relationship, and (2) he will not acknowledge the problems that she experiences in the relationship after she becomes orgasmic. To understand the couple's images of orgasm, one often asks about images of relationships, sexual behaviors, and having children. This material helps formulate, on a symbolic level, where avenues for and barriers to change might be.

Affect

Many anorgasmic women do not feel that their body, or its sexual responses, belongs to them. Or, if they do have a sense of ownership, their body image may be so negative that they cannot feel good about being sexual. This issue can take many forms. Women may report that they find their bodies ugly and their genitals disgusting. They may try to make their bodies, including their genitals, "look better." However, because appearance standards are derived from social norms, conforming to these norms implies that society is at least co-owner of women's bodies. Alternatively a woman may report feeling nothing when her body, especially her genital area, is touched. These examples of disconnectedness are also examples of historical and current *territorial* themes. The woman may feel that any partner who touches her touches something she does not like, cannot feel, and/or does not own. This gives the partner ownership with a sense of burden and responsibility when sex does not go well. How crucial is a sense of bodily ownership to orgasmic responsivity? No one knows. It depends on what is missing from the woman's sense of self when she is involved in a relationship. Some sense of ownership over her own body does seem to be important for the woman whose orgasm evades her. It seems especially useful for women with histories of abuse because they have had experiences of having their bodies invaded territorially. The masturbation program (LoPiccolo & Lobitz, 1972; Heiman, LoPiccolo, & LoPiccolo, 1976; Heiman & LoPiccolo, 1988) can be used as a means for women to claim their bodies and sexual sensations.

Ranking-order interactions commonly present in the form of "I want to have orgasm for my partner," or "I do everything I can to try to please her so that she will get aroused." One person is in charge of trying to get the interaction to move in a particular direction. Although this pattern is not necessarily a problem, if orgasm is elusive one person's steering the other to obtain orgasm rarely works. A man we were seeing reported that he was constantly trying different forms of stimulation in order to get his wife closer to orgasm. As a result, he was irritated, she was distracted, and each felt inept. Using sensate focus as a medium, the therapist had the couple focus on the touching he enjoyed giving (rather than touching they thought would get her aroused) and on her initiating tender caressing if she felt pressured. Ranking-order interactions were thus corrected with an *exploratory-attachment* interaction that helped to resexualize the couple's experience.

Sensate Exchanges

Women and their partners often have difficulty facilitating arousal and communicating about the stimulation they want during sexual activity.

Many women do not know what is arousing or are committed to a restricted arousal pattern. Often partners feel out of tune with each other. For example, the male may ejaculate too quickly. Greater sensate exchange for the woman can overstimulate the male, increasing the nonorgasmic woman's sense of being left behind. The interaction will need to be slowed down, perhaps by excluding ejaculation for a while or introducing attachment interaction patterns such as nongenital tender stroking.

There are other sensate patterns, however. Some time ago, we saw a woman who had been having an affair for the prior 2 years with a man she had decided not to "commit to" because of a clash in values. Ann was a 34-year-old divorced nurse with one daughter. She has been raised in an authoritarian Calvinist family. Although orgasmic in masturbation, she never had experienced an orgasm with a partner. Her masturbation pattern began as a young girl, when she would urinate as part of her masturbation ritual. She no longer urinated during masturbation, although she did occasionally urinate with her boyfriend during high arousal. For her, urination was connected with "total relaxation." Her sensate exchange pattern was in tune with her boyfriend, even to the point of "letting go." However, orgasm was not the result. She enjoyed sex with her boyfriend more than masturbating. Her experience of the difference between masturbation and partner sex (illustrating an interaction between symbolic and affective levels) was that masturbation connected to what she called her erotic, pornographic, genital center. It was not connected to what she called her "heart center."

The major effort of four sessions of therapy was (1) to appreciate her current pattern, as it allowed her both to enjoy mutual sex and to sequester orgasm, her most private sexual experience, from a relationship of limited commitment potential; and (2) to suggest *Becoming Orgasmic* (Heiman & LoPiccolo, 1988) as preparation for eventual merging of orgasm and partner sex. Ann left therapy feeling good about herself although not orgasmic with her partner. Ann is an example of someone whose sensate exchange pattern reflected conflicts in the symbolic-affective interaction level with respect to sex and her relationship with her boyfriend.

CASE EXAMPLES

My contact with patients has been exclusively within a medical school, university-based reproductive and sexual medicine clinic, which I have directed, with collaboration from urology and obstetrics and gynecology. Because of this setting and visibility, we increasingly are asked to see etiologically complex or previously treated individuals and couples. Thus the following case examples are instructive for these features, but if the reader is looking for the more straightforward approaches to orgasmic disorders,

they can be found in the cognitive-behavioral literature as highlighted in the earlier sections. The following cases reflect our current practice—a mixture of brief 1-hour consultations and ongoing treatment. A 1-hour consultation interview requires selectivity of focus while attending to a wide array of possible contributing etiological factors. Typically the outcome is to refer for further evaluation or to return recommendations to the referring therapist.

Consultation Case

Anita: Somatic Focus and Neurophysiological Questions

Anita, a 39-year-old woman of Finnish background, was referred by her primary therapist who was treating her for panic disorder. She complained of lifelong lack of orgasm. She was married 9 years to her second husband. Her first husband had died of cancer 2 years after they were married. She had no children.

Anita's *medical and psychiatric history* was significant for several features. She had an atrial septum defect (ASD) leading to a stroke and surgery to repair the ASD 2 years prior to the consult. She had fully recovered from the stroke. She also had panic disorder, which had begun at age 25 but which had worsened in the last 2 years. Her panic disorder symptoms included heart palpitations, shortness of breath, nausea, and numbness in her extremities. Anita described her panic symptoms as severe and stressful. She acknowledged no other psychiatric symptom history except for a brief period of anxiety when her first husband was ill. She reported other symptoms: decreased organization and concentration; sudden fatigue, in spite of adequate sleep, including recently falling asleep while driving; and a job demotion in the prior month after years of excellent performance reviews. She said that a gynecologist had diagnosed her with an "immature cervix" and suggested that there was evidence that she was a diethylstilbestrol (DES) baby as her mother had several miscarriages and she was born prematurely.

As a child, Anita said she had fallen "very hard" directly on her groin while riding a boy's bike, resulting in visible bruising. Her current medications included Paxil (paroxetine), Prozac (fluoxetine), Klonopin (clonazepam), and Lotensin (benazepril hydrochloride), all with potential sexual side effects. She reported no recreational drug use, no nicotine, and less than one alcoholic drink per week.

With respect to *her current relationship and sexual life*, Anita noted a decrease in sexual desire within the last 6 months only, adequate sexual arousal and lubrication, and no pain associated with sexual activity. Only her anorgasmia was lifelong and global. She reported no history of sexual

or physical abuse or coercion around sexual activity. She stated that she was "very happy" in her current relationship but that the sexual issue, including her lack of orgasm and especially her more recent decrease in desire, was creating some problems. During sex, when her husband would try to touch her genitals, especially around her urethral area, she was extremely sensitive and had to ask him to stop. However, this information was probably imprecise, given that at the close of the interview, Anita acknowledged that she was not sure of the location of her clitoris and requested an illustration of female genitalia.

IMPRESSION AND RECOMMENDATIONS

There were a variety of possible explanations for Anita's lack of orgasm. Contributing factors included (1) neurophysiological elements, including the childhood groin injury, correlates of her cardiovascular health, and possible very long-standing anxiety spectrum disorder; (2) current medications—the SSRIs were likely to decrease orgasm latency even further and her more recent desire decrease could be influenced by the recent addition of Prozac and Lotensin to Paxil; (3) congenital factors as suggested by the diagnosis of immature cervix and possible DES history; and (4) sexual inhibition with respect to discomfort with high arousal and release of tension (her panic disorder symptoms perhaps increasing her discomfort with these experiences).

It was clear that Anita was vigilant about her body's conditions and symptoms. Whether this focus was excessive, meaning it comaintained her anorgasmia, needed further exploration. With her history, she had reason to be vigilant about her body. Thus it may come as no surprise that when offered the option of further assessment and treatment, she selected the workup for possible pelvic nerve damage over pursuing behavioral therapy and attempting to increase arousal via more intense stimulation with a vibrator.

Anita accepted the following treatment recommendations: (1) a referral to urology, where a more careful look at her pelvic nerve conduction and genital anatomy could be undertaken (even though this might produce a diagnosis that contained considerable uncertainty about its functional effects); (2) a photocopied diagram of female genitalia for identifying the exact location of her clitoris and urethral meatus; and (3) the option to return for behavioral treatment, which might include vibrator use, and tolerance for high levels of sexual arousal. The option of changing her medications was discussed briefly but Anita was adamant that she would do nothing to put her in further "danger" of panic attacks as she had only recently become stabilized on her current regimen. Also, this did not seem like a first-line approach since her anorgasmia was lifelong and her medication use spanned only the past year.

FOLLOW-UP

About 1 year following this initial consultation, Anita returned. She had been evaluated for pelvic nerve damage by a specialist and no abnormalities were found. Anita had decided to work on her panic disorder with cognitive-behavioral therapy. After 8 months of treatment, she was able to overcome her panic symptoms and had stopped all medications except for occasional Klonopin use. She had tried masturbation and was experiencing greater sexual arousal, but she now wanted to work with her husband on their sexual relationship. Her ability to reclaim her body from her former experience of panic and fear related to her early trauma apparently allowed her to move ahead with greater optimism about improving and enhancing her marital sexual life.

Ongoing Treatment Cases

Ella: Lifelong Anorgasmia and Limited Sexual Contact

BACKGROUND

Ella was referred for treatment by her individual and group therapist in a community about 3 hours from the clinic. She was 52 and had been married for 10 years to Tom, a man who had been injured in military combat and who had developed a long-term drinking problem. Ella worked full time and Tom had not worked regularly for at least 20 years, though he did maintain their house and property. Ella's goal in therapy was to "take care of her sexuality along with other aspects of her health." In particular she wanted to address her avoidance of physicians. Her last visit to a gynecologist had occurred 10 years earlier and the examination had to be terminated because Ella found it so painful. She now wanted to overcome her avoidance of gynecological examinations as well as learn how to have orgasms. In fact, she brought the self-help book *Becoming Orgasmic* to her first session. She was forthright, slightly shy yet hearty, easy to laugh, thoughtful, and very motivated to change.

Ella was born in the rural Midwest of the United States to a family that was loving, understated, and dependable. She was the younger of two sisters, the older of whom was a successful musician. Her family was Catholic and the patient felt that a lot of her sexual beliefs were influenced by Catholic teachings. She had always tried to be a good girl and to obey church teachings. Ella never felt as attractive as her older sister, a woman who could "turn heads" when she was younger, and who lived in a long-term committed (nonmarital) relationship. She felt slightly closer to her father than her mother, but her family interactions were essentially friendly and accepting. No one in the immediate family had a drinking problem. Ella was a strong student, a good sport, and was pals with men but rarely

dated. There were no reported negative sexual events or coercion as a child or as an adult.

Sexually, Ella said she never experienced coitus or orgasm and, in fact, had experienced very little genital touching with men and none with women. She was uncertain if she had even been sexually aroused. She had never masturbated or attempted to do so. She reported an "inattentive" relationship with her genital area and it appeared as if she was embarrassed by, and avoided touching, her genitals. She reported some wishful desire for male physical companionship, and did occasionally cuddle in bed with her husband. She seemed a little uncertain about attempting coitus but was willing to consider this as a possible treatment goal. Her marriage had never really been sexual, except for some kissing and holding. Ella was not even sure if her husband had desire or erectile difficulties since they never discussed sex.

Her relationships with men seem to have been chosen to insure a lack of sexual contact. She had had two male friends before her husband. They were buddies and her role was to be helpful. All had some kind of drinking problem about which she tried to be helpful or accepting. She was kind and seemed to benefit from the fact she could be useful in the relationships. That came up more clearly during therapy.

TREATMENT

Ella was seen monthly over a period of about 3 years because she could not afford to miss work and the distance to the hospital was considerable. Treatment consisted of both systemic and cognitive-behavioral strategies. We explored why she remained in the relationship with Tom, given his problems. Although she had raised concerns about his drinking, Tom denied he had a problem and refused to go for treatment. Ella said she felt safe with Tom. Although he was often withdrawn or irritable, he never threatened or physically hurt her.

We spent the first few sessions anticipating and preparing for a visit to a sympathetic local gynecologist who was experienced in dealing with sexual problems. Ella practiced relaxation and Kegel exercises and we reviewed the general parameters of the gynecological examination. We rehearsed how to tell the physician if Ella felt any physical discomfort (e.g., "I would like to stop for today") if the exam became too uncomfortable. Ella agreed to pay for the session even if she stopped early. This gave her a sense of predictability and control which, along with a prepared and patient doctor, helped result in a successful examination. During the examination, it was discovered that there were some cervical cells that needed removal. This experience, which included taking care of her body and tackling something she had dreaded so long, was a springboard to moving ahead with her self-examination and sexual efforts.

The next issues revolved around where she wanted to go with her sexuality and her relationship. She was hesitant about proceeding with the exercises described in the *Becoming Orgasmic* chapters. Ella was encouraged to move at her own pace and even advised to go slowly. She needed to anticipate the possibility that her sexual changes might not be viewed positively by Tom as her sexual avoidance and lack of pressure on him regarding sexual intimacy may have protected him. We discussed inviting him to take part in a session but she felt she needed to sort issues out for herself and see what she really needed to address.

Ella changed gradually, working on her appearance "from the inside," meaning committing to becoming healthier by losing 40 pounds with modest exercise and greater selectivity about food. She and her husband taught some classes together in animal training techniques with dogs and worked well together. Her physical changes were accelerated after her mother died following an illness. We discussed family relationships at this time, with special attention to Ella's remarkable "natural" abilities to make herself helpful and useful. At that point she adopted a new and more flattering hair style and wardrobe. She felt good within her body, and she felt "girlie," which for her, with a background of flannel overshirts and jeans, was liberating and identity enhancing.

At this time, her husband received a DUI (driving under the influence of alcohol), his first. This seemed to startle him into awareness of the impact of his drinking, and he stopped drinking and started attending AA sessions for about 8 months. This resulted in more open communication between them. We also discussed the fact that Ella had worried that Tom would no longer need her if he stopped drinking. This was important for her and helped her become more committed to her own growth while hoping Tom would stay sober. About 9 months later, he did begin to drink again and it became clear to Ella that at some point, she would need to be clearer about whether or not this was acceptable to her.

After about 18 more sessions, using the book and her own reactions, Ella gradually explored and practiced genital and feeling explorations and slowly began to experience sexual arousal. Ultimately she tried a vibrator and within 4 months of using it, began to experience orgasm. She was very pleased, expressing a sense of acceptance about her "womanness." She remained uncertain of how or whether this new aspect of her sexuality can be incorporated into her relationship but this has not detracted from her sense of accomplishment and self-respect.

Diane and David: A Good but Elusive Interactional Fit

BACKGROUND

Diane and David were referred following marital therapy and conflict issues that had arisen following David's serious illness. Both were 46 years

old, married for 16 years, with two children, ages 11 and 13. David owned his own business and Diane was a homemaker. Two years prior, David had a 6-month life threatening viral infection that led to work and family problems since he was used to being independent and the primary wage earner. His illness had taught him that "time is crucial," and he began making changes that Diane had asked for over the years. Sex had been a problem almost from the beginning of their relationship—David's main complaint was that it was not frequent enough (about once a month) and was not pleasure focused. Diane reported low desire and infrequent orgasm, some arousal difficulty, but no pain during sex.

Initially, low desire seemed to be the major problem. But by the end of the first session it was clear that there were more sexual symptoms as well as interactional issues. His goal was to get sex to be "normal" and to signify their uniqueness as a couple. Her goal was to feel "special" to him and to have more affection expressed outside the bedroom. She had a long history of not disclosing what bothered her sexually. For example, she refrained from telling him that he ejaculated too quickly for her to feel satisfied, and she felt she used sex in order to solicit better treatment from David. In addition, she had a great deal of trouble refusing sex, so she often consented to sex despite a lack of any interest at all. His premature ejaculation had improved and was no longer viewed as a problem.

In terms of *medical and psychiatric history* factors, David was currently healthy and working full time. With the exception of this illness, neither David nor Diane had a history of medical problems, nor was either currently taking any medications. Diane had recently had knee surgery and wore a knee brace for stability, which somewhat limited her movements. She had been having irregular periods for the last 12 months but no other symptoms that indicated menopause. The couple rarely drank alcohol.

There were several important features of their *relationship and sexual histories*. In his family of origin, David was usually ignored by his parents, who were extremely hard-working owners of a small food market and did not take much time for their four children. David learned to work hard and to fend for and quietly take care of himself. During his viral illness 2 years earlier, his parents did not visit him in the hospital, although they lived only 35 miles away.

Diane was one of four children, the only girl. She grew up on a ranch in a small community in Montana. She summarized her early family relationship in two phrases: "never getting acknowledged" and "girls work, boys play." These schemas remained part of her filter on her current relationship. She reported that her mother was the disciplinarian and was judgmental and hard to please, though Diane continued to try to please her into adulthood. She was more in tune with her father's interests than with her mother's. David said little about his prior sexual relationships except that Diane was the first person he wanted to marry, commenting, "I have always known we were the two." He reported having 10 lifetime sexual

partners. Diane said that she had previously been involved with men (10 to 20 lifetime sexual partners) who were very possessive and jealous. This appealed to her because she felt special and her attention needs were soothed. However, from the beginning of the relationship with David, he was not possessive but instead supportive of her developing her own interests.

TREATMENT

The course of treatment consisted of (1) a focus on symbolic and affective (attachment and territorial) interaction patterns and (2) pursuing replacements for past interactional hurts, disappointments, and protective beliefs. When the couple returned for their second session, with no assignment given except that they do whatever they usually did in terms of affection and sex, they reported two sexual encounters. He reported enjoying them but experienced some performance worries, which were defined as "wondering whether what I was doing was what she wanted." He had reason to be uncertain because Diane had never complained about her unhappiness with his rapid ejaculation and was still not able to say anything about what she wanted. Indeed, though she also felt both experiences were good, she felt "a little pressured about enjoying myself" and was aware of the pressure he felt to perform. She did experience orgasm on one of the occasions. Each was also aware that she preferred sexual intercourse rather than other sexual activities, though she did say she wished for more kissing and hugging outside of sex. After David's illness, he had made an effort to be more physically affectionate (and help with the children), but he felt she did not really notice and, especially important to him, it made no difference in her sexual interest and involvement.

The suggestions at the end of that session were to develop a "hurt museum" (explained below), initiate sex "only if you feel like it, say no to an initiation if you are sure you do not want to, during sex try to get something out of it for yourself, and allow yourself to give feedback that would increase or maintain your own enjoyment." These topics were raised so that each would take responsibility and ownership over their own desire, arousal, and orgasm. Diane's inability to say no to sex combined with her lack of communication about what pleased and displeased her meant increased resentment toward David and disconnection from her own desire and response.

At the next session, Diane reported having negative affect consisting of feeling anxious, upset, irritable, and not finding pleasure in her usual activities. They had had some physical affection and two sexual encounters but she was not really in the mood and had no desire for them and, in spite of the discussion of the prior session, acquiesced anyway. I decided to meet with her individually and gave her the Beck Depression Inventory (BDI) to complete. She scored 24 (moderately depressive range) on the BDI but said

she had now felt much better than the day she completed it. In obtaining a family history, it was clear that Diane had never felt accepted, and currently felt like she was "not worth anything to David," because he almost never said to her, "Have I told you how much I like you," or "How good you look!" I suggested that they both wanted the same thing: attention and acceptance. I also suggested that perhaps the reason she had chosen David rather than the possessive men she had known, and did not accept attention well, was that she was suspicious and even fearful of receiving attention because it did not match her worldview. She was surprised by this remark but considered it.

The *symbolic interaction* issues with this couple were that they were similarly intelligent, used words sparingly, and were more comfortable with action than language (thus more reactive than reflective). They had a small 10-acre farm and enjoyed horses, skiing, and fishing together. Conversations were less satisfying and they were not particularly careful about how they chose words. Diane would often be a bit extreme, once saying, for example, that she felt forced ("like a rape") to have oral sex when in fact she had never simply said she did not want to have oral sex but went along because "he wanted it." This type of word choice would either start David asking questions in a Socratic method or withdraw from further conversation. His use of language was usually tentative and rather vague, and his style of saying "you" when he meant himself was actually confusing and resulted in an in-session request to use "I," which he did after some practice. He was more likely to give Diane gifts as a sign of caring while she preferred verbal appreciation, so there were resentments and disagreements over this symbolic difference.

The *affective patterns* we focused on were attachment because both wanted to preserve and increase their affiliative bond and territorial interactions. Diane did not have a clear sense of what the territory of her own desire, arousal, and orgasm was, as she was always going along with David. Repeated assignments around the topic of "Yes means I want it and I need to say no when I do not" were helpful but cost Diane significant effort and required repeated encouragement and discussion.

Probably the most challenging theme in therapy was Diane's fearful grip on all the past disappointments with David. In each of the early sessions she would bring up examples from past situations or make interpretations based on earlier patterns—all having little to do with what David was actually doing and feeling currently. This is a common issue in relationship therapy and can ossify any attempts to change behaviors or interpretations. We discussed this from many perspectives. The "hurt museum" is a technique that allows the person or couple to come up with a list of past hurts, discuss them briefly, and then "enter them" in this museum. It helps if incidents are written down briefly. The point is to use this as a device for remembering but putting aside the past, in a place where it can be

reviewed and updated from time to time. This worked minimally in their case. More helpful was challenging Diane's interpretations by asking her whether she was talking about then or now. It was easier to see David in the old ways because if she accepted that he was indeed being attentive and appreciative, she might risk losing this new pattern and be hurt again. Across 20 sessions and about 9 months, David and Diane made changes. Diane was able to experience greater desire and become more assertive about what she did and did not want, and she experienced orgasms in about 50% of their contacts. David was reassured that Diane was enjoying sex more and, consequently, he was able to relinquish worrying about whether she was really interested or engaged since she would now tell him so directly. They did not become more at ease verbally but did develop a pattern of measured, careful, and brief exploration of conflictual issues in the area of affection and sex.

FOLLOW-UP

Three years later, Diane phoned about a referral for her 16-year-old, who was having anxiety and depression problems. We spoke briefly on the phone and she indicated that their marriage actually continued to improve after they left therapy as did her sexual feelings. While "not perfect" she felt they were well connected and closer than they had been when therapy was completed.

SUMMARY

The value of women's orgasm and the classification of orgasmic disorders are clearly a product of history and culture. This chapter has summarized the prevalence and classification of orgasm disorders as we currently define them, and assessed treatment effectiveness. There is evidence that cognitive-behavioral interventions are effective, particularly with primary orgasmic disorder, and that an active approach to treatment is more effective than a purely reflective one. In addition, a systems framework provides a theoretical perspective with which to understand and implement effective treatment modalities. The cases discussed point out the need for broadly based assessments, psychological and physiological knowledge, a multidisciplinary clinical referral network, and strategies for treatment when there are multiple diagnoses. One would expect a number of additions to knowledge about this topic over the next decade, particularly in the area of increased knowledge of women's sexual arousal, more physiological information, more information on medications for treating sexual arousal, and perhaps orgasm and desire problems. Without question, treatment efficacy data are limited and further testing of psychological and physiological

treatments, alone and in combination, would benefit women and their partners.

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CHAPTER 5

Dyspareunia and Vaginismus

So-Called Sexual Pain

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In this chapter, Binik, Bergeron, and Khalifé articulate and argue persuasively for a rather unique view of dyspareunia and vaginismus—namely that these are not primarily sexual disorders, but rather are secondary reactions to the recurrent or anticipated experience of genital pain and/or vaginal penetration and should, therefore, be classified as pain disorders.

Given the many physical and psychological contributions to dyspareunia and vaginismus, which tend to co-occur, Binik, Bergeron, and Khalifé emphasize the critical importance of a multidisciplinary approach to assessment and treatment. Treatment of vaginismus has tended to focus on in vitro and in vivo desensitization with mixed success. Evidence-based research looking at the ultimate success in penile–vaginal penetration is modest, and is lower than that reported in uncontrolled case reports. In fact, Binik and his colleagues wonder if it is even reasonable for penile–vaginal penetration to be considered a criterion for treatment success.

The etiological contributions to dyspareunia are even more varied than those factors contributing to vaginismus. Treatment has tended to include both psychosocial approaches focusing on decreasing hypervigilance, catastrophizing, and anxiety and a variety of medical or physical treatments, including topical creams, oral medications, biofeedback, pain management therapies, and complementary or alternative therapies.

Binik, Bergon, and Khalifé recommend that a gynecological exam be routine in

the assessment of both vaginismus and dyspareunia. They believe that a skilled gynecologist can be helpful in detecting possible obstructions to penetration, but, more significantly, in assessing and characterizing the location, quality, intensity and time course of associated pain complaints. It is important to determine whether the pain is provoked or unprovoked as well as its duration. Dyspareunia associated with vulvar vestibulitis often subsides rapidly after the provoking stimulus is removed, whereas unprovoked genital pain (associated with essential, dysethetic, or generalized vulvodynia) can last for hours. Of interest, women vary widely in terms of their continued engagement in sexual activity, with some withdrawing totally and others persisting despite pain or discomfort. Similarly, there is considerable variability in the degree to which these sexual problems contribute to relationship distress.

Assessing how each individual woman copes with genital pain is critical since this guides treatment interventions. Some women react with complete sexual withdrawal when they experience mild pain while others tolerate routine sexual intercourse despite severe pain.

Binik, Bergeron, and Khalifé advocate for a multimodal approach to treatment with collaboration of a physician, a psychologist/sexologist, and a physical therapist. Teaching women about their pelvic floor musculature is helpful as well as directing attention to psychological and relationship issues. Relaxation training is an integral part of treatment and can take the form of breathing exercises or systematic muscle relaxation. Cognitive strategies to increase self-efficacy are important as well.

Although Binik, Bergeron, and Khalifé believe that sexual pain complaints should be treated by pain specialists, they are not optimistic that this is likely to occur in the near future. Consequently, it is important that sex therapists develop expertise in the assessment of the sexual pain complaints of their patients and in coordination of treatment.

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THE PAINFUL MESSAGE OF THIS CHAPTER

In our view, vaginismus and dyspareunia are not sexual problems (Reissing, Binik, Khalifé, Cohen, & Amsel, 2004). Although the presenting complaints of many women diagnosed with vaginismus and dyspareunia are sexual, these complaints are secondary to the recurrent or anticipated experience of genital pain and/or vaginal penetration. It is this experience, not the resulting sexual dysfunction, that is the primary problem. While this view is not widely accepted (see the February 2005 special issue of

Archives of Sexual Behavior), we argue on theoretical, experimental, and clinical grounds that the traditional views of "sexual pain" have outlived their usefulness and need to be reconsidered.

We appreciate that such an approach is a hard sell to the audience of professionals who have been the unchallenged authorities in this area for the last generation. Most professionals, including us, have been trained with the idea that we can cure vaginismus and that in the absence of organic disease, we can greatly improve the sex lives of women suffering from dyspareunia. While there is little doubt that we have helped some women some of the time, we believe that a critical reexamination of our therapeutic effectiveness is also in order. Although there is an important role for sex therapy in the treatment of vaginismus and dyspareunia, this role must be integrated into a wider multidisciplinary treatment framework that focuses on reducing pain. There is little hope for sexual pleasure while a woman is experiencing intense genital pain.

Part of the motivation for this new approach is the mounting evidence that we have dramatically underestimated the prevalence of vaginismus and dyspareunia. Although there are no state-of-the-art epidemiological estimates for vaginismus, there is now converging evidence that recurrent dyspareunia is likely to have a population prevalence of approximately 15% (Laumann, Paik, & Rosen, 1999). This number is enormous and one epidemiologist has termed it an epidemic (Harlow & Stewart, 2003; Harlow, Wise, & Stewart, 2001). Twenty years ago, dyspareunia was not a common presenting complaint at our university hospital-based sex and couple therapy service; today, we cannot effectively deal with the number of women requesting help. We do not know why women suffering from dyspareunia did not approach our clinic in the past, but we suspect that many suffered in silence.

A BRIEF HISTORY OF SEXUAL PAIN

Vaginismus

As far as we are aware, the first mention of a condition similar to vaginismus appears in a work attributed to an Italian woman physician of the 11th century, Trotula of Salerno: "On the matter of tightening of the vulva, so that even a woman who has been seduced may appear a virgin" (Salerno, 1940, p. 37). Victorian physicians (Sims, 1861) presumably described a similar condition in the following terms: "It was a spasmodic contraction of the sphincter vaginae, resulting from an irritable condition of the nerves of the part which I could not explain" (p. 358). Masters and Johnson (1970) formalized this definition, which was ultimately translated into the terminology of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) in the fol-

lowing way: "recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse" (p. 280). Until recently, almost all professionals uncritically accepted the Masters and Johnson/DSM definition. This probably occurred because the standard sex therapy treatment based on progressive vaginal dilatation was directed at the presumed mechanism, muscle spasm, and was considered to be highly efficacious.

Dyspareunia

Pain during sexual intercourse was described in the Ramesseum Papyrus written circa 2000 B.C. (Barns, 1956). This document appears to emphasize the pain of dyspareunia rather than its sexual interference because it differentiates pain in the vulva from other types of genital pain and links dyspareunia to menstrual difficulties. The current term "dyspareunia" was coined by a 19th-century Victorian physician (Barnes, 1874) who attributed the pain to primarily physical causes but who also emphasized its interference with sexual functioning. In the last century, the conceptualization of dyspareunia has followed the traditional organic–psychogenic distinction that has been accepted for most medical/psychiatric classification. In DSM-IV-TR (American Psychiatric Association, 2000) dyspareunia is defined as follows: "recurrent or persistent genital pain associated with sexual intercourse in either a male or a female" (p. 556).

As far as we can determine, clinicians and researchers have for the most part treated vaginismus and dyspareunia as distinct problems. Although they have been grouped together under the category of "sexual pain disorder" since DSM-III-R (American Psychiatric Association, 1987), the diagnostic criteria, associated etiologies, and treatments have been quite different. Until recently, vaginismus has generally been considered one of the classic sex therapy success stories; dyspareunia, on the other hand, has typically been medicalized and ignored by mental health oriented sexologists.

THE NOSOLOGICAL NIGHTMARE OF "SEXUAL PAIN"

Although many professionals feel that attention to classification is not highly relevant to clinical concerns, we disagree. How we classify a problem often has important implications for who treats the problem and how it is treated. Although there has been a consensus that vaginismus is the result of recurrent muscle spasms, it has been classified as a psychogenic sexual dysfunction and treated primarily by sex therapists. Until recently, no one considered involving the logical professional, an expert on the pelvic musculature. Because DSM-IV-TR classified "dyspareunia not resulting

from a general medical condition" as a sexual dysfunction, sex therapists have typically been the primary clinicians involved. It is therefore not surprising that they focused on sexual issues and tended to either ignore the pain or treat it as the result of sexual inadequacy.

Recently, other professional groups have begun to take an interest in the classification of vaginismus and dyspareunia (Basson et al., 2000). Their classification efforts have not solely revolved around interference with intercourse but have also focused on pain or its presumed mechanisms. The most active group has been the International Society for the Study of Vulvovaginal Disease (ISSVD). The recently proposed ISSVD classification has differentiated the pain based on its location, whether or not it is provoked by an external stimulus, and whether it is associated with a known disease (Moyal-Barracco & Lynch, 2004). Other groups, such as the International Association for the Study of Pain (Merskey & Bogduk, 1994) and the American College of Obstetrics and Gynecology ([ACOG]; 1997) have also attempted classifications. While this increased multidisciplinary attention will probably pay off in terms of new treatments, it has created a literature filled with new terms such as *generalized*, *essential*, or *dysesthetic vulvodynia*, *vulvar vestibulitis*, *vestibulodynia*, *focal vulvitis*, and so forth, in addition to older diagnostic labels like dyspareunia, vaginismus, and pelvic pain. Table 5.1 illustrates how a woman presenting with a burning, cutting vulvar pain upon penetration could be treated in very different ways after being diagnosed by the different professionals.

Table 5.1 does not include less common treatments prescribed by recognized professionals or the increasing number of alternative treatments that women are trying because of the lack of efficacy of existing interventions. Although there are now numerous professional disciplines involved, there is little knowledge concerning the potential mechanisms mediating the pain.

A BIOPSYCHOSOCIAL PAIN-FOCUSED CONCEPTUALIZATION OF VAGINISMUS AND DYSPAREUNIA

Our approach to assessing and treating so-called sexual pain is to shift the focus from sex to pain and fear. This approach is also based on the idea that multidisciplinary assessment and treatment is the ideal way to deal with the complex interaction of physical problems and psychosocial issues associated with vaginismus and dyspareunia. Although the database to justify our view is growing (it is reviewed below), much of what we propose is based on controversies that are not likely to be resolved soon. Our basic argument is that what is currently called dyspareunia encompasses several different vulvovaginal/pelvic pain syndromes. Pain also appears to be asso-

TABLE 5.1. Diagnostic and Treatment Variability for Vulvar Pain as a Function of Professional Specialty

Professional	Diagnosis	Treatment
Sex therapist	Dyspareunia	Sensate focus/Vaginal dilation
Dermatologist	Lichen sclerosus	Corticosteroids/Hormone creams
Gynecologist	Vestibulodynia	Anesthetic creams
Psychiatrist	Somatization	Antidepressant
Physical therapist	Pelvic floor hypertonicity	Physical therapy/Biofeedback
Urologist	Cystitis	DMSO
GP/Family physician	Vulvar fissures	Corticosteroid cream

ciated with many cases of vaginismus but what best differentiates dyspareunia from vaginismus is an intense fear or phobia of vaginal penetration (Reissing et al., 2004).

There are a number of theoretical/logical reasons underlying our approach. First, we ordinarily do not classify problems on the basis of the activities with which they interfere. Dyspareunia and vaginismus interfere with sex but so do headaches, which we would not define as sexual problems. Second, the current DSM definition of sexual dysfunction is based on interference with a specific portion of the sexual response cycle. The interference resulting from dyspareunia and vaginismus is varied and nonspecific. Third, the primary symptom of dyspareunia is genital pain and most women suffering from vaginismus also experience such pain. Fourth, the primary symptom of vaginismus is not vaginal spasm; in fact, pelvic floor changes may be the result, rather than the cause, of vaginismus. Fifth, the focus on interference with intercourse has prevented attention to pain characteristics that are essential to clinical description and classification. As a result, a 20-year-old woman suffering from a burning/cutting vulvar pain is classified in the same way as a 45-year-old premenopausal women who is suffering from a dull/throbbing deep pain over her right ovary. Sixth, women with dyspareunia meet all the DSM criteria for pain disorder. In fact, DSM-IV-TR recognizes this by specifically excluding dyspareunia (without any explanation) as a potential pain disorder (see Criterion E for Pain Disorders, American Psychiatric Association, 2000, p. 503). Finally, the term "sexual pain" makes little sense since it implies the existence of two distinct kinds of pain: sexual and nonsexual. If there is a sexual pain, it is more likely akin to sadomasochism rather than to either dyspareunia or vaginismus (Reissing et al., 2004).

A useful analogy to consider is the development of our ideas and conceptualizations concerning headache. The currently accepted classification has been the result of over 50 years of theorizing and research. It

is based on pain characteristics (location, quality, intensity, time course, etc.) and associated symptoms. The potential parallels between headache and "genital ache" are striking: (1) the main symptom for both is pain; (2) pain characteristics appear to be important classification markers; (3) physical pathology appears closely related to some but not other subtypes of both problems; (4) disability is not linearly related to diagnosis or pain intensity; (5) there exists a similar controversy for both problems concerning whether the proposed subtypes are qualitatively or quantitatively different.

RESEARCH SUMMARY

Vaginismus

There has been remarkably little research concerning vaginismus. It is unclear why this has been the case, but it is tempting to speculate that the inflated claims of therapeutic success have dampened researchers' enthusiasm. Perhaps the most recent and somewhat sobering therapy outcome data (discussed below) will rekindle it. Another possible reason for the lack of research is practical. Research using DSM criteria requires a gynecological examination to confirm the diagnosis. Since avoidance of vaginal penetration is a symptom characteristic of vaginismus, it is difficult to recruit women for studies requiring vaginal examination. There are several recent, critical, and comprehensive reviews of the available literature (Reissing, Binik, & Khalifé, 1999).

Epidemiology and Diagnosis

Since current diagnostic definitions require a gynecological examination to confirm the existence of vaginal spasm, it will be very difficult to carry out a reasonable epidemiological study. The rates reported in existing studies are primarily based on clinic samples and therefore do not reflect the general population (Reissing et al., 1999).

Several studies have suggested that is difficult for clinicians to reliably differentiate between dyspareunia and vaginismus; these studies have also suggested that the diagnostic spasm criterion is neither reliable nor valid (Basson, 1996; de Kruiff, ter Kuile, Weijenborg, & van Lankveld, 2000; Reissing et al., 2004; van Der Velde & Everaerd, 2001). Reissing et al. (2004) showed there is significant overlap between women with vaginismus and those with dyspareunia on measures of pain and pelvic muscle tension. The factor that appeared to best differentiate vaginismus and dyspareunia resulting from vulvar vestibulitis syndrome was a behavioral measure of avoidance/fear of vaginal penetration.

Etiology

There is a rather consistent literature suggesting that a variety of elements, including negative sexual attitudes, religious orthodoxy, lack of sexual education, traumatic sexual events, dyspareunia, among others, are potential etiological factors in vaginismus. However, this research is unconvincing since, as far as we are aware, there are only a few etiological studies that have a control group of any kind (e.g., Reissing, Binik, Khalifé, Cohen, & Amsel, 2003; van der Velde, Laan, & Everaerd, 2001). Reissing et al.'s (2003) study suggests that there is an elevated incidence of childhood sexual abuse/interference associated with vaginismus. A replication of this study with a larger total sample and more comprehensive measurement of sexual abuse/interference should be carried out.

Therapy Outcome

Recently, there has been interest in medically oriented therapies for the treatment of vaginismus. For example, several recent uncontrolled studies have reported on the use of local injections of botulinium toxin (Ghazizadeh & Nikzad, 2004; Romito et al., 2004). In the past, anxiolytic medications have been combined with sex therapy (Plaut & RachBeisel, 1997). How effective such approaches are has not been systematically evaluated.

A randomized controlled trial comparing *in vitro* and *in vivo* desensi tization in the treatment of vaginismus (Schnyder, Schnyder-Luthi, Ballinari, & Blaser, 1998) appears to confirm Masters and Johnson (1970) and other uncontrolled reports of a very high treatment success rate based on a criterion of full penetration during intercourse. Critical reviews, however, suggest that such high rates of success may not be typical (Heiman & Meston, 1997; Kao, Lahaie, & Binik, in press; Lahaie & Binik, in press). There is one recently completed large and well-controlled randomized trial (Van Lankveld et al., 2006) comparing a Masters and Johnson–adapted group cognitive-behavioral therapy (CBT) with bibliotherapy and a waiting list control. There were no significant differences in outcome between the group CBT and the bibliotherapy conditions but both were superior to the waiting list control. Overall, however, the rate of successful penile–vaginal penetration for the CBT and bibliotherapy groups was less than 25%. This rate is far lower than has been reported in uncontrolled trials.

Perhaps the combination of physical therapy, medical/pharmacological interventions, and CBT will improve success rates. A crucial issue is whether penile vaginal penetration is an appropriate outcome criterion. It has been reasonably suggested that sexual pleasure accompanying penetration should be the goal (Kleinplatz, 1998). As far as we are aware, such a research criterion has rarely, if ever, been used and it is not clear how many

women with vaginismus could attain it. We are concerned that the adoption of this outcome criterion would be similar to requiring women with snake phobias to become cobra charmers.

Dyspareunia

Epidemiology and Diagnosis

Recent and well controlled epidemiological studies have focused on vulvar pain as a cause of dyspareunia (Harlow & Stewart, 2003; Harlow et al., 2001). These studies suggest that vulvar pain may account for two-thirds of the reported cases of dyspareunia in premenopausal women. Future studies should investigate dyspareunia throughout the life span and might be usefully supplemented by gynecological assessment of the location of the pain.

There is only one published diagnostic reliability study for dyspareunia (Bergeron, Binik, Khalifé, Pagidas, & Glazer, 2001). This study suggested that with training, two experienced gynecologists could reliably make the diagnosis of vulvar vestibulitis syndrome (VVS). Our clinical experience and further unpublished research, however, has suggested that there is great variability in how gynecologists and other health professionals assess women who report pain during intercourse (see the section below on gynecological assessment).

Etiology

The literature concerning the etiology of dyspareunia has been growing rapidly but almost all the studies deal with VVS. As is often typical, the literature is divided between psychosocial and biological approaches. If our hypothesis is correct that the terms "dyspareunia" and "vaginismus" encompass a series of different genital pain syndromes, then it is unlikely that there will be a single simple etiology. Even if the validity of current syndromes such as VVS is confirmed, it seems unlikely that any single factor can account for the problem.

Psychosocial approaches focus on cognitive-emotional and psychophysical factors related to pain. For example, certain cognitive styles (e.g., hypervigilance and catastrophizing) and personality traits (e.g., heightened anxiety and somatization) are associated with dyspareunic pain (Granot, 2005; Payne, Bergeron, Khalifé, & Binik, 2005; Pukall, Binik, Amsel, Khalifé, & Bushnell, 2005). Women suffering from VVS also demonstrate lowered vulvar and nonvulvar/nongenital sensory thresholds and an increased incidence of other pain problems (Danielsson, Sjoberg, & Wikman, 2000; Granot, Friedman, Yarnitsky, Tamir, & Zimmer, 2004; Pukall, Binik, Khalifé, Amsel, & Abbott, 2002). These women also report an ele-

vated number of other pain problems and demonstrate the typical pain signature found in other fMRI pain studies (Pukall, Binik, et al., 2005). A recent study suggests an association between the experience of childhood violence and VVS (Harlow & Stewart, 2005).

Organic approaches have noted certain medically related risk factors or have examined physical changes in the vulvar vestibule. Among the risk factors are an elevated history of recurrent yeast infections (Binik, Meana, Berkley, & Khalifé, 1999), early contraceptive use (Bouchard, Brisson, Fortier, Morin, & Blanchette, 2002), and elevated genetic susceptibility to inflammatory disorders (Babula et al., 2005). In addition, there is much current research focusing on various local changes in the vulvar vestibule (Bohm-Starke, Hilliges, Blomgren, Falconer, & Rylander, 2001; Westrom & Willen, 1998). There are several recent publications that critically review this literature (Foster, 2002; Payne, Bergeron, et al., 2005; Pukall, Lahaie, & Binik, 2005). We hope that future research will begin to test integrated biopsychosocial models.

Treatment

There are numerous treatment reports concerning dyspareunia. These treatments include topical creams, oral medications, biofeedback, physical therapy, cognitive-behavioral sex and pain management therapies, specific pain management techniques such as nerve blocks, acupuncture, and hypnosis, surgery, and numerous complementary or alternative therapies including diet and herbal remedies (Haefner et al., 2005; National Vulvodynia Association [NVA], 2004). There are, however, only three completed randomized controlled trials all of which target vulvar vestibulitis syndrome. Two of these trials examine medications (cromolyn and fluconazole) and found that they are not better than placebo (Bornstein, Livnat, Stolar, & Abramovici, 2000; Nyirjesy et al., 2001). The other examines CBT-oriented pain management/sex therapy and compares it with surgery (vestibulectomy) and with biofeedback/physical therapy (Bergeron, Binik, Khalifé, Pagidas, Glazer, et al., 2001; see also Weijmar Schultz et al., 1996). All the therapies resulted in significant clinical improvements with surgery demonstrating almost twice as much pain relief as the other two. A 3-year follow-up of the Bergeron study (Bergeron et al., 2006) suggests that CBT may ultimately catch up to surgery in terms of pain relief.

ASSESSMENT

It is unlikely, in our view, that any single clinician can carry out a comprehensive assessment of vaginismus and dyspareunia. Such an assess-

ment would require a Renaissance clinician experienced in assessing pain, sexual functioning, gynecological pathology, pelvic floor muscle tension, and psychosocial functioning. In principle, it should not be difficult for a gynecologist, physical therapist, and mental health professional to carry out a comprehensive assessment in the same setting at the same time. The following examples illustrate how costly mistakes can be avoided by using this assessment strategy:

1. It is highly unlikely for a physician to dismiss the patient as "crazy" and prescribe ineffective psychotropic medication if the mental health professional points out that the client is "normal."
2. It is equally unlikely for a mental health professional to assume that the pain is the result of some medical factor and refer for additional invasive examinations and tests when the physician points out that this is unnecessary.
3. It is now rare for either the gynecologist or psychologist authors of this chapter to use Kegel or vaginal dilatation exercises to treat vaginismus or dyspareunia because we have learned from our physical therapy colleagues that we are likely to do it wrong, basing it on inadequate assessment.

When working in such a team, some difficult assessment tasks become much easier. For example, it is often reported that some women suffering from vaginismus cannot be examined gynecologically. Our experience is that this is rarely the case when there is adequate preparation and time taken by the examiner. This is often facilitated on the spot by breathing exercises, pelvic massage/stretching, and mental preparation. Any post-examination pain or distress is immediately dealt with so this does not cause further harm and concern about future therapeutic interventions. Client satisfaction with such multidisciplinary assessment is typically very high, but it is unfortunate that such assessment is difficult to organize given the constraints of our health systems. Our focus in this section is primarily on the part usually carried out by the mental health clinician, but we also discuss the role of the gynecologist; physical therapy assessment is dealt with in the chapter by Rosenbaum (Chapter 6, this volume).

Gynecological Assessment

Vaginismus

The traditional role for gynecological assessment of vaginismus has been to confirm the diagnosis by assessing vaginal spasm. As a result, mental health professionals have traditionally referred women with "vaginismic-

like symptoms" to a gynecologist for such confirmation. It is odd that DSM-IV-TR, a psychiatric classification system, defines a sexual disorder in such a way that only a non–mental health professional can make the diagnosis.

What actually happened in these examinations was a bit of a mystery to most mental health professionals since they were not present. However, retrospective reports from both clients and gynecologists made one thing clear: these examinations were almost always difficult and sometimes traumatic. We believe that this is true because most women suffering from vaginismus are highly fearful/phobic of attempted vaginal penetration. Thus a gynecological examination is tantamount to flooding, or confronting a phobic client with her feared stimulus. Such fear will naturally result in increased pelvic floor and whole body muscle tension, increased avoidance, great distress, and potential traumatic sensitization. If our fear/phobia hypothesis is correct, then a crucial part of any gynecological examination should be to prepare the client and reduce or control the fear so that the examination is possible and does not cause further sensitization. This can usually be accomplished by providing adequate information, and teaching simple coping techniques such as self-statements, relaxation, and paced breathing. It has been our experience that almost all women with vaginismus can be examined with this type of preparation.

Once we began to critically observe gynecological examinations, it became clear that there was great variability in what gynecologists actually did during their assessments. On many occasions the women were so fearful and avoidant that an examination was not even attempted. Some gynecologists that we observed or discussed this issue with would diagnose vaginismus based on this fearful/avoidant pattern of behavior without ever detecting a spasm (Reissing et al., 2004). We believe that the following self-report criteria yield the typical picture of what has been called vaginismus:

1. Women who have never experienced full vaginal intercourse despite at least 10 attempts on separate occasions.

or

2. Women who have never been able to experience full vaginal intercourse but have attempted it fewer than 10 times. These women must have made at least two attempts on at least two separate occasions and must show *other interference* with vaginal penetration.

or

3. Women who have been unable to have vaginal intercourse for at least 12 months but who have experienced at least one full vaginal penetration in the past. In addition, these women have to have had

a history of *other interference*[1] with vaginal penetration since the onset of the problem.

Some have recommended that gynecological examinations should be avoided because of potential negative/traumatic effects. This may be a reasonable interim solution until there are adequate preparation and coping resources. In our view, however, an appropriate gynecological examination is ultimately highly desirable in order to detect admittedly uncommon but possible "obstructions" to penetration (e.g., vaginal septa or imperforate hymens). It is also desirable for health reasons such as annual Pap smears. The completion of a successful gynecological examination can also be seen as an important step in overcoming one of important stages in the hierarchy of feared vaginal penetration situations.

Dyspareunia

The traditional gynecological assessment strategy for dyspareunia presupposes that there are relatively separate physical versus psychological causes and that physical causes must first be assessed. If physical causes are found, they are treated with the presumption that the pain will be "cured." If physical determinants are not found, then the cause is presumed to be psychogenic and the women are referred to a mental health clinician.

We believe that this strategy is based on faulty theory. While there is little doubt that there are physical determinants of dyspareunia, there are no available reliable or valid criteria by which to determine these or to separate them from psychological causes. By the same token, there are no reliable or valid criteria by which to determine psychological causes. At the moment, an assessment strategy based on the organic–psychogenic dichotomy or mechanisms related to this dichotomy is not likely to be either reliable or valid. Most unfortunately, it is also likely to result in numerous delays, leaving the client with unnecessary recurrent pain and distress. In our view, the gynecological assessment should be part of the multidisciplinary assessment approach already discussed.

The gynecologist can play a special role in pain assessment. During an examination, a skilled gynecologist can provoke pain very similar to the pain reported by the woman during intercourse. This allows for a precise localization of the pain, and a characterization of its quality, intensity, time course, and so on. A number of instruments have been created to standard-

[1] *Other interference* is defined as an average of less than one attempt every 2 months since the first time intercourse was attempted despite being involved in an intimate relationship or reporting opportunities to have intercourse. In addition, at least one of the following two criteria has to be met: (1) never having seen a health professional for or never having completed a pelvic exam; (2) never having used tampons.

ize such assessments (Baguley et al., 2003; Giesecke et al., 2004; Pukall, Binik, & Khalifé, 2004).

After having observed many gynecologists carrying out dyspareunia assessments, we strongly believe that the clinician's manner and approach can dramatically affect diagnosis and pain characterization. For example, the first gynecologist we observed said the following before initiating the examination: "This is really going to hurt but we have to get through it so that I can find out what's wrong." This was in sharp contrast to the comment of another gynecologist: "If something begins to hurt, then let me know and I will stop until you are ready to continue." These differing instructions are likely to have dramatic effects on the intensity, quality, duration, and other features of the pain reported.

Furthermore, the actual physical examination procedures and their ordering seem to vary markedly. For example, we were quite surprised to observe that the cotton swab test, the standard procedure used to assess vulvar pain, was not carried out uniformly by different gynecologists. Some clinicians push firmly while others roll the cotton swab along the vulva; others lightly touch the same area repeatedly. The vulvar locations that were tested also varied. We empirically demonstrated this variation by having two different gynecologists assess the same clients with the Q-Tip test. One gynecologist reliably elicited more pain than another. We called this the "testosterone effect" since it was the male gynecologist who always elicited more pain, presumably because he consistently pushed harder (Pukall, Payne, Binik, & Khalifé, 2003).

Psychosocial Assessment

The psychosocial assessment of dyspareunia can be usefully divided into the assessment of pain, of interference with sexuality and relationships, and of the patient's general coping and adaptation style.

Pain assessment for dyspareunia is, in general, similar to assessment for all other pain problems. Since most pain complaints are identified by their location, it is important to determine the exact location(s) of the pain. The DSM criterion of interference with intercourse ignores location and runs the risk of confusing dyspareunia associated with vulvar pain with dyspareunia associated with deeper pain. Use of a diagram or model may facilitate assessment. If the woman has difficulty in reporting location, it is sometimes helpful to ask her to assess this at home with the use of a mirror, cotton swab, or finger. Often, careful assessment will indicate more than one painful area.

Pain intensity is the second factor that is important to carefully assess. This can usually be easily rated by the client on a simple 0 (no pain) to 10 (worst pain ever) scale. More formal methods might include the use of psychometric instruments such as the McGill Pain Questionnaire (Melzack

& Katz, 1992). A third standard descriptor is pain quality. Burning pains are potentially different from shooting or dull pains and it may be possible to differentiate different genital pains on this basis. Many clients, however, lack the vocabulary to describe the quality of their pain; showing them the list of adjectives from the McGill Pain Questionnaire may facilitate qualitative description. Optimally, the gynecologist's and physical therapist's assessment of pain location, intensity, quality, and temporal pattern will converge with or supplement the client's description. It is important to note, however, that there is no reason to expect that the pain elicited in a gynecologist's office will be identical in all respects to that experienced during intercourse. Context, type of stimulation, attributed meaning, and other factors are quite different in these two situations.

Other important pain characteristics include whether the pain is provoked or unprovoked and how long it lasts once it starts. For example, there is controversy (Reed, Gorenflo, & Haefner, 2003) concerning whether provoked vulvar pain (often called vulvar vestibulitis or vestibulodynia) is a different syndrome from unprovoked vulvar pain (often called essential, dyesthetic, or generalized vulvodynia). Dyspareunia associated with vulvar vestibulitis often subsides quite quickly after the provoking stimulus is removed. There are, however, some women who complain of pain for many hours after the termination of intercourse. They might also report pain during subsequent urination. Finally, we typically ask women for their personal explanation as to the cause of their pain. Most are able to respond to this question and these theories are often useful in clinical management (Meana, Binik, Khalifé, & Cohen, 1999). Women suffering from vaginismus may not be able to describe or report any genital pain since it may have been a long time since they attempted vaginal penetration. They often, however, will report an intense fear of different types of genital/pelvic pain including penetration, childbirth, and breaking of the hymen.

The *sexual interference* resulting from vaginismus or dyspareunia is not specific to one part of the sexual response cycle. Thus the comorbidity with problems of arousal, orgasm, and particularly desire appears to be high. Whether this comorbidity is higher for vaginismus and dyspareunia than it is for sexual problems in general is not known.

Many women suffering from dyspareunia continue to have intercourse despite excruciating pain. While their overall frequency of intercourse is less than that of age-matched controls, they continue to acquiesce to coitus for a variety of reasons (e.g., to please their partners, in the hope that the pain will disappear, to maintain self-esteem). These motivations should be carefully assessed but we believe that they clearly reflect the fact that the decision to engage in intercourse is not solely based on pleasure. By the same token, if therapy is successful in reducing pain, one should not necessarily expect intercourse frequency to increase proportionately. Women diagnosed with vaginismus show a very low to zero frequency of inter-

course despite the fact that they often have similar pain. We believe that this lowered frequency reflects a fear/phobia of vaginal penetration and a resulting increase in pelvic muscle tension.

Relationship distress, in our clinical experience, is a frequent correlate of both dyspareunia and vaginismus. However, to date, the published empirical literature has not found elevated scores on relationship dissatisfaction questionnaires. This may be an artifact of several factors (Weijmar Schultz et al., 2005): Sexual functioning is only one ingredient contributing to relationship satisfaction; many women continue to have intercourse despite their pain in order to please their partners and maintain their relationships; some couples adapt to lower frequencies of penetration by engaging in other, nonpenetrative activities. The history and context of the couple relationship may also determine how dyspareunia affects relationship quality. For example, the relationship satisfaction of a 60-year-old woman married for 35 years may be less affected by the recent onset of dyspareunia than that of a 22-year-old university student who moved in with her boyfriend 6 months ago.

These varying couple dynamics are well illustrated by women suffering from vaginismus. Many come to therapy only when they wish to conceive. When conception occurs, even without full penetration or pleasure, they often "drop out." From the woman's or couple's perspective, this does not constitute a treatment failure since the major goal of conception has been achieved.

Despite the lack of conclusive results concerning relationship distress in samples of women with dyspareunia and vaginismus, relationship factors may nonetheless play a role in exacerbating pain and worsening sexual functioning. In fact, many studies in the pain literature have shown that specific characteristics of romantic relationships are associated with pain and pain-related disability, in particular, spouse solicitousness (Kiecolt-Glaser & Glaser, 2001). In addition, two recent studies focusing on women with dyspareunia have shown that (1) lower dyadic adjustment predicts higher pain intensity (Meana, Binik, Khalifé, & Cohen, 1998), and (2) lower dyadic adjustment predicts worse sexual functioning (Jodoin, Bergeron, Khalifé, & Dupuis, 2005). Therefore, assessment of couple dynamics needs to focus both on how the pain affects relationship adjustment, and how relationship factors may impact on pain and sex.

Individual coping styles can dramatically affect the presentation of symptoms at the initial assessment and the willingness of the client to accept certain clinical interventions. Particular attention should be paid throughout to mood assessment since anxiety and depression are known correlates of chronic pain in general and vulvar pain in particular (Payne, Binik, Amsel, & Khalifé, 2005). Women suffering from dyspareunia or vaginismus who engage in "emotionally focused coping" often display emotions such as anger, depression, helplessness, anxiety, fear, and disgust.

Such women may catastrophize (Sullivan, Lynch, & Clark, 2005) about their situation, become hypervigilant (Crombez, Van Damme, & Eccleston, 2005) about their pain or genitalia, engage in excessive self-blame, and adopt unrealistic expectations about treatment outcome. Moreover, some women, particularly those suffering from vaginismus, may engage in "avoidant coping" in which they distance themselves from the problem or the potential solutions. In extreme cases, they deny or dissociate. We do not know if these coping styles are general or specific to genital pain. Psychosocial treatment programs for persistent pain (and for sexual dysfunction) require clients to take an active role. It is important to assess whether the client is ready to do this (Keefe, Rumble, Scipio, Giordano, & Perri, 2004).

Failure to understand how women cope with genital pain may lead to inaccurate evaluation and diagnosis. Depending on the point of view of the clinician as well as the woman's history, the coping style may or may not seem reasonable. Consider the following example of a 22-year-old woman, June, complaining of excruciating pain on penetration as well as during and after intercourse. The gynecologist who performed the physical exam could detect only relatively minor (2 out of 10) pain during the cotton swab test and noted that June was engaging in intercourse twice weekly with her partner. He referred June to a physical therapist, who found relatively normal pelvic floor muscle functioning.

During a psychological assessment, the client was alternately tearful and angry because "she wasn't crazy and didn't understand what pain had to do with needing to see a psychologist." During this interview, it became apparent that June had always avoided using tampons because "she didn't really need them and was worried about toxic shock." She also reported having experienced some discomfort or pain with previous partners. The pain had been becoming steadily worse since she moved in with her current partner 2 years ago. She was deeply in love and wanted to marry him. He had been very supportive and accepting of the pain but had been asking her to seek help for over a year. She had refused and insisted on continuing engaging in intercourse despite the fact that the pain was worsening. She began to focus more on her pain sensations and started to worry that her relationship would not survive. She came for help only when her boyfriend told her that if she didn't seek treatment, he would move out.

Although there had clearly been long-standing but relatively minor genital pain, it probably became progressively worse because of June's avoidant coping style, her fears about the future of the relationship, and her catastrophizing and hypervigilance. Formulating the assessment in this way made her behavior quite understandable. Based on this formulation, we did not expect her to respond well initially to problem-focused CBT, which requires her active participation. We recommended some couple ses-

sions to focus on the partner's ultimatum followed by individual sessions to motivate her active participation necessary for CBT.

TREATMENT OF GENITAL PAIN INTERFERING WITH SEX

Why Sex Therapists Avoid Treating Genital Pain and Clients with Genital Pain Avoid Consulting Sex Therapists

Although they are often reluctant to admit it, many sex therapists do not view women with genital pain as among their preferred clientele. Nobody likes to feel powerless, and women with genital pain often make us feel that we do not know what we are doing. There are probably many reasons for this, the first one being that pain is not a symptom that disappears easily despite the best therapy and the most motivated client. To further complicate things, women suffering from genital pain often meet DSM criteria for many female sexual dysfunctions. Multiple sexual difficulties, in turn, are likely to impact negatively on romantic relationships, particularly in young couples, which further complicates the therapist's task.

As much as sex therapists may be reluctant to treat genital pain, it is important to keep in mind that most women sufferers are not particularly happy to find themselves labelled with a sexual problem. They wonder what a mental health professional can do for them since they experience their pain as a physical symptom. They have generally consulted more than one physician to obtain a diagnosis, and they have usually come to sex therapy only after a series of disappointing medical interventions. Finally, the way in which referrals are often formulated can be a further deterrent to entering therapy (e.g., "I cannot find anything physically wrong with you"). Women who consult sex therapists for genital pain are thus skeptical concerning the chances of therapy being successful and ambivalent about fully engaging in the therapeutic process for fear of being disappointed once again. Ignoring these factors can lead, at best, to starting therapy on the wrong foot and, at worst, to treatment dropout.

A Multidisciplinary Approach to Treatment

Considering the potential treatment pitfalls, as well as the multiple areas of functioning affected by the pain, the adoption of a multimodal perspective is most likely to bring relief (Bergeron et al., 1997). A multimodal, multidisciplinary approach is currently the gold standard in the treatment of other pain problems and has proven successful in reducing pain and associated disability (Flor, Fydrich, & Turk, 1992). Our therapeutic approach is based on the conceptualization of genital pain as a multidimensional phenomenon influenced by the interplay of cognitive, behavioral,

affective, relational, and biomedical factors. It typically involves the collaboration of a physician, a psychologist/sexologist, and a physical therapist. This follows directly and naturally from our assessment strategy. Of particular relevance for mental health professionals are recent findings showing that up to 44% of the variance in genital pain can be explained by cognitive and affective variables such as self-efficacy, catastrophization, hypervigilance, internal attributions, and fear of pain (Desrochers et al., 2005; Jodoin et al., 2005). In addition, higher dyadic adjustment has been found to predict lower subjective evaluations of pain during intercourse in women with dyspareunia (Meana et al., 1998). Although the sexual functioning of women who experience genital pain is partly related to pain intensity, it is also influenced by such other psychosocial factors as self-efficacy and dyadic adjustment (Desrochers et al., 2005; Jodoin et al., 2005). Taken together, these results point toward the importance of integrating cognitive-behavioral and couple interventions in the multidisciplinary treatment of genital pain.

Sex therapists are often mental health professionals who are knowledgeable about the medical aspects of sexual functioning. As such, they are well positioned to treat many facets of genital pain and coordinate treatment efforts within the context of a multidisciplinary team. The role of sex therapists can include providing the following: (1) emotional support; (2) education about pain and sexuality and how they interact with each other; (3) education about the different treatment possibilities, and their sequencing and success rates; (4) interventions aimed at reducing pain and relieving associated sexual dysfunction; (5) interventions aimed at improving couple functioning; (6) interventions aimed at optimizing the benefits of other ongoing treatments such as compliance with physical therapy exercises or a medical regimen; and (7) interventions aimed at enabling the client to engage in other forms of treatment such as reduction of fear by inserting a biofeedback sensor into the vagina.

Recent evidence suggests that the functioning of the pelvic floor musculature of women with vaginismus and vulvar vestibulitis differs from that of women without pain (Reissing, Brown, Lord, Binik, & Khalifé, 2005). These findings indicate that chronic pelvic floor hypertonicity is probably contributing to genital pain and should be dealt with directly in treatment with pelvic floor physical therapy. Results from a retrospective study examining the effectiveness of physical therapy for vulvar vestibulitis showed that this form of treatment yielded a complete or great improvement in over 50% of participants (Bergeron & Lord, 2003). Our clinical experience suggests that pelvic floor physical therapy and cognitive-behavioral therapy can readily be combined in the multidisciplinary treatment of genital pain as they use different methods to achieve similar goals (i.e., decreasing the fear of pain and increasing the ease of penetration).

Since biomedical factors are implicated in many genital pain condi-

tions, the expertise of a knowledgeable gynecologist or dermatologist is highly desirable. Depending on the medical condition associated with the genital pain, topical or systemic medications may be prescribed. If conservative medical and psychosocial interventions fail, surgery may be proposed. Although there is much controversy about whether surgery should be attempted, there is accumulating evidence that vestibulectomy is efficacious for the treatment of vulvar vestibulitis (Bergeron, Binik, Khalifé, Pagidas, Glazer, et al., 2001; Haefner et al., 2005) and that hysterectomy may be useful for the treatment of dyspareunia associated with conditions such as endometriosis or fibroids (Flory, Bissonette, & Binik, 2005). Despite the fact that our research (Bergeron, Binik, Khalifé, Pagidas, Glazer, et al., 2001) is one of the strongest pieces of evidence to support the use of surgery for the treatment of vulvar vestibulitis syndrome, the gynecologists who participated in this research still strongly prefer to avoid surgery until other less invasive treatment options are attempted.

Adopting a multidisciplinary perspective is difficult in North America, where the organization of health services does not facilitate the application of this model of care. It requires that all health professionals learn about the different domains of expertise of their colleagues, share responsibility, and accept the reality that no single specialty has a monopoly on the truth. Communication between members of the team is essential, even when they are located in different buildings or even different cities. Contradictions between health professionals are bound to negatively impact the client's involvement in the treatment process and ultimately her recovery. An important determinant of the success of a multidisciplinary approach is the presentation to the client of a coherent explanation of her genital pain problem and its treatment (Bergeron et al., 2003).

Cognitive-Behavioral Pain Relief Therapy

Sex therapy interventions for vaginismus and dyspareunia can easily be carried out within the framework of cognitive-behavioral pain relief therapy. In keeping with our view that genital pain interferes with sex but does not constitute a sexual problem per se, we have developed a treatment program that integrates pain management and sex therapy by modifying some of the traditional sex therapy strategies (Bergeron et al., 2002). This program can be delivered in an individual, couple, or group format. We have primarily used a group format and found in a randomized controlled trial that this treatment reduces pain by an average of 38%, with 40% of women reporting great improvement or complete elimination of the pain (Bergeron, Binik, Khalifé, Pagidas, Glazer, et al., 2001). A second randomized controlled trial is presently under way to examine whether this program is superior or equivalent to standard medical treatment.

Initial Phase of Therapy: Alliance Building, Education, and Goal Formulation

The first phase of therapy is crucial in establishing a solid collaborative working alliance, addressing client doubts and fears, providing education concerning a multidisciplinary conceptualization and treatment approach, and formulating realistic yet optimistic goals.

A first step in developing a therapeutic alliance is the adoption of a pain perspective which asserts that the pain is real. This acknowledges the client's main complaint and her experience, which are often ignored. It also reduces blame for any sexual problems that may be occurring and avoids reducing the problem to a medical condition over which the client may feel little control. Following the initial phase of treatment, continuing to make pain the central focus of therapy further strengthens the alliance.

Client doubts and fears need to be addressed directly in the very early stages of therapy. What are the woman's treatment expectations? What reservations does she have concerning psychological interventions for pain? What does she believe will happen if treatment does not help? The therapist's attitude will determine the client's comfort level in revealing her concerns, and will also determine whether she can incorporate new information that may contradict her current personal theory about her condition. A validating, empathic, and open attitude is optimal for allowing negative expectations to be voiced and for eventually introducing a new way to view the genital pain problem. Gradually, the woman is led to reconceptualize genital pain as a multidimensional phenomenon influenced by her thoughts, emotions, behaviors, and couple interactions—an empowering view that promotes a hopeful outlook.

A pain intensity diary that records thoughts, emotions, behaviors, and couple interactions that preceded and followed each intercourse attempt can prove useful. The client often begins to notice which factors tend to influence her experience of pain, a process that may facilitate working on pain control. The pain diary gives the therapist access to a wealth of information concerning different dimensions of the client's pain experience, not to mention a useful tool to assess change over time. It is also useful to recommend educational materials concerning the particular form of genital pain that the woman is experiencing. For example, the newsletter of National Vulvodynia Association provides up to date and accessible information concerning vulvar pain (see www.nva.org).

Since self-efficacy is correlated with both pain intensity and sexual functioning (Desrochers et al., 2005), and confidence in treatment is related to treatment outcome (Bergeron, Binik, Khalifé, Pagidas, Glazer, et al., 2001), the formulation of goals needs to be carefully planned so as to foster the client's trust in the therapeutic process and in her ability to re-

duce her pain and sexual dysfunction. Unrealistically high goals will only erode this trust. Two examples of potentially detrimental goals are (1) the complete elimination of pain and (2) a dramatic increase in frequency of intercourse. Goals that focus on reducing the number and intensity of painful sexual activities and facilitating the experience of pleasurable sexual encounters are usually more productive. These will enable therapist and client to explore the client's sexual needs and preferences and to gradually steer the focus away from intercourse.

Active Phase of Therapy: Cognitive and Behavioral Strategies

One of the first behavioral exercises suggested is genital self-exploration with an emphasis on the localization of painful areas. Despite years of suffering, many women still do not know where their pain is located, and hence cannot inform their partners as to which areas to avoid touching during sexual activities. This exercise can be threatening at first and many women react with disgust and anger at the thought of examining their genitals.

A behavioral strategy that is a basic component of any pain management program is the practice of relaxation. This can take the form of breathing exercises taught within a therapy session and practiced at home, or of a mindfulness practice, such as yoga. It is often useful for clients to use the relaxation techniques during physical therapy sessions or gynecological examinations.

As indicated previously, we have learned that two of the key components of sex therapy for dyspareunia and vaginismus—Kegel exercises and vaginal dilatation—may actually be ineffective when prescribed by mental health professionals. In addition, suggesting prematurely that a woman insert a finger or penis into a tense vagina may actually cause additional pain and failure rather than help. We have coordinated such exercises with the progress of physical therapy enabling the woman to experience success and avoid failure. Once that is accomplished, sex and physical therapists can together coordinate a systematic desensitization program that will help break the association between pain and penetration, thus reducing the fear of both.

Cognitive strategies aimed at increasing self-efficacy as well as controlling catastrophization and hypervigilance will contribute to the reduction of pain and improvement in sexual functioning. Such strategies consist of identifying maladaptive thoughts via the pain diary or within the therapy sessions, examining their impact on pain, affective reactions, and sexual functioning, and suggesting alternative ways of thinking about pain and sex. An interesting way to accomplish this is to have the client generate thoughts for three different time periods: (1) during anticipation of pain (e.g., during sex play); (2) during the experience of pain; and (3) after the

experience of pain. These strategies are often among the most powerful in de-dramatizing the pain experience.

Finally, given that higher dyadic adjustment is associated with lower pain intensity and better sexual functioning (Jodoin et al., 2005; Meana et al., 1998), it is important to involve the partner as early and as frequently as possible in treatment, including attendance at medical visits and physical therapy sessions. The partner's presence facilitates communicating sexual needs and preferences, expanding the sexual repertoire, and steering the focus away from intercourse. The partner can also participate in many of the exercises; for example, he can insert the biofeedback sensor as part of a systematic desensitization program.

Challenges Involved in Practicing Cognitive-Behavioral Pain Relief Therapy

The sexual dysfunction resulting from years of living with an undiagnosed genital pain condition is sometimes so pervasive that more in-depth work needs to be conducted. We have found it essential to involve the partner when working on sexual desire. In doing so, we try to help the couple see how they have each contributed to the current polarization of sexual roles and the resulting diminished quality and frequency of sexual activities. From a systemic perspective, helping the partner to view himself as a co-creator of some of the sexual difficulties often moves things along more quickly, and actually increases his sense of control over the situation rather than confining him to the role of frustrated bystander.

Some women with particularly intense or long-standing genital pain will argue that sex can never be good and may resist or avoid working on the sexual aspects of their relationship. Allowing women to blame all sexual problems on the pain may not be a useful therapeutic stance because it leaves the therapist very little room to maneuver. Although pain reduction is always a main goal of treatment, it is important not to make decrease in pain a prerequisite for improvement in sexual functioning.

Other women may not want to work on pain reduction because they fear that once the pain is less of a problem, or once they have had a successful intercourse attempt, the partner will pressure them to engage in sex more often, despite the fact that they experience no increase in sexual desire. Part of the solution to this therapeutic dilemma lies in separating the pain from the sex and in involving the partner. The woman's concern can be voiced in therapy in front of the partner, who will often show more realistic expectations than imagined by the woman. The remaining lack of desire can be normalized and presented as a separate issue that can be dealt with on its own. Lastly, the couple can be educated concerning their mutual responsibility in reestablishing a satisfying sex life, independent of the changes in pain.

CASE PRESENTATIONS

The following two case histories illustrate many of the treatment issues and challenges that mental health professionals will face in treating women with dyspareunia and vaginismus.

Successful Case: Heather and Steven

Assessment

Heather and Steven, ages 31 and 35, were referred by their gynecologist with a diagnosis of vulvar vestibulitis syndrome. The gynecologist had also referred them to a physical therapist, and pelvic floor rehabilitation had already begun when the couple came to see us.

Heather and Steven had been married for 5 years and reported a good relationship. Heather was an accountant and Steven was a pharmacist. They planned to have children but wanted to wait until the genital pain problem was resolved. Prior to the diagnosis of vulvar vestibultis, the couple had begun to limit all forms of sexual contact and both experienced self-doubt, each wondering how they were contributing to the problem. At the time of the psychosexual assessment, they were beginning to feel better and had attempted to engage in intercourse, attributing this to the positive effect of having received a diagnosis and a proper referral for treatment.

Their familial histories were similar; each had one parent who had been depressive and who was absent for long periods of time from the daily routine of family life. They each had one sibling, to whom they were not particularly close. The two had always done well in school, excelled in sports, and had had significant past romantic relationships before meeting one another. They currently lead busy and active lives, with many nights taken up by work or sports. The genital pain problem had begun a few years ago, but had been bearable until a year ago, when it had worsened following a particularly stressful time in Heather's career. They had consulted two physicians prior to receiving an appropriate diagnosis. Pain during the most recent gynecological examination had been a 6 out of 10, and pain during intercourse was 4 out of 10. The problem had affected Heather's sexual desire, which fluctuated but had generally decreased. They both believed that intercourse was an important part of sex and felt inadequate for not engaging in it more often. They were interested in taking part in therapy as a couple.

Description of Therapy

Initial goals were to explore factors related to Heather's desire fluctuations and to decrease the intensity of her genital pain. Among the first issues that

we worked on was lifting some of the obstacles to having uninterrupted time together and to find ways to connect other than sex. Heather often leaned on Steven for support, and in return Steven tended to overprotect Heather to the point of neglecting his own needs. We also did some cognitive restructuring to separate sex from intercourse and to reduce catastrophizing about pain. Information was provided concerning vulvar vestibulitis and sex education focused on broadening their definition of sex and on decreasing the emphasis they placed on intercourse. Both were very receptive to these interventions and made significant efforts to integrate new knowledge and behaviors between sessions.

Outcome

Heather and Steven were seen for a total of 18 sessions. The couple learned to create high-quality moments for intimacy and sex, and felt more connected than at the start of therapy. They reduced the pressure that they were putting on themselves to have intercourse and expanded their view of sexual expression. They developed coping strategies other than problem solving, for example opening up more to each other about their respective difficulties. In doing so, they learned that they could cope with intermittent episodes of pain.

During therapy, we learned that both felt unlovable at times, and that this drove many of their reactions to each other. Heather improved her management of emotions and Steven began to concentrate more on his own needs. At the end of therapy, both reported that sexual desire was no longer a major issue and that the pain was negligible.

Comment

The many academic successes and talents that Heather and Steven had while growing up seem to have protected them against the negative impact of their depressive parents. Both Heather and Steven dealt with their difficult childhoods by placing a high value on creating a healthy marriage; in addition, they were obviously committed to doing whatever work was necessary to ensure this outcome. The fact that they had previously enjoyed pain-free sex may have contributed to Heather's recovery from pain and the restoration of her sexual desire. The relationship work that was accomplished during the course of therapy helped Steven become less passive both inside and outside of the bedroom. Finally, the increased emotional intimacy of the couple along with the decreased focus on intercourse may have helped the couple to reinject passion into their sex life.

Partially Successful Case: Lily and Mark

Assessment

Lily and Mark, a couple in their late 30s, had been married for 7 years when they were referred by their gynecologist with diagnoses of vaginismus and vulvar vestibultis. Both felt the tightness in her vagina, which they said made intercourse impossible. On the few occasions that they had attempted intercourse, she had experienced a pain located at the introitus that was described as burning and ripping.

Lily reported an intense fear of intercourse, a loss of interest in all sexual activity, and conservative sexual attitudes. She had been referred to a physical therapist but preferred to begin with sex and couple therapy in order to address relationship issues. She may have also preferred "talk therapy" to further avoid attempts to insert anything into her vagina. Mark also reported a loss of interest in sexual activity, although not as dramatic as Lily's. Both felt that the vaginismus problem had recently become a critical issue because Lily's "biological clock was ticking" and they wanted to start a family.

Lily worked as a computer programmer and appeared to be an anxious woman who wanted things to be just so; Mark, a social worker, was gentle and supportive, yet somewhat aloof. Both had living parents who had suffered from different types of addictions. However, Lily and Mark reacted to their family difficulties in different ways; Lily became anxious while Mark was detached. They often found themselves in endless arguments about sex, their future together, and their different styles of reacting to family issues and the daily events in their lives.

Description of Therapy

The goals of therapy were to reduce genital pain, to make intercourse possible, to develop a mutually satisfactory quality and frequency of sexual activities, and to limit escalation during conflicts. Individual goals included reducing Lily's stress level, increasing her overall comfort with sexuality, and increasing Mark's assertiveness. It was recommended that Lily begin physical therapy as soon as possible, which she eventually did after much discussion and preparation over the course of six sessions. Much of the therapy focused on couple issues such as commitment, ambivalence about having children, and the techniques for deescalation of the couple's fighting. Therapy also consisted of identifying each partner's sexual needs and preferences as well as determining optimal conditions for vaginal dilatation exercises, which they did together as directed by a physical therapist. Dealing with Lily's fears about and avoidance of vaginal penetration was an important therapeutic focus. Progress on this issue helped with the physical

therapy, which in turn provided *in vivo* practice. Stress management and exploration of sexuality-related fears for Lily and assertiveness training for Mark also occupied much therapy time.

Outcome

Lily and Mark were seen together and in individual sessions over a period of 2 years. By the end of treatment, their sexual repertoire had expanded, and penetration was possible but still painful; penetration with a dildo, however, was not. Although Lily could tolerate penetration relatively easily, she still did not really like it. Both described their sexual interactions as more stimulating and more frequent, although Lily was remained inhibited sexually. The couple continued to prefer nonpenetrative sexual activities but were more satisfied with their sexual life overall than prior to therapy. They found it difficult to perform the physical therapy exercises on a regular basis and eventually stopped that treatment because they felt they could not benefit from it anymore. They were better in conflict management and more accepting of their individual differences. During one of the last therapy sessions, they announced with great joy that Lily was pregnant.

Comment

The outcome of this case and the length of therapy are in line with the complexity of the presenting complaints. Considering the couple's relationship difficulties and Lily's lifelong vaginismus coupled with severe vulvar pain, it is not surprising that the outcome was mixed. Although we strongly recommended to the couple that they should return to therapy after the birth of their child, we doubt that they will.

CONCLUSION

Our research and clinical work is limited in a variety of ways. First, all of our clients and subjects have been women. We have no experience with genital pain in men but it appears from the existing literature that such pain is more prevalent than we thought and seriously affects men's sexual functioning (Luzzi, 2003). Second, the vast majority of our clients and subjects have been heterosexual. It has not been difficult, however, to adapt our approach to the few lesbian individuals and couples whom we have assessed or treated. Recently, several articles have appeared describing anodyspareunia in homosexual men (Damon & Rosser, 2005). Third, there is also a syndrome termed "anismus" affecting both heterosexual and

homosexual men and women that may resemble "vaginismus" in many respects (Kuijpers & Bleijenberg, 1985; Park, Choi, Piccirillo, Verzaro, & Wexner, 1996; Schouten et al., 1997). Fourth, the vast majority of our clients have also been relatively young and have suffered from "medically unexplained" vulvar pain. Vaginismus or dyspareunia associated with deeper pelvic pain or occurring after childbirth or menopause may present different diagnostic and therapeutic challenges. We are currently expanding both our research and clinical work to investigate these problems and populations. Our initial impression is that our proposed multidisciplinary but pain-focused approach is a useful starting point.

Sex therapists are not the only health professionals who attempt to avoid patients suffering from vaginismus and dyspareunia. Our impression is that many physicians exhibit similar, if not greater, avoidance. Although we have argued strongly for a pain- rather than sex-focused conceptualization of vaginismus and dyspareunia, it seems unlikely in the near future that pain clinics will develop sufficient expertise to be able to treat genital pain problems. At the very least, sex therapists will continue to have a crucial role in assessing and relieving the sexual concerns and dysfunctions associated with genital pain; at most, they will take the lead in coordinating and innovating future multidisciplinary treatment.

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CHAPTER 6

Physical Therapy Management and Treatment of Sexual Pain Disorders

TALLI Y. ROSENBAUM

Given the variety of physical and psychological contributions to sexual problems, the importance of working from an interdisciplinary perspective is increasingly recognized. One of the important members of a multidisciplinary team is the pelvic floor physical therapist who has the dedication, training, and skill to provide "hands-on" intervention. While physical therapists are generally trained to restore physical function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities, pelvic floor therapists, in particular, have specific training in the evaluation and treatment of pelvic floor dysfunction.

In her chapter, Talli Y. Rosenbaum highlights the unique contribution of the pelvic floor physical therapist in treating sexual pain disorders. She provides an overview of the anatomy and function of the pelvic floor musculature and its role not only in supporting internal organs but also in optimizing sexual functioning. She explains that pelvic floor muscle dysfunction is classified as either low or high tone dysfunction. Low tone dysfunction exists in situations of pelvic floor laxity and muscle weakness, which contribute to complaints of deep dyspareunia during thrusting. High tone dysfunction is characterized by increased pelvic floor muscle tonus and is often observed in superficial as well as deep dyspareunia and in patients with vaginismus.

In the treatment of sexual pain disorders, pelvic floor therapists can offer anatomical and physiological education, cognitive-behavioral interventions, instruction in the

use of vaginal dilators, rehabilitative advice as to pelvic floor muscle strengthening, relaxation exercises, and palliative treatment modalities to decrease pain and improve tissue mobility. Rosenbaum reviews manual therapy techniques utilized by pelvic floor clinicians and explains how therapists help clients overcome a wide array of sexual pain complaints. In some instances, pelvic floor physical therapists have even reported success in increasing the intensity of orgasms.

Initial assessment by the pelvic floor therapist includes pinpointing when and where pain occurs, if it is superficial or deep, if it occurs with arousal or orgasm, and how (and whether) the pain may be alleviated. Questions regarding voiding are included as this may indicate primary dysfunction of the pelvic floor. In addition, the pelvic floor physical therapist undertakes a comprehensive musculoskeletal, vulvar, and pelvic floor examination and observes a patient's posture, breathing, and gait. Careful assessment is made of the strength, length, and mobility of the pelvic and lumbar joints as well as the surrounding musculature of the pelvis and hips.

Treatment includes education, manual therapy, and home exercises. In some cases, pelvic floor biofeedback as well as pelvic floor electrical stimulation to alleviate levator ani hypertonus and pelvic pain is recommended. As Rosenbaum illustrates in her case report, treatment includes consideration of the relational and contextual factors that may be contributing to, or maintaining, sexual difficulties. Ideally, pelvic floor physical therapists and sex therapists work together throughout treatment in helping clients overcome debilitating and distressing sexual pain.

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According to classical sex therapy references, sexual pain disorders are divided into *dyspareunia*, describing a condition of painful sexual intercourse, and *vaginismus*, which has been traditionally described as a condition of vaginal muscle spasm preventing sexual intercourse. The approach to these disorders in the past was two-dimensional; that is, either the problem was found to be caused by a clearly defined physical source such as infection or disease, or failure by the physician to determine a cause rendered the pain or difficulty "emotional" and requiring treatment of a psychological nature. While the physiological phenomenon of vaginal muscle spasm in response to attempted penetration has never been well evidenced (Reissing, Binik, Khalifé, Cohen, & Amsel, 2004) vaginismus was traditionally described as a contraction of the outer third of the vaginal muscles in response to penetration (American Psychiatric Association, 2000) and was purported to result from a variety of possible psychological and emotional causes, for example, sexual inhibitions due to repression, religion, or resentment toward men (LoPiccolo, 1984; Masters & Johnson, 1970).

While painful intercourse certainly carries negative implications about

a woman's sexual self-esteem and her partner relationship, it has been suggested by Binik, Meana, Berkley, and Khalifé (1999) that sexual pain disorders are to be viewed as primary pain disorders that affect sex, rather than disorders intrinsically sexual in nature. Whereas in the past dyspareunia and vaginismus were thought to be linked to past sexual abuse and/or sexual repression, the literature has not demonstrated evidence of such an association (Meana, Binik, Khalifé, & Cohen, 1997) and, in fact, much more attention has been paid to the organic nature of these conditions. In the mid-1980s the ISSVD (International Society for the Study of Vulvar Disease) identified and named a condition now known as *vestibulodynia*, which is the most common cause of dyspareunia in premenopausal women, affecting 15% of women in this age group. This condition is also referred to as vulvar vestibulitis syndrome (VVS). The defining criteria used to diagnose VVS (Friedrich, 1988) are (1) pain with attempted penetration, (2) pain at points along the vestibule (vaginal entry) with touch, and (3) erythema (redness) of varying degrees. The causes of VVS are multifactorial and they involve the nervous system, musculoskeletal system, immune system, and vascular system. On a cellular level, findings at the vulvar vestibule of patients with VVS include increased mast cells, indicating chronic inflammation (Bornstein, Sabo, Goldshmid, & Abramovici, 2002), increased nociceptors and pain receptors, and increased vascularity (Bohm-Starke, Hilliges, & Brodda-Jansen, 2001). Genetic findings (Witkin, Gerber, & Ledger, 2002) include variation of interleukin-1 receptor antagonist and melanocortin 1 receptor genes. This variation affects the ability to fight inflammation and may explain why certain women are more vulnerable to recurrent bacterial and yeast infections.

Though it is not a defining criterion, often a woman with VVS will present with the inability to allow penetration due to the pain, or the fear thereof. In some cases, she is unable to allow the physician to examine her to determine her diagnosis. Therefore, in a clinical setting, VVS and vaginismus often present as overlapping conditions and the usefulness of separating these conditions diagnostically and therapeutically is questionable (Basson & Riley, 1994; Van Lankveld, Brewaeys, Ter Kuile, & Weijenborg, 1995). Other recognized conditions contributing to or causing superficial or deep intercourse pain, or a reaction of contraction in order to avoid painful penetration, could include (but are not limited to) vaginal dryness, a thickened or septate hymen, scarring from stitches due to childbirth or gynecological surgery, or pelvic floor muscle dysfunction. As a result of the attention paid by medical health practitioners to these various conditions, the treatment of sexual pain disorders has extended to health professionals outside of the sex therapy realm. Alternative approaches to sexual pain disorders now recognize the importance of a multidisciplinary team that includes the discipline of physical therapy.

THE PELVIC FLOOR: RELEVANCE TO SEXUAL DYSFUNCTION

The pelvic floor is a group of muscles, fascial tissue, and ligaments that connect from the pubis bone in front to the coccyx, or tailbone, in back and act as a sling to support the internal organs and promote bowel and bladder continence. The pelvic floor is divided into two layers, a superficial diamond-shaped layer, known as the perineum, containing the urogenital and anal triangles, and a deeper layer known as the pelvic diaphragm. The perineum contains the superficial muscles, including the superficial transverse perineal muscle, which supports the perineal body, the bulbocavernous and ischicavernous muscles, which are active in sexual function, and the external anal sphincter, which promotes fecal continence. The pelvic diaphragm consists of the deeper muscles of the pelvic floor, the pubococcygeus (PC), iliococcygeus, and puborectalis. Although these muscles are generally known collectively as the levator ani muscle group, only the pubococcygeus (PC) and iliococcygeus are part of the levator ani, which acts primarily to lift and dilate the internal organs. The puborectalis is a constrictor that functions with the external sphincters to provide continence (Shafik, 2000). Optimal function of the pelvic floor musculature is essential in maintaining appropriate function of the pelvic organs, as well as appropriate sexual functioning.

Pelvic floor muscle dysfunction is generally categorized as low tone and high tone dysfunction. Low tone dysfunction refers to situations of pelvic floor laxity and pelvic floor muscle weakness. Patients with low tone pelvic floor dysfunction may present with general pelvic laxity and organ prolapse, which may result in deep dyspareunia during thrusting. High tone dysfunction is characterized by increased pelvic floor muscle tonus and is commonly observed in superficial as well as deep dyspareunia and in patients with vaginismus. It is important to note that patients with increased pelvic floor tone often present with pelvic floor muscle weakness, just as do patients with low tone, and that high muscle tone is not to be necessarily associated with an increase in strength.

Sex therapists have traditionally used verbal instruction for pelvic floor muscle exercises in the treatment of anorgasmia (Barbach, 1984) as well as vaginismus (LoPiccolo, 1984), indicating an understanding that conditioning of these muscles may have an impact on the sexual response (Graber, 1982). However, optimal pelvic floor function requires more than simply contracting and relaxing the vaginal muscles. Physical therapists view the muscles of the pelvic floor not as an isolated muscle group, but as part of an integrated unit, which also includes the diaphragm, lower abdominals (transverse abdominus), and spinal muscles (multifidus). These muscles act synergistically to provide trunk stability, enable painless mobility, and prevent bowel and bladder incontinence. Engaging these muscles effectively requires proper breathing, coordination, and timing. Because

the pelvic floor plays such an important role in sexual function, particularly when there is pain, patients presenting with pain with intercourse should undergo a thorough evaluation of the pelvic floor by a professional best trained in evaluation and treatment of muscle and connective tissue disorders.

ASSESSMENT BY A PHYSICAL THERAPIST

Physical therapists treating patients suffering from illness or disease address the sensory, inflammatory, neurological, and musculoskeletal aspects of the disease and their effect on function. The physical therapy intervention generally consists of both evaluation and treatment. Physical therapy evaluation of patients with sexual pain disorders includes taking a detailed history, musculoskeletal assessment through observation and physical examination and a vulvar and pelvic floor examination (Rosenbaum, 2005).

History Taking

Given the variation of sexual feelings, experiences, and backgrounds of women referred with vaginismus, and its overlap with dyspareunia and vulvar pain syndromes, a very thorough medical and sexual history is integral to assessment and treatment, as well as to determining the coinfluence of psychosexual, cultural, educational, and psychodynamic factors. The history includes gathering information regarding the patient's chief presenting complaint. In most cases, patients with vaginismus seek treatment when it becomes apparent that this condition interferes with sexual intercourse, and the ability to have sexual intercourse is the goal of treatment. However, the inability to allow penetration extends to other, non–sexually related functional activities as well, such as inserting a tampon or undergoing a gynecological exam.

When the presenting complaint is pain with penetration or attempted penetration, a thorough pain assessment is necessary. Location of pain and its characteristics are the strongest predictors of its organicity (Meana et al., 1997). The pain description (burning vs. aching, diffuse vs. local, spontaneous vs. provoked) reflects its somatic, visceral, or neuropathic nature and will help determine direction for physical examination and treatment. It is important to determine at what point the pain occurs, if it is superficial or deep, if it occurs with arousal or orgasm, and if the pain can be alleviated and how. It is critical to ask questions regarding voiding function as this may indicate a primary dysfunction of the pelvic floor. Questions regarding childhood enuresis are relevant as well, particularly for patients with VVS, as early childhood voiding patterns may be associated with VVS (Greenstein, Sarig, et al., 2005). Comorbidity with vulvar pain syndromes has been reported for interstitial cystitis (IC), pelvic pain, and urinary ur-

gency and frequency (Doggweiler-Wiygul, & Wiygul, 2002; Jamieson & Steege, 1996). These conditions are related to muscle hypertonus and muscle trigger point irritability and should be addressed concurrently (Travell & Simons, 1992).

Observation and Musculoskeletal Examination

Observation and musculoskeletal exam consists of the following:

1. Observation of the patient's posture, movement, and breathing.
2. Assessment of posture, mobility, and strength.
3. Palpation for areas of tightness and decreased mobility.
4. Evaluation of the viscera to note hypomobile areas.
5. Checking of spinal, sacral, and pelvic alignment.
6. Muscle testing for length, strength, and trigger points.

General observation reveals the patient's posture, breathing, and gait. Observation of the patient, including body language, posture, and movement patterns, actually begins when she walks in the door. The patient is observed breathing normally and asked to demonstrate diaphragmatic breathing. Proper breathing is critical to effective engagement of the diaphragm, which in turn facilitates effective isolation and contraction of the pelvic floor. Conditions of chronic anxiety, for example, are manifested by shallow breathing patterns, ineffective excursion of the diaphragm, and increased muscle tone of the abdominal oblique muscles, which places increased intrabdominal pressure on the pelvic floor and creates dyssynergic breathing patterns and pelvic floor muscle dysfunction. When performing the musculoskeletal exam, careful assessment is made of the strength, length, and mobility of the pelvic and lumbar joints as well as the surrounding musculature of the pelvis and hips. A typical musculoskeletal presentation of patients with vaginismus is tightness in the hip flexors and adductors, muscles related to posture of "pulling in." Interestingly, these patients are commonly found to present with weak, undeveloped pelvic floor muscles when asked to perform an active contraction.

Vulvar and Pelvic Floor Examination

The physical therapist's assessment of the vulva differs from a gynecological examination. Both the external and internal exams focus on the mobility and integrity of the muscular, fascial, and connective tissue components. The vulvar and pelvic floor exam consists of the following:

1. Observation of the vulva, perineum, and anus to note areas of redness, raised areas, scar tissue, or edema.
2. Palpation to note areas of tenderness to touch.

3. Internal exam to assess pelvic floor muscle tension as well as tightness, tone, range of motion, and hymen presence and thickness.
4. Assessment of internal muscle trigger points.
5. Determination of the integrity of the pelvic organs and possible presence of prolapse of the bladder, uterus, or rectocele.
6. Anorectal internal exam when indicated by history.

Pelvic floor muscle tone is assessed by both manual examination and sEMG assessment with a vaginal probe. The presence of pelvic floor hypertonus and decreased resting- and working-level muscle stability evidenced by a high standard deviation has been associated with VVS (Glazer, 1998). Pelvic floor hypertonus has been associated with other dyspareunia-related conditions such as IC, levator ani syndrome, and proctalgia fugax (Kotarinos, 2003). Pelvic floor muscle assessment determines muscle tone at work and at rest, contractile amplitude, reaction times, and muscle stability.

PHYSICAL THERAPY TREATMENT

Women with dyspareunia or vaginismus have limited ability to function sexually and often present with musculoskeletal and neurological findings appropriately addressed by a trained physiotherapist. While pelvic floor surface electromyography (sEMG) biofeedback has been researched in several studies (Bergeron et al., 2001; Glazer, Rodke, Swencionis, Hertz, & Young, 1995; McKay et al., 2001) the inclusion of physical therapy in the team approach to treating women with sexual pain disorders is a relatively recent advancement and its exact role is not widely understood by either doctors, mental health professionals, or laypersons.

Treatment tools available to the physical therapist are educational (providing anatomical and physiological information), cognitive-behavioral (particularly with the use of vaginal dilators), rehabilitative (pelvic floor muscle strengthening and relaxation with tools such as biofeedback), and palliative (treatment modalities to decrease pain and improve tissue mobility). Physical therapists also use a variety of manual therapy techniques and have reported success in decreasing penetration pain and improving sexual function, and even in improving orgasm intensity (Holland, 2003; Wurn, 2004).

Specific therapeutic techniques chosen are guided by the findings of the history and examination. Physical therapy treatment generally consists of the following components:

1. Setting of treatment goals with patient.
2. Providing a home program of exercise and behavioral therapy.
3. Manual therapy.

4. Exercise.
5. Biofeedback.
6. Electrical stimulation and other modalities.

Setting of Treatment Goals

Prior to embarking on a treatment program, it is crucial to discuss goal setting with the client. Some women may be very focused on the ability to have pain-free sex, but this may not be the case for other women, who may consider pain relief their primary goal. The goal assessment also provides the patient with an explanation of the treatment and with options regarding what will work best for her considering her schedule and the amount of time and energy she wishes or is able to invest. For example, some patients with urinary urgency and frequency may want to invest in treating this concurrently while some women may not be bothered by these particular symptoms. When pain-free sexual intercourse is the goal, discussion may ensue regarding other aspects of improvement in sexual function. Was sexual intercourse ever pleasurable and is the ability to enjoy and derive pleasure from intercourse a goal of the patient? Are there other areas of difficulty in sexual function, such as decreased interest and genital and subjective arousal, and to what extent are they related to the pain? Are there difficulties in the relationship that either predate the pain or have resulted from it? Goal setting includes determining what the possible benefits will be of the physical therapy treatment along with referral to appropriate team members to help address the psychosocial components.

Home Program and Behavioral Therapy

The patient is instructed in self-care including avoidance of irritants such as synthetic garments and detergents, as well as feminine products. Depending on the presentation, she may be instructed to take baths with oils such as lavender, tea tree, and sea buckthorn, natural oils known for their anti-inflammatory qualities. Patients with VVS are often instructed to take calcium citrate to absorb excess oxalates, thought to possibly contribute to VVS (Solomons, Melmed, & Heitler, 1991) although its value has been questioned (Greenstein, Militscher, et al., 2005). Glucosamine sulfate to help thicken vulvar tissue has been suggested; however, this has not been studied.

In conditions of pain due to local inflammation, reduced sensory pain threshold, neuropathy, or a combination thereof, sensory rehabilitation provides relief of symptoms by raising pain threshold and "accustomizing" the affected area to touch. Patients with VVS have been found to demonstrate reduced pain threshold and more acute pain perception with touch (Granot, Friedman, Yarnitsky, & Zimmer, 2002; Pukall, Binik, Khalifé, Amsel, & Abbott, 2002). Patients with VVS often demonstrate behaviors

of avoidance regarding allowing direct touch or contact to the area, which hypersensitizes the area even more. Introduction of daily light touch by the patient herself with applications of vitamin E oil provide the therapeutic benefits of increasing proprioception and body awareness, and decreasing local tissue hypersensitivity.

In conditions with associated voiding dysfunction, such as urinary frequency and urgency, the patient is asked to keep a bladder diary and is taught timed voiding, in order to allow greater bladder capacity with less frequent need to void. In these cases, she is also instructed in avoidance of bladder irritants, such as caffeine and bladder-irritating foods.

In conditions of superficial dyspareunia, introital tightness, or vaginismus, the patient is instructed in home use of vaginal dilators, and in therapeutic exercise including deep breathing, relaxation, and pelvic floor conditioning as well as self manual stretching.

Manual Therapy

Various hands-on techniques are applied to treat musculoskeletal abnormalities, postural and skeletal asymmetries, and soft tissue immobility. Trigger points are discrete, focal, hyperirritable spots located in a taut band of skeletal muscle (Alvarez & Rockwell, 2002; Simons & Travell, 1983; Travell & Simons, 1992). They produce pain locally and in a referred pattern and often accompany chronic musculoskeletal disorders. The application of trigger point massage in the pelvic area and transvaginally has been described in connection with the treatment of pelvic pain and IC (Weiss, 2001) and for the treatment of vulvar pain syndromes (Fitzgerald & Kotarinos, 2003). Additional techniques include massage and connective tissue and scar tissue release. Osteopathic techniques such as visceral and urogenital manipulation, which are taught to physical therapists in advanced training courses, are effective techniques as well (Baral, 1993). Other techniques available to the physical therapist treating musculoskeletal dysfunction associated with pelvic and vulvar pain include muscle energy, contract/relax, and passive and resisted stretching designed to normalize postural imbalances, improve blood circulation in the pelvic and vulvar areas, and improve pelvic and vulvar mobility. Dilators are used not only to help overcome penetration anxiety but to stretch the introital opening. Perineal dilators designed for predelivery perineal stretching in women hoping to avoid episiotomy, is useful for introitus and perineal stretching in women with introital tightness (Cohain, 2004).

Exercise

Therapeutic exercises are designed to strengthen weak muscles, stretch tight muscles, improve mobility and flexibility, increase endurance, and decrease pain. Sexual activity, which requires some amount of physical stam-

ina as well as muscle strength, may be hampered by physical limitations and often pelvic exercises are indicated. For dyspareunia, specific exercises are taught to improve circulation, increase healing of the vulva and pelvis, and increase introital mobility. In the case of vaginismus, often certain muscle holding patterns are noted, such as hip adduction and internal rotation. Often the inner thighs are very tight and need stretching, simply to be able to maintain comfort when lying down with legs apart. Finally, the patient is instructed in proper performance of pelvic floor muscle exercise. Research has shown (Bump, Hurt, Fantl, & Wyman, 1991) that verbal instruction alone does not produce effective results and that only 50% of women respond to verbal instruction with proper isolation and contraction of the pelvic floor muscles. Furthermore, for pelvic floor muscle exercises to be effective, proper coordination, timing, and synergistic recruitment of other core postural muscles is necessary.

Pelvic Floor Biofeedback

Pelvic floor sEMG biofeedback involves insertion of a probe into the vagina, which measures the activity of the pelvic floor muscles and displays it in graph form on the computer monitor. The patient is then able to visualize the activity of her muscles and learn to relax them as well as strengthen, stabilize, and coordinate them. The value of biofeedback in treatment of voiding dysfunction and urinary incontinence is well documented (Jundt, Peschers, & Dimpfl, 2002; Weatherall, 1999). The application of biofeedback in the treatment of vulvar pain syndromes was first explored by Glazer, who noted that the baseline EMG of women with vulvar pain and VVS differed from women with pelvic floor dysfunction related to conditions such as prolapse and urinary incontinence. Women with VVS are likely to exhibit increased baseline resting tone, and decreased stability, both at work and at rest (Glazer, 1998). Glazer proposed that variables such as standard deviation, recruitment, power latencies, power density, and spectral frequency are relevant specifically to VVS and developed the Glazer protocol, which measures and accounts for these values in treatment (Glazer et al., 1995). The goals of sEMG biofeedback are to normalize pelvic floor muscle tone, decrease hypertonus, and improve contractile and resting stability.

Electrical Stimulation and Other Modalities

Other modalities available to the physical therapist include pelvic floor electrical stimulation. Use of pelvic floor electrical stimulation has been studied in the treatment of levator ani hypertonus and pelvic pain (Fitzwater, Kuehl, & Schrier, 2003) and is reported to successfully improve pelvic floor muscle strength and reduce pain in the treatment of VVS (Nappi

et al., 2003) The use of perineal ultrasound, the application of deep heat produced by frequency waves, for the treatment of dyspareunia has also been reported on in the literature (Hay-Smith, 2000).

THE MIND–BODY APPROACH TO TREATMENT OF SEXUAL PAIN DISORDERS

Successful treatment of sexual pain disorders requires a comprehensive approach. VVS, for example, has been shown to be a primarily physical disorder (Bornstein, Zarfati, Goldik, & Abramovici, 1999). Various studies have failed to link VVS with childhood sex abuse or history of trauma (Dalton, Haefner, Reed, Senapti, & Cook, 2002; Edwards, Mason, Phillips, Norton, & Boyle, 1997) or demonstrate a primary psychological cause for vulvar pain (Meana et al., 1997). However, several studies have linked VVS with psychological distress (Brotto, Basson, & Gehring, 2003; Sackett, Gates, Heckman-Stone, Kobus, & Galask, 2001), including increased states of depression and anxiety as well as sexual distress (Reed et al., 2000), and have concluded that it is important to address psychological and sexual distress in women with vestibulitis (Danielsson, Sioberg, & Wikman, 2000; Gates & Galask, 2001; Nunns & Mandal, 1997; Sackett et al., 2001). Although physical therapists are not psychologists or social workers, the therapeutic benefit of physical therapy treatment far surpasses only the physical. Throughout treatment, the patient is encouraged and given practical tools to overcome her fear and anxiety and is given hands-on direction for activities that sex therapists are traditionally able only to discuss, such as insertion of dilators. Practical suggestions for dealing with decreased libido and arousal are part of treatment; however, when the need for psychological treatment is identified the patient should be referred for therapy. An interdisciplinary approach, in which communication between therapists enhances the results of both treatments, is superior to simply multidisciplinary treatment, where practitioners may be working with the client independently. The case of Ayelet D highlights this well.

CASE STUDY: AYELET

History

Ayelet was referred to physical therapy by her gynecologist. She appeared at the clinic well dressed and groomed, pleasant and eager to please, if somewhat anxious.

Her history was as follows: She was a recently married 28-year-old Israeli lawyer, who first attempted intercourse at age 18, but had never been able to allow complete penetration, primarily due to pain. She grew

up in a Jewish but religiously secular household, and in her social circle, her friends began to have sexual intercourse between the ages of 17 and 19, usually just prior to or during the mandated 2-year post–high school army service. She did not recall ever associating sex with guilt, and in fact, shortly after beginning her first serious relationship at the end of high school, she asked her mother, with whom she discussed sexual matters freely, to accompany her to the gynecologist for birth control pills. At the time the gynecologist did not examine her because of her virginal status. She related that she was never able to successfully insert a tampon and had to use sanitary pads, and while she expected the first time she would have intercourse might be painful, she was very surprised to find she was unable to successfully complete the act. After a few unsuccessful attempts, she gave up trying, and eventually the relationship ended, for reasons she stated were not related to her inability to have intercourse. She then dated regularly without getting to the stage of attempting to have intercourse and only tried again 3 years ago, at age 25, with Ofer, then 27, the man to whom she is currently married. She related that she always enjoyed sexual activity including kissing, petting, and manual and oral stimulation and climaxes easily. She recalled masturbating since her early teens. She stated that she loved her husband and found him attractive, and she was aroused by him, but due to the pain and frustration of not being able to have intercourse, she had little sexual interest. She related that she had seen several physicians and therapists. The first time she underwent a gynecological examination, she couldn't be examined, and the doctor said she had vaginismus but did not offer any specific advice other than to relax and perhaps drink some wine before having sex. This did not work. She then saw several physicians, who had difficulty examining her, but diagnosed her with various yeast and bacterial infections and prescribed ointments and creams, which she used for over a year to no avail. The gynecologist she saw most recently, who referred her for physical therapy, also had difficulty examining her, but told her that he suspected that she suffered from vulvar vestibulitis syndrome. He suggested the possibility that she may consider a surgical procedure known as a perineoplasty, however, due to the invasive nature of surgery, suggested she try physical therapy first.

She also related experiences with several mental health practitioners prior to seeing this doctor. First, she saw a psychologist for a year. She enjoyed working with this psychologist and discussing all sorts of things with her. She believed it helped primarily by improving her self-esteem, and helping her cope with the loss of a good friend who was killed in a terrorist attack. However, they rarely discussed sex, and no specific suggestions were given regarding her sexual problem. She was then referred to a sex therapist whom she saw only briefly. This therapist told her that the pain was psychological, and that although she may not have any recollection of a trauma (she did not), she must have been sexually abused and blocked it

out. She considered the possibility, but she felt delegitimized by the therapist's insistence that her pain wasn't real, and discontinued after three sessions. She then put all the therapy and treatments on hold until she met Ofer. She recalled that from the beginning of the relationship, he was caring, supportive, and patient, and even told her that he didn't mind having sex without penetration, which they did for the first year. At a certain point, however, tensions began in the relationship and he admitted to her that not having intercourse was a problem for him and that he wants a "normal" sex life. Based on her first unfortunate experience with sex therapy, she was anxious and hesitant to begin again, but this time she was pleased with the couple/sex therapist suggested by a good friend of her mother's. She and Ofer attended the sessions together. She stated that the sessions allowed Ofer to express his frustrations and enhanced their ability to communicate with each other. Regarding direct treatment of the vaginismus, she was given a set of four dilators and instructed in how to use them at home. She was able to insert the first and second dilators and even allowed Ofer to insert them, but could not get the third one in despite several attempts. When it proved too painful the therapist suggested applying a 5% lidocaine solution 20 minutes prior to trying, and though this dulled the pain somewhat, she still could not get it in. It was at this point that the therapist sent her to the gynecologist, suggesting that perhaps he would diagnose VVS and suggest physical therapy. The gynecologist did, in fact, diagnose VVS, and referred Ayelet to physical therapy.

Ayelet then began physical therapy treatment. Ayelet reported a medical history free of illness and was not taking medications other than birth control pills. When asked, she admitted she did have urinary frequency but denied childhood enuresis (bedwetting). She denied recollection of abuse. Since working with the dilators she was now able to insert tampons, but did not like how they felt and preferred not to. When asked about the pain, she stated that it only hurt with touch, attempted penetration, or attempted gynecological exam. Regarding location of pain, she described the pain to be at the vaginal entrance, at the bottom and on both sides.

Physical Exam

Ayelet is an attractive woman, of average height, with a slim figure. Her postural exam revealed a slight forward head inclination, slight spinal scoliosis (curvature), and an increased lumbar lordosis. Muscle testing revealed tight hip flexors and tight hip adductors (inner thighs).

Ayelet was clearly nervous but was cooperative during the vulvar/pelvic examination. She allowed me to observe the vulva and vagina, which looked normal, although mucosal dryness and atrophy were noted. She had noted tenderness at points 5:00 and 7:00 with Q-Tip testing on the vestibule, and slight redness at the posterior fourchette was noted. When

asked if I might insert a finger, she readily agreed, but as my finger neared, she closed her legs, visibly anxious. I advised her to take a deep breath and on the second attempt she allowed me to insert one finger, with which I was able to determine increased pelvic floor muscle tone, as well as thickened hymenal tissue. When asked to actively contract her vaginal muscles, she did so minimally, but subsequent relaxation of the muscles was not well determined. Also noted was tightness at the perineum and along the posterior portion of the introitus. She was also asked to demonstrate how she inserted her dilators.

Ayelet was instructed in a home exercise program designed to improve connective tissue integrity and increase vulvovaginal mobility, decrease tenderness to touch, decrease pain, and allow painless penetration, eventually of a penis. This would consist of daily applications of vitamin E oil while stretching. She was instructed in techniques to stretch the tight areas of the vulva with the oil, particularly externally at the perineum and at the superficial interoitus. She was also instructed in proper pelvic floor exercises and in techniques to relax the pelvic floor muscles. She was instructed in ways to actively use her muscles to counteract the reflexive manner in which she pulls her legs inward when attempted penetration is about to take place. This would prove to be particularly helpful with the dilator insertions, which she was observed to perform forcefully, against closed legs and holding her breath. She was taught the proper positioning, breathing, and technique for inserting the dilator in a manner that should feel as though it were gliding in, rather than being pushed in. She was also taught positions such as posterior pelvic tilting in supine using gluteal rather than abdominal muscles, as well as internal hip rotation. These positions increase vaginal interoitus opening by decreasing puborectalis activity while slightly increasing levator activity, which acts to help dilate the vagina. Communication with the gynecologist regarding the mildly atrophic condition of her vulva resulted in the decision to begin applications of vaginal estrogen cream and temporarily discontinue birth control pills.

At the second visit, Ayelet demonstrated her ability to insert the first two dilators effortlessly using the new techniques she learned. She allowed me to insert them as well, while she concentrated on actively opening her legs and relaxing her pelvic muscles during insertion. I then inserted the vaginal sEMG probe, which was slightly larger than the second dilator. The sEMG assessment revealed that Ayelet had a high resting baseline amplitude of 3.5 microvolts. Normal resting amplitude should be under 2.0 microvolts. During the contraction phase, she was able to contract to a relatively high amplitude average of 40 microvolts, but her stability was poor and the standard deviation was 4.5, significantly higher than the norm of 0–2. This and subsequent biofeedback sessions consisted of strengthening the muscles with the goal of increasing stability and coordination, and relaxation techniques to decrease the base resting tone.

Manual therapy techniques were initiated as well, consisting of visceral manipulation and myofascial release. These techniques employ gentle pressure on the body's tissues and organs to improve breathing and mobility and promote relaxation. Manual techniques were performed at the vulva and vagina as well, including internal and external massage of the pelvic muscles and manual stretching of the hymen and interoitus. Still, when attempting to insert the third dilator herself, she was unable to. She reported that the problem was not so much the pain anymore as that she felt it was blocked. After several sessions of manual stretching of the hymen, I was able to insert the third dilator and after that she was able to as well. Because this is where she had plateaued, she felt that this was a real breakthrough and that finally, through this physical breakthrough, things were beginning to move forward.

After 2 months of treatment the physical improvement, both subjectively and objectively, was significant. I would often ask Ayelet how things were going in the marriage, sexually and otherwise, and about her sexual desire. I had instructed her and Ofer to avoid attempting penetration but had given them sensate focus exercises to do together to counteract the mechanical, nonsexual effect that dilator work tends to have on a couple. She responded that they have both been very busy and have not had much time to be together. I also noted that her husband did not accompany her to treatments and wondered how she felt about that.

Through our conversations, many issues emerged. When they had gone to sex therapy together, he was involved in the treatment, and it was perceived as a couples problem that they worked on together. He became frustrated, however, when she didn't progress past the second dilator and when she was diagnosed with VVS, Ayelet felt as though Ofer "checked out" of treatment. She realized that she was doing a lot of work, attending weekly physical therapy sessions, and working at home with the exercises and dilators, and she began to internalize the inherent message that she was the one with the problem and she needed to fix it. When she was ready, they could resume their sex life. It was clear she was feeling neglected and angry that she was doing all the work alone and I encouraged her to suggest to Ofer that they resume the sex therapy sessions with the couples therapist. However, at the next visit, she stated that after our session she and Ofer talked for many hours. She expressed to him her feelings of isolation and he admitted to her his feelings of frustration, and that he was afraid to initiate sexual activity with her, yet she never did so herself. They agreed to set aside time three times a week for the sensate focus exercises, and also resumed working together with the dilators. Ayelet then said they decided to hold off on resuming the sex therapy for now.

After 3½ months of treatment, Ayelet displayed significant progress. Her EMG resting levels were down to normal and her muscle stability improved. She was able to insert the fourth (and largest) dilator, and the pain

was minimal. She also related that her sexual desire had improved somewhat and she and Ofer made a point of having non-intercourse-based sexual relations at least once a week. He could even put two fingers in her vagina now, and though she didn't find it particularly pleasurable, it didn't hurt. It was time to discuss attempting penetration. Rather than instructing Ayelet to go home and try to have intercourse, I told her that as far as I was concerned, the restriction no longer applied, but preferably she should do it when they are both aroused and in the mood, and not just attempt it in order to see if the treatment was effective. I asked Ayelet about her feelings about attempting to have intercourse and she revealed the following:

1. Fear of failure. ("What if after all this hard work, I still can't have intercourse?")
2. Worry that intercourse wouldn't be pleasurable. ("Is this what all the fuss was about?")
3. Concern about setting boundaries. ("Once I can have sex, does this mean I will have to all the time?")

I cautioned Ayelet not to get upset if it was painful or it didn't go well and that it would not be an indication that the treatment didn't work. I noted her perfectionist tendencies and her desire to succeed and explained that this is a process that may take some time and may not work perfectly on the first try. Regarding her concern that intercourse would feel neutral at best, I encouraged her to begin to attempt to reassociate intercourse with pleasure rather than pain, by fantasizing while masturbating using her fingers internally or while using the dilators. Finally we discussed the fact that, naturally, fear of failure is accompanied by fear of success. Succeeding at intercourse, even though she was cognitively very motivated to do so, was as scary as failing, because it was a major change in the status quo upon which the relationship had been based for nearly four years. I encouraged her by saying that because she and Ofer have such good communication with each other, she does not need the VVS in order to avoid intercourse. If she doesn't want to have intercourse she doesn't have to, but isn't it good to know she can when she does want to? I also reassured her that it may take some time for it to be pleasurable, that she may or may not reach orgasm during intercourse, and that according to research studies, many women don't, but also suggested positions to maximize clitoris stimulation during intercourse in order to facilitate the possibility. We also discussed resumption of birth control; however, Ayelet stated that she and Ofer were anxious to begin a family.

Lastly, I warned her not to worry or get upset if Ofer lost his erection or ejaculated prematurely before intercourse. I explained that this commonly occurs after treatment for vaginsimus and vestibulitis, as he may have developed his own insecurities that could result in "performance anxiety" and stressed to her that this was not a performance. After these dis-

cussions, she agreed to return to the couple/sex therapist for a few sessions. The therapist and I communicated regarding the issues that arose in physical therapy. In addition, the therapist provided me with the insight that an additional difficulty in transitioning into intercourse was the fact that Ofer in many ways symbolized a father figure to Ayelet and awareness of this was important to avoid the incestuous associations Ayelet was feeling.

I saw Ayelet again 3 weeks later. She stated that they had intercourse four times. She related that her husband, Ofer, was very pleased and that she, too, was happy to have been able to have intercourse. She described the feeling as slightly uncomfortable, but not painful, and was surprised that she actually enjoyed the feeling of him inside her. She returned for follow-up visits once a month for the next 3 months, and at the final visit related that she successfully underwent a complete gynecological examination without pain. Two months later she called to happily announce her pregnancy.

Case Discussion

The above case study well illustrates the crucial role of the physical therapist in treating and managing the patient's sexual pain disorder as well as the effectiveness of an interdisciplinary approach between physician, sex therapist, and physical therapist. Ayelet's case, however, does not represent the ideal management and presents with several complicating factors. These include the fact that her original physician did not identify her condition, validate her pain, or provide a referral to an appropriate psychosexual or physical therapist. Furthermore, while the original therapy she underwent was helpful to her in dealing with her friend's tragic murder and in improving her self-esteem, it did not address her sexual difficulties. Additionally, when she did see a sex therapist, she was made to feel her pain wasn't real, and the therapist's insistence that she must have undergone a sexual trauma of some sort contributed to an overall negative therapeutic experience. This caused her to put aside dealing with the issues until they became very relevant when she was in a new relationship.

Fortunately, the new sex therapist she saw was familiar with the symptoms of VVS, and referred her to a gynecologist who she was aware also had an interest in sexual pain disorders. The referral to this physician and subsequent diagnosis of VVS, as well as treatment with physical therapy, facilitated Ayelet's progress both physically and emotionally. While the sex therapist offered helpful suggestions regarding treatment of Ayelet's condition, she was limited in providing the actual hands-on physical treatment that was necessary, Similarly, while the physical therapist was very helpful in elucidating Ayelet's fears and helping her relieve her anxieties on a cognitive level, as well as provide sensate focus exercises and suggestions for improving nonpenetrative sexual activity, she did not possess the training necessary to address the psychodynamic issues regarding Ayelet's father

or to provide couple therapy. While it would have been ideal had Ayelet been diagnosed properly originally, then referred simultaneously to physical therapy and sex therapy, the above case demonstrates how eventually both disciplines worked together with the physician in her care and were ultimately helpful in the successful resolution of her condition.

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PART III

MALE SEXUAL DISORDERS

CHAPTER 7

Sexual Desire Disorders in Men

WILLIAM L. MAURICE

> The sudden loss of libido produced forms of suffering I had not anticipated. . . . I taught at a university each day . . . because I had lost the capacity to experience desire did not mean that I was not tormented by the *memories* of desire. Surrounded by the presence of youthful Eros . . . I began to feel a crushing weight of loss.
>
> —HARROD (2003)

As with women, sexual desire disorders in men tend to be among the most challenging sexual difficulties to treat. Often the man with low sexual interest is far less troubled by the condition than is his partner, who may feel thwarted not only by the lack of physical affection and touch, but of procreative opportunities as well. This is particularly true for the young woman who wants to start a family.

In this chapter, Maurice points out that there are many different subtypes of desire complaints in men and that it is important to differentiate between them. Not surprisingly, the prognosis for acquired/situational and acquired/generalized problems tends to be better than that for lifelong/generalized types. Taking a comprehensive sexual history with the man alone is essential to determining evidence of sexual interest that may not be readily acknowledged in front of a partner, as well as family of origin issues.

While sexual interest problems tend to be much less prevalent in men than in women, they do seem to increase with aging. Maurice discusses the controversy concerning the existence of andropause in men. He notes that it is difficult to distinguish this syndrome from age-related confounding variables such as nonendocrine illnesses, poor nutrition, smoking, alcohol use, and medications. Nevertheless, there is

evidence that there are changes in androgen levels in men as they age, although they are not as dramatic as the changes in estrogen during women's menopause.

There are many psychological, interpersonal, and biological contributions to sexual desire problems and rarely a single etiological determinant. Low or absent sexual desire often coexists with erectile problems and it is important to try to determine which came first (although Maurice suggests that it is usually more expedient to treat the erectile dysfunction before the desire problem). Both individual and couple therapy is often useful.

Despite the best efforts of the sex therapist, treatment success is often mixed. Although there have been a paucity of psychotherapy outcome studies for sexual problems generally and for treatment of hypoactive sexual desire disorder (HSDD) specifically, those that do exist suggest only modest increases, if any, in sexual desire. Rather, treatment more reliably results in greater relationship satisfaction and erectile success.

Maurice illustrates the complexity of treating the various subtypes of HSDD in men by presenting three case examples. While treatment involves many familiar sex therapy interventions, the outcome in each case is quite different. In his concluding comments, Maurice reminds the reader that it is necessary to restrain expectations when confronted with HSDD and to be humble in accepting the limitations of treatment.

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Men not interested in sex? To most, the idea is an oxymoron. After all (so the argument goes), is it not true that the vast majority of sexual mischief that we read about in the newspapers each day is a result of the uncontrolled (and seemingly uncontrollable) sexual desire of men? And the nature of the partner does not seem to matter: women, other men, children, computers, and even animals (the current popularity of Albee's [2003] *The Goat, or Who Is Sylvia* attests to that!).

Sexual desire problems in men are simply off the radar screen—for the general public and even for most health professionals. Patients, physicians, and drug companies are all so focused on the trajectory of a man's penis that few seem to be at all interested in how this is determined. It is as if when it comes to sex and men, the brain does not exist. How often does one hear that it (a man's penis) has "a mind of its own"? As if to underline this notion, it is not so unusual for clinicians to hear of an angry woman slapping her male partner's erection—as if his penis and not his cerebral cortex was responsible for his sexual behavior!

However, there are at least *two* people who know the meaning of ab-

sent sexual desire in a man full well: the man who has experienced a loss (see quote at the beginning of this chapter) and his woman partner (in the case of a heterosexual couple), who either misses his pleasuring or has not had much opportunity to enjoy this from the beginning. In the latter instance, she is often in misery over the lack of touch and affection (all of which calls into question his love for her in her own mind)—not to mention the absence of babies.

WHAT REPRESENTS NORMAL SEXUAL DESIRE FOR MEN?

Any discussion of sexual desire problems in men begs the question: what is normal? (The subtext of this question is: How is sexual desire different for men and women?) The answers are quite unclear, but some information can be found from contributions of both science and clinical experience.

One of the few contributions from science was the Massachusetts Male Aging Study (MMAS; Feldman et al., 1994; McKinlay & Feldman, 1994). This random sample survey of 1,709 men between 40 and 70 years old in the general population posed the question of what happens to men sexually as they age. Questions involved aspects of *both* their sexual behavior and subjective thinking, including sexual desire. The survey results found "a consistent and significant decline with age in feeling desire, in sexual thoughts and dreams, and in the desired level of sexual activity" (McKinlay & Feldman, 1994, p. 271). Those who are penis-centric would do well to note the following: the decline in sexual interest neither preceded nor followed a similar decline in sexual behavior or events. "They appeared to occur together" (McKinlay and Feldman, 1994, p. 271). Since the data were cross-sectional, it was not possible to answer the question about which came first. (Parenthetically, the authors also found that *satisfaction* did not follow the same path in that "men in their sixties reported levels of satisfaction with their sex life and partners at about the same level as younger men in their forties" [McKinlay & Feldman, 1994, p. 272]).

In a departure from the cross-sectional information cited above as well as in Kinsey's study (1949) and others, Araujo and his colleagues (2004) conducted a 9-year follow-up study of a large cohort (n = 1,085) of men who originally participated in the MMAS and examined a large number of sex-related variables (including sexual desire). The rationale for following these men and not simply being satisfied with data from one point in time was that "differential socialization of those born at different time periods may make comparisons between birth cohorts misleading" (p. 1502). The authors reported that all sexual variables studied (including sexual desire; $p < .001$]) declined with age—the one exception being ejaculation with masturbation. A fresh finding was that the change was nonlinear, that is, the magnitude of the variation was not the same in all age groups. In re-

lation to sexual desire, the size of the change increased significantly with each age group. In reflecting on the meaning of the data (as well as its implications for the concept of andropause—see below), the authors asked a crucial question, namely, if

> sexual decline is an inevitable part of the aging process or part of the process of aging . . . it is unknown whether declines represent universal changes that are independent of disease and environmental influence (i.e., part of the aging process) or whether observed declines are due to factors that are associated with aging such as weight gain, comorbidity and medication usage but which are not intrinsic to chronological aging itself (i.e., part of the process of aging). (p. 1507)

Studies of *women's* sexual desire has, paradoxically and unintentionally, provided more information about sexual desire in men. Several examples will suffice. First, a comparative study of heterosexual, gay male, and lesbian couples (Blumstein & Schwartz, 1983) found that lesbian pairs were the least sexually active. Since men are often the initiators of sexual activity and since there is no male in a lesbian couple, less sexual activity will occur. Nichols (1988) offered a different interpretation when she speculated that women are "wired" differently. Baumeister and his colleagues (2001) reviewed the literature on the comparison of the "sex drive" of men and women and found that on a number of measures, men are cognitively and behaviorally more sexually energetic than women. For example, men think about and fantasize about sexual matters more than women, want to engage in sexual activity more often regardless of sexual orientation, masturbate more frequently, experience earlier onset of sexual desire, and are drawn to a wider variety of sexual practices. They concluded that "the role of biology is moderated by social factors more for women than men." Conversely, they speculated that, as far as men were concerned, biology overshadowed social influences. Basson (see Chapter 2) has commented that the individual sex response cycle described by Masters and Johnson (1970) (modified by Kaplan, 1979, and incorporated into DSM-IV-TR [American Psychiatric Association, 2000]) represents a "linear" development that is more fitting for men than women, whose experience could be described more accurately as "circular." Moreover, and specifically related to women, she distinguishes between desire that is "innate" and that which is "responsive." (By inference, desire in men would be conceived of as primarily, or even exclusively, as the former.)

When considering what is normal for men, one can also examine the clinical experience of health professionals who treat people with sexual problems. In instances of a *lifelong* problem of low sexual desire in a man, women sexual partners come asking for help because they know that something is wrong based on their personal life experience of often having

to fend off the sexual pressures of teenage boys, and later, adult men. In addition, those women hear from women friends about the sexual demands or exploits of their male partners. They know all too well just how different most men are from their own husbands.

CLASSIFICATION

The editor of this book is to be applauded for separating sexual desire problems in men and women rather than using the more common approach of lumping the two together. Anatomy dictates that some sexual dysfunctions affect only *one* sex (e.g., erection problems or difficulties with vaginal lubrication). However, the same cannot be said about desire disorders. The male–female split is unconventional. After all, not even the principal system used for the classification of sexual disorders (DSM-IV-TR; American Psychiatric Association, 2000), nor a more recent attempt at defining sexual dysfunctions (Lue et al., 2004), separates sexual desire disorders in men and women. This chapter attempts to explain why the split is justified.

DSM-IV-TR (2000) includes "sexual desire disorders" as one of the "sexual dysfunctions." The latter, in turn, represents one kind of problem in the major category of "sexual and gender disorders." Sexual desire disorders include two types of problems: "hypoactive sexual desire disorder" (HSDD) and "sexual aversion disorder" (SAD). Since the diagnosis of SAD is rarely made in men, and given that a recent review of the subject had exceedingly little information about men (Janata & Kingsberg, 2005), the rest of this chapter will only consider HSDD.

For the diagnosis of HSDD, DSM-IV-TR (American Psychiatric Association, 2000) requires the fulfillment of three criteria: (1) a deficiency or absence of sexual fantasy and desire for sexual activity, (2) the fact that it causes "marked distress or interpersonal difficulty," and (3) that the disorder is not better viewed as a result of a major psychiatric or medical condition, or of substance abuse.

SUBCATEGORIES OF HSDD

DSM-IV-TR (American Psychiatric Association, 2000) directs clinicians to subcategorize sexual dysfunctions generally, and desire disorders specifically, according to whether the difficulty is (1) *lifelong* (always evident since puberty) or *acquired* (following a period of uncomplicated sexual function), and (2) *generalized* (existing in all sexual circumstances) or *situational* (only in some). Reasons for subcategorizing sexual dysfunctions relate to the origin(s) of the disorder and include the clinically evident notion

that an acquired problem requires an explanation and diligent search for a reason for the change; likewise, a situational difficulty means that the patient's body is not impaired and that one need not look for a biogenic explanation for its origin (Maurice, 1999). (An exception to the previous statement is the observation [Schwartz, Bauman, & Masters, 1982] that some patients with hyperprolactinemia may appear to have a situational problem—see the section on hormones later in this chapter.)

Theoretically, there are five possible subtypes of sexual desire disorders in men (Maurice, 1999). However, in clinical practice, men primarily display one of the following three:

1. Lifelong/generalized: the occasional man who has never been interested in any form of sexual activity and functions at an atypically low level of desire (see comment from Kinsey in the "Etiology" section below).
2. Acquired/situational
   a. The man who begins a relationship with sexual enthusiasm but soon becomes disinterested in partner-related sexual activity in contrast to solo sexual interests involving masturbation while looking at visual depictions of undressed women in magazines, videos, or on the Internet.
   b. The man who is quite sexual with women where there is no possibility of an intimate relationship but sexually disinterested in women with whom he is otherwise close (e.g., the madonna/prostitute syndrome [Freud, 1905/1977]—see "Etiology" below).
3. Acquired/generalized
   a. The man who was once sexually avid but has lost sexual desire seemingly as a result of medical problems (e.g., medications, illness, hypogonadism due to, for example, a medical procedure such as some treatments for prostate cancer [see epigraph at the beginning of this chapter]).
   b. The man who (and this is somewhat controversial) is experiencing andropause or one of its variants (see the subsection "Age-Related Hypogonadal Syndrome" in "Etiology" below).

EPIDEMIOLOGY

Information on the epidemiology of sexual disinterest in men comes from surveys of the general population and convenience samples. In the literature on this subject, little attempt is made to distinguish between the different diagnostic subtypes described above.

A prime source of population-based information on sexual disinterest in men is the National Health and Social Life Survey (NHSLS). Laumann

and his colleagues (1994) interviewed a probability sample of 3,432 adults (including 1,410 men) in the United States between the ages of 18 and 59. In a 90-minute interview on many sex-related subjects, one of the questions asked was "during the last 12 months has there ever been a period of several months or more when you lacked interest in having sex?" Overall, 16% of the men replied "yes" to this question (vs. 33% of the women).

Some social factors examined in the study by Laumann et al. correlated with lack of sexual desire in men. Those who were more likely to answer affirmatively included men who were never married, older, less educated, black, and poor. (The relationship to poverty was striking in that 25% of poor men responded positively compared to 13–15% of men at other income levels.) In addition, the greater the impairment of health and the magnitude of unhappiness, the greater the extent of sexual disinterest. Risk factors found to be predictors of low sexual desire in men included "daily alcohol consumption," having ever experienced "same-sex activity," and having been "sexually touched before puberty."

A U.K. survey using a stratified probability sample (Mercer et al., 2003) concerned the prevalence of sexual function problems in people who had at least one heterosexual partner in the past year. The study took place from 1999 to 2000 and involved 11,461 men and women ages 16–44. The response rate was 65.4%. Problems were reported according to two duration periods: those that lasted at least 1 month in the past year, and those that lasted at least 6 months in the past year. Thirty-five percent of men reported at least one sexual problem in the past year, and "lack of interest in sex" was the most common concern (17%) in the shorter time period; however, the prevalence dropped to 2% when considering the longer time frame.

Similarly, when a sample of gay men (Rosser, Metz, Bockting, & Buroker, 1997) were asked about sexual concerns including "lack of interest in or desire for sex," 16% said it was a current problem and 49% indicated that it was a problem at some time in their lives.

CLINICAL ASSESSMENT

Clinical assessment of sexual desire disorders in men occurs with history taking, physical examination, and laboratory testing.

In delineating the man's history, the first step is determining the *pattern* of the problem, that is, clarifying whether the difficulty is lifelong or acquired, and also whether it is generalized or situational (see above). Topics that are essential to this process are outlined in Table 7.1; these provide the basis for questions. Specific questions for each of the topics have been formulated elsewhere (Maurice, 2005, pp. 81–82). An organizing principle is that all questions relating to sexual desire can be subsumed un-

TABLE 7.1. HSDD: History-Taking Topics

1. Duration of disinterest
   a. Has there ever been partner-related sexual activity?
   b. What has been life experience with masturbation?
   c. Have there been periods of sexual desire in the past that have not been sustained (i.e., periods of episodic desire)?
   d. Has there been a period of persistent desire in the past but not now?

Comment: The reason for asking an "ever" question in relation to sexual activity is that there are indeed some people (especially those with substantial psychiatric disorders) who have never (or rarely) engaged in sexual activity with a partner.

2. Thoughts, fantasies
   a. Has the content been partner-related and/or involving people and/or atypical behavior?
   b. If involving people, is the person (i) usual partner? (ii) other women? (iii) other men? (iv) children?
   c. If atypical behavior, what kind?

Comment: There is hardly anything so private as a sexual fantasy. While some may choose to share the content with a sexual partner, most people with sexual problems are quite reticent to do so. The topics outlined above involve questions that are potentially threatening to the couple relationship and should be asked without the partner present.

3. Partner-related touch
   a. What is the experience with affection (holding hands, hugging, kissing)?
   b. Do he and his partner sleep in same bed?
   c. Do they go to bed at same time?
   d. What bedclothes do each of them wear?

Comment: Since touch is so intrinsic to partner-related sexual behavior, there is little use in asking about anything sexual if touch is a major source of difficulty. Regularly going to bed at different times may represent a method of avoiding sexual activity; bedclothes can be similarly protective.

4. Usual partner sexual activity
   a. What has been the sexual frequency in the past 6 months?
   b. When did sexual activity last occur?
   c. And the time before that?

Comment: Six months is an arbitrary period of time. The number could be different. In addition, for a variety of reasons, couples in which one partner has a sexual desire concern often engage in sexual activity just prior to an appointment with a health professional even though it might not have occurred for some time before. Thus it is worthwhile asking about the last two *sexual events.*

5. Other partner sexual activity
   a. Ever?
   b. Other women?
   c. Other men?

Comment: As with the comments above about sexual fantasies (see no. 2), questions about actual experiences with other people (current or past) might be quite damaging when asked in the presence of a partner.

(*continued*)

6. Atypical sexual activity
   a. What has actually taken place?
   b. With partner or alone?
   c. Details of condom use
   d. Frequency?

Comment: Such information is crucial since the desire for atypical activity may explain the apparent disinterest that a man manifests. In addition, and not necessarily related to the issue of sexual desire, if the man is sexually active with a partner outside his usual relationship, one must ask about the nature of sexual activities and condom usage to determine if there is a risk of transmission of STDs generally and HIV/AIDS, in particular, to the usual partner.

7. Masturbation experiences and fantasy
   a. What is the frequency?
   b. Are there visual accompaniments (magazines, videos, Internet)?
   c. What is the content of the pictures (mainstream activities, paraphilic behavior, couples, individuals, same sex, opposite sex, children, violence)?

Comment: With assurance of confidentiality, men who are apparently uninterested in their usual partner will discuss their masturbation experiences and thoughts during that activity. Again, such information is crucial for two reasons: it establishes whether the lack of sexual desire is situational, and it may help to explain the reason for the apparent lack of sexual desire with his usual partner.

8. Real-life visual erotic stimulation
   a. What is his response to seeing women with fewer clothes (in summer), or without clothes?
   b. What is his experience with "strip" shows?

Comment: These are interesting issues and seemingly worth asking about but no one presently knows the extent to which they are correlated with other aspects of the absence of sexual desire in a man.

der three headings: (1) phenomena that are mental or psychological (fantasies and dreams), (2) behavior that involves oneself (masturbation), and (3) behavior that involves a partner (same or opposite sex).

The initial clinical assessment of a couple in which the man has a sexual desire concern may involve secrets that will not be revealed in the presence of a partner. Thus, *in this instance, the value of the common process of assessing a sexual dysfunction with both partners together on a first visit becomes debatable* (assuming one knows what the main concern is beforehand). In any case, whenever each partner is seen individually, it is usually wise to see the person *without* the desire complaint *first* so one does not have the duplicitous experience of talking with the other person while possibly being aware of secrets and simultaneously being bound by a pledge of confidentiality.

Once the pattern of sexual desire is clarified, the clinician can establish whether it is an acquired and generalized problem—in which case physical

and laboratory exams are not only warranted but mandatory. Since the origins of acquired and generalized low sexual desire in a man are so varied, it is impossible to state what physical or laboratory exams are necessary in all circumstances. In instances where low sexual desire accompanies a medical, psychiatric, other sexual disorder or the use of a medication, one would expect this to have become evident in the history-taking process.

When the explanation for a generalized loss of sexual desire is not obvious, a comprehensive physical and lab examination is required. Endocrine disorders can manifest in a subtle manner and may be related to testicular or hypothalamic–pituitary dysfunction. Since testosterone (T) and prolactin (PRL) are so influential in sexual desire, they should always be measured when the pattern is acquired and generalized. (On a practical level, measurement of T is best performed in the morning because of the diurnal variation in blood levels—less pronounced in older men [Bremner, Vitiello, & Prinz, 1983].) In addition, when a sexual desire disorder is accompanied by erectile dysfunction (ED) and the etiology of both is unclear, the assessment of the latter must be included. From a lab perspective the clinician would want to know about lipid levels, fasting blood sugar, and thyroid function, in addition to T and PRL.

ETIOLOGY

General Considerations

Sexual desire can be viewed primarily from a biological, psychological, or social perspective.

Kolodny, Masters, and Johnson (1979) saw "sex" as "natural" (that is, in accord with nature). "To define sex as natural means just as an individual cannot be taught to sweat or how to digest food, a man cannot be taught to have an erection . . . [however] because the reflex pathways of sexual functioning are inborn does not mean that they are immune from disruption due to impaired health, cultural conditioning, or interpersonal stress." While Kolodny and his colleagues spoke little of sexual desire specifically, they undoubtedly would have seen the absence of sexual desire in men (and women) as "unnatural."

Levine (1992, pp. 37–48), and subsequently Maurice (2003), provided perspectives on sexual desire with a focus on the issue of "intimacy." (As is the case with Kolodny et al., 1979, both acknowledged the contributions of both the biological and the social/cultural perspectives.) The powerful implications of the absence of intimacy were described in patients who have a serious mental illness:

> The roots of intimacy difficulties are in the patient's past. . . . This . . . needs to be thoroughly explored because it may well have included turmoil

> in his or her family-of-origin, as well as a dearth of love and nurturing connections which are so often a rehearsal for love relationships later in life. Likewise, the patient's past may not have included the experimental love and sexual relationships of adolescence in which so much learning takes place about oneself and others. (Maurice, 2003, p. 401)

In contrast to the biological and psychological perspectives, Tiefer (1995) sees sexuality as being "socially constructed." Her point of view is that "the primary influences on women's sexuality are the norms of the culture, those internalized by women themselves and those enforced by institutions and enacted by significant others in women's lives." While Tiefer's writings have focused on women, she would likely see the sexual desire of men and its absence through the same prism since social constructionist theory does not require a different way of thinking depending on the nature of the problem.

These three ways of looking at sexual expression are not mutually exclusive. One or another factor may hold sway at different points in a man's life or some combination may explain an absence of sexual desire at one particular time. In addition, the three concepts outlined above make no distinction between men and women—a potential source of faulty logic. (It might well be that one notion may, in general, better explain sexual desire in men but not in women. For example, hormones might be more influential in men [therefore making desire more "natural"] or the social constructionist way of looking at the human sexual world may be more applicable to women.)

Etiological Factors Governing the Three Subcategories of Low or Absent Sexual Desire in Men

The etiology of low or absent sexual desire that is both lifelong and generalized is unknown. Only Kinsey and his colleagues (1949) seemed willing to speculate: "there is a certain skepticism in the profession of the existence of people who are basically low in capacity to respond. This amounts to asserting that all people are more or less equal in their sexual endowments, and ignores the existence of individual variation. No one who knows how remarkably different individuals may be in morphology, in physiologic reactions, and in other psychological capacities could conceive of erotic capacities (of all things) that were basically uniform throughout a population" (p. 209).

Etiological factors for the acquired syndromes are outlined in Tables 7.2 and 7.3.

In the acquired/situational form, sexual desire is present when the individual is alone but not (usually) when together with a partner, or a man might have a strong inclination to be sexual in situations with a partner

TABLE 7.2. Etiology of Acquired/Situational Diminished Sexual Desire

- Intimacy difficulty
- Madonna/prostitute syndrome
- Relationship discord
- Other associated sexual dysfunctions
- Paraphilia-related disorder or "sexual addiction"
- Paraphilia
- Partner sexual difficulty
- Chronic and severe illness in partner
- Child sexual abuse
- Severe psychiatric disorder
- Psychosocial issues (e.g., infidelity)

but where the relationship is devoid of closeness (e.g., with a prostitute). On other occasions where there is a partner, the encounter is so filled with apprehension (e.g., severe psychiatric illness) that in spite of the urge, the man's erection and the sexual opportunity are lost.

In the disorders or conditions listed in Tables 7.2 and 7.3, a sexual desire problem does not always exist and even when it does, the separation between all subtypes is not perfect. For example, while sexual desire is often diminished in depression, the opposite exists in some men (Nofzinger et al., 1993). Issues relating to intimacy provide yet another example. An intimacy problem may be developmental in origin and, as a result, lifelong and situational in its manifestation, but it could also be connected to a specific relationship and therefore be acquired/situational. Likewise, sexual desire in the context of a medical disorder that waxes and wanes, can appear at different times to be situational or generalized.

Some of the items listed in Tables 7.2 and 7.3 have been the subject of empirical research while for others, one must rely on clinical observation. A few common etiological contributions to desire problems are described below.

Madonna/Prostitute Syndrome

Freud (1905/1977) speculated that a man may choose one woman for love and another for sexual activity and be seemingly unable to fuse the two. He referred to this idea as the madonna/prostitute syndrome. This notion seems especially applicable to some young men nowadays who also relate experiences consistent with an acquired and situational form of HSDD.

Intimacy

The meanings of the absence of an intimate relationship are evident in the prostitute–john connection and also in the patient with a severe psychiatric

TABLE 7.3. Etiology of Acquired/Generalized Diminished Sexual Desire

I. Medical disorders
  1. Cardiovascular
  2. Cancers
  3. Epilepsy (especially temporal lobe)
  4. Genetic (especially 47 XXY)
  5. Testicular
    i. Primary hypogonadism (undetermined etiology)
    ii. Mumps
    iii. Trauma
    iiv. Undescended testicles
  6. Secondary hypogonadism (resulting from hypothalamic–pituitary disorders)
    i. Cushing's syndrome
    ii. Diabetes mellitus
  7. Hyperprolactinemia
  8. Multisystem disease
    i. Chronic renal failure
    ii. Chronic liver failure
    iii. AIDS

II. Psychiatric disorders
  1. Major depression
  2. Bipolar disorder
  3. Schizophrenia
  4. Anxiety disorder

III. Medications
  1. Antipsychotics (some via increased PRL)
  2. Antianxiety agents (especially alprazolam)
  3. Antidepressants (all types: tricyclics, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors)
  4. Mood stabilizers (especially lithium)
  5. Drugs used in urological practice (finasteride, flutamide [with or without luteinizing hormone releasing hormone or finasteride]), luteinizing hormone releasing hormone agents, androgen receptor blockers)
  6. Cardiovascular drugs
  7. Cytotoxic drugs (used in cancer chemotherapy)
  8. Anticonvulsants
  9. "Recreational" drugs (alcohol, nicotine, heroin, marijuana)
  10. Drugs used in gastroenterology practice (especially cimetidine)

IV. Gender identity disorder (treated with antiandrogens)

V. Andropause/ADAM/PADAM

illness. But it may also become apparent in more ordinary situations, such as when a man's partner, whom he has always loved and to whom he is devoted, becomes severely and chronically ill (Maurice, 1999). In these circumstances, she ceases to be an equal participant in the relationship and he might feel that he is "taking advantage of" someone in a subsidiary position, as is the case when an adult engages in sexual activity with a child (see the second case history in this chapter, below).

Relationship Discord

In a study that might help clarify the sexual consequences of relationship discord (Beck & Bozman, 1995), twenty-four men and women, all university students, were asked to rate their level of sexual desire in relation to audiotapes describing different sexual events. When subjects were then also presented with a stimulus that provoked anger, the authors found that significantly more men (79%) than women (21%) indicated that they would have continued the sexual encounter.

Is it possible that men are relatively less affected by relationship discord than women in so far as desire is concerned? Clearly, more research is needed in this area.

Major Depression

Diminished sexual desire is often seen as a feature of depression (Kennedy, Dickens, Eisfeld, & Bagby, 1999). Using an elegant and highly original strategy, Schreiner-Engel and Schiavi (1986) looked at the relationship between HSDD and depression. They examined couples where one partner reported generalized HSDD (22 of the men and 24 of the women—all of whom described normal mood at the time of the study) and compared them to a control group. Those with sexual desire difficulties were found to have had a significantly higher *lifetime* rate of affective disorder—almost twice as high as the control group. The authors speculated about possible explanations: that there was a common biological etiology to the two disorders, or that affective psychopathology contributed to the pathogenesis of the desire disorder.

Concurrent Sexual Dysfunction

Schiavi (1999) reviewed 2,500 charts of individuals and couples referred between 1974 and 1991. This survey included 1,775 men, of whom 13.3% (n = 236) were 60 years old or older (range 60–84). Most of the men (66%) were diagnosed with erectile disorder but 28% had HSDD, either alone or associated with another sex-related diagnosis. In some, ED was the cause while in others it was the result. In most "it was not possible to determine the primary dysfunction" (p. 115).

Psychosocial Issues

Examples of what LoPiccolo and Friedman (1988) referred to as "psychosocial issues" affecting desire include: religious orthodoxy, anhedonic or obsessive–compulsive personality traits (accompanied by difficulties displaying emotion as well as discomfort with close body contact), widower's syndrome (found in a man after his partner has died and resulting from at-

tachment to his partner or the unfamiliarity of sexual activity with a new person), lack of attraction to partner, and primary sexual interest in other men.

Hormones

Two hormones influence sexual desire in men: androgens generally—of which the most consequential is T—and PRL. (For an extensive review of T in relation to components and measurement, origin, production and control, actions, effects on sexuality, and changes in effects with age, as well as comments on PRL, dehydroepiandrosterone [DHEA], and its sulfate [DHEAS], see Maurice, 2005.) Although crucial in the display of sexual desire, the role of T and PRL in promoting and sustaining this feeling in the adult man is not entirely clear. Bancroft demonstrated (1989, pp. 92–93) that if T is mostly or entirely removed (i.e., the man becomes hypogonadal—most dramatically illustrated when a man is castrated [90% of T in a man derives from his testes] or with the use of antiandrogen medication), then within 3 to 4 weeks his sexual desire will diminish greatly, sexual activity will take place much less often as a result, and his capacity to ejaculate will likewise disappear. When androgen replacement is given, these phenomena are reversed within 7 to 10 days. As well, the impact of androgen replacement on sexual desire is dose related.

Fantasy- or imagery-associated erections and nocturnal erections are both androgen dependent, and will cease as a result of androgen withdrawal. However, the fact that only certain aspects of erectile function are affected suggests that the impact in this area is indirect, that is, on the man's central nervous system rather than directly on his genitalia. Segraves has suggested that when a man experiences erectile dysfunction in the context of T deprivation, the origin of the difficulty can be described as "performance anxiety" superimposed on a biogenic desire disorder (1988, p. 278).

Segraves and Balon summarize the impact of the therapeutic use of T in "eugonadal" men by saying that "a relatively low level . . . is sufficient to maintain normal sexual activity, and . . . there is no demonstrable relationship between sexual function and variations of testosterone above this threshold value" (2003, p. 215).

Elevated PRL in men (and women) results in diminished sexual desire, as well as the possibility of erection and/or ejaculatory problems in the form of diminished volume. In a very informative study of men presenting to a clinic because of sexual disorders and who were later found to have an elevated level of PRL, Schwartz et al. (1982) concluded that it was generally futile to attempt to separate "psychogenic" and "organic" sexual problems since many of the these men presented with a *situational* pattern that seemed to be exacerbated by psychological factors and that improved

at times of increased arousal. Even more striking (and a sobering lesson to those who are not flexible in their approach to treating sexual problems in men), sex therapy administered before the hyperprolactinemia was discovered actually resulted in improvement!

Most men with HSDD who are apparently otherwise healthy have levels of these two hormones in the normal range and it thus becomes difficult to understand what, if any, role they play in the etiology. To further complicate the issue, when men who have been discovered to be hypogonadal (i.e., to have a lower than normal level of T) are given supplementary amounts as a treatment method, their sexual interest level does not necessarily improve.

Age-Related Hypogonadal Syndrome

"Hypogonadism" refers to the consequences of diminished function of the gonads. It occurs at any age and for a variety of reasons and is classified into two forms based on the source of the problem, that is, either of testicular origin or as a result of disorder in the hypothalamic–pituitary axis.

The term "andropause" indicates a particular type of hypogonadism that is related to aging in men and is described by Wespes and Shulman (2002) as consisting of the following: diminished sexual desire and erectile function, decrease in intellectual activity, fatigue, depression, decrease in lean body mass, skin alterations, decrease in body hair, decrease in bone mineral density resulting in osteoporosis, and increase in visceral fat and obesity. The word "andropause" is an attempt to draw a parallel in men to the experience of menopause in women. While menopause occurs abruptly, andropause is said to occur quite slowly. As well, menopause is associated with the irreversible end of reproductive life whereas in men spermatogenesis and fertility continue into old age. In the opinion of some observers (Kaufman & Vermeulen, 1997), trying to equate the two is rather questionable.

The existence of andropause is a subject of controversy partly because of great difficulty distinguishing this syndrome from age-related confounding variables such as nonendocrine illnesses (both acute and chronic diseases), poor nutrition (inadequate or excessive food intake), smoking, alcohol use, and medications (Wespes & Shulman, 2002; Vermeulen & Kaufman, 2002). Some observers (Morales & Tenover, 2002) have less doubt about the existence of the disorder but prefer to use a different name: ADAM (androgen decline in the aging male) or PADAM (partial ADAM—androgen decline but still within the normal range).

To explain the diminution of sexual desire in andropause/ADAM/PADAM, a great deal of emphasis has been given to changes in laboratory values, especially in T. However, the typical evolution of sexual desire in men as they age has received much less attention.

TREATMENT APPROACHES

General Considerations

The treatment of sexual desire disorders in men follows diagnostic subtyping.

1. If lifelong and generalized, change is highly unlikely and the clinician should direct therapeutic efforts toward helping the person (or the couple) to adapt.
2. If lifelong and situational, a biogenic explanation is unlikely and individual psychotherapy seems reasonable.
3. If acquired and generalized, the clinician must make substantial efforts toward finding the explanation(s) for the change. One might envision how, for example, a lack of sexual desire can cause ED. However, the opposite is not so clear, that is, the extent to which the presence of ED can result in a generalized lack of sexual desire appears to be entirely unknown.
4. If acquired but situational, a biogenic explanation is unlikely (with the possible exception of hyperprolactinemia—see above). In this circumstance, psychotherapy seems indicated but, depending on the apparent etiology, could be provided individually or together with a partner.

Treatment approaches to sexual desire disorders in men involve psychotherapy, drugs, and hormones. Having said that, clinicians should realize that evidence for the efficacy of each of these methods is meager. That being the case, a clinician is obliged to use a combination of treatment techniques, which, in turn, may well include other health professionals with different skills.

Initial Clinical Approach

Unless there are obvious contrary reasons (e.g., two people who intensely dislike each other), initial but nonspecific treatment can focus on exchanges of affection rather than sexual events. This approach has the advantage of relieving the man of pressures that are both internal (guilt) and external (from his partner). Partners are usually quite accepting of this direction since from their point of view, "something is better than nothing."

Psychotherapy

When treating situational HSDD, psychotherapy either alone or together with a partner seems the most reasonable treatment approach. Yet the evidence for the utility of psychotherapy is regrettably sparse. O'Carroll

(1991) surveyed the psychological and medical literature from 1970 to 1989, searching for controlled treatment studies of HSDD. He found eight such reports (two of which involved only men), no controlled studies with a homogeneous sample in which psychotherapy was the mainstay of treatment, and none that included both drug/hormone treatment and psychotherapy.

Nevertheless, the following is a brief review of the existing literature on the efficacy of psychotherapy for HSDD in men. Heiman and her colleagues (1995) considered studies on the treatment of sexual desire disorders in couples. None of the reports involved only men. Of the three studies that included any men , only one incorporated information concerning diagnostic subtyping. The authors concluded that initially there was a lower rate of sexual activity when the man was the "identified patient," that men tended to initiate sexual activity more often, and that men were more likely to have an acquired and situational form of desire difficulty. With a behavioral form of treatment, the authors found that significant treatment gains had been made and maintained at follow-up. In addition, they also claimed that the lifetime/acquired and global/situational distinction "did not predict therapeutic outcome." (Readers should note that this latter statement failed to identify whether it was a man or a woman who was the identified patient, an unfortunate omission since it is conceivable that the distinctions have more meaning for one gender than the other.)

The review by Heiman and her colleagues described another study (De Amicis, Goldberg, LoPiccolo, Friedman, & Davies, 1985) involving a 3-year follow-up of 38 couples treated for sexual dysfunction (SD). The group included six men identified as having HSDD with or without another SD diagnosis. The authors pessimistically concluded: "the diagnostically relevant items [that were measured], that is, desire for sexual contact and frequency of sexual contact, clearly demonstrate a lack of sustained success for both men and women" (p. 480).

O'Donohue and his colleagues (1999) surveyed the sex-related literature on the psychological treatment of male sexual SD. They explicitly excluded studies that relied only on medical intervention. The authors concluded that *"no controlled treatment-outcome studies were found for the treatment of . . . hypoactive sexual desire disorder . . . in men"* (p. 611; emphasis added).

Drugs

O'Carroll's review found only one study (Crenshaw, 1987) in which a drug was used therapeutically by itself for patients with HSDD (only some of whom were men). The investigation concerned the use of bupropion in a nondepressed population. The study subjects involved 60 patients of which half were men. All of the patients had low desire and 14 out of 25 men had

another SD diagnosis as well. Significantly more (63%) of the bupropion-treated group reported being much or very much improved (vs. 3% of the placebo group), but changes in the *frequency* of sexual behavior were "much less dramatic and consisted largely of trends." Unfortunately, study results were not reported separately for men and women (an exception being the statement that "more men (86%) than women (44%) showed . . . improvement" with the drug).

Testosterone

Only one study (O'Carroll & Bancroft, 1984) reported on the therapeutic use of a hormone alone. This investigation involved a double-blind crossover comparison of T and placebo in a group of men with normal circulating T levels. Ten men complained principally of loss of sexual interest and 10 of ED. The authors found a significant increase in sexual interest produced by T in the first group but qualified this by saying that in only 3 out of 10 subjects was it considered to be an "adequate form of treatment," and that in the others, "the changes were either small or did not generalize to the sexual relationship." O'Carroll concluded his review by saying that T "may have a modest role to play in the treatment of some men who present with low sexual interest." However, he also cautioned that this study involved a group of only 10 men.

Treatment of Age-Related Hypogonadal Syndrome: Andropause/ADAM/PADAM

Not only has the validity of an age-related hypogonadal syndrome in men provoked controversy, but it has also raised the issue of whether it should be treated with T. In 2002, the National Institute on Aging and the National Cancer Institute asked the Institute of Medicine (IOM) to conduct an independent assessment of the potential benefits and adverse health effects of therapy with T in older men and to offer recommendations. The result was the report titled *Testosterone and Aging* (2004).

Treatment with T is approved for the care of *clearly established* male hypogonadism at any age. However, there have been few studies (especially randomized, double-blind, and placebo-controlled) on the use of T in healthy middle aged or older men who may have a T level in the low range of a young adult but may also have one or more symptoms that are common both to hypogonadism and aging (diminished sexual desire being one example). The IOM report summarized its review of studies on the use of T in older men by cautioning that while it found 31 placebo-controlled trials, the largest sample size involved 108 subjects, the duration of treatment in 25 of the trials was 6 months or less, and only one lasted more than 1 year. The report concluded that "assessments of risks and benefits have

been limited, and uncertainties remain about the value of this therapy for older men" (pp. 1–2).

One can do little better than quote a general conclusion from the IOM report:

> Experience with the use of postmenopausal hormone therapy in women and the growing body of scientific evidence about its risks and potential benefits provides an apt and timely example of the need for sustained analysis of short- and long-term effects of new treatments and the caution that must be exercised in widely prescribing drugs as preventive measures. (p. 163)

Treatment of Drug-Induced Diminished Desire

The medical treatment of drug-induced hyperprolactinemia is beyond the scope of this chapter. Strategies for treating antidepressant-induced diminished sexual desire are reviewed by Ashton in Chapter 17, this volume.

CASE ILLUSTRATIONS: THREE OF THE MANY FACES OF SEXUAL DESIRE DIFFICULTIES IN MEN

Case 1: Lifelong/Generalized HSDD

Nick was a 39-year-old financially successful geologist who had been married to Susan, age 33 and a nurse, for 9 years. In the context of a routine pelvic exam with their family doctor several years prior, she described her husband's long-standing sexual disinterest and said that she wanted to have children but was confused about what to do with her life since she thought that the likelihood of this happening with Nick was minimal. After he underwent a thorough physical examination and routine laboratory testing (none of which indicated any abnormality), the couple was referred to a psychiatrist. However, Nick refused to continue after the first visit, saying that he did not see this as useful. On many subsequent occasions, she offered to find another therapist that they could see together, but he continually balked. One month ago, and following a categorical declaration that she was leaving him, Nick changed his mind and agreed to see a sex therapist.

When Nick and Susan were seen together, Susan was quickly in tears as she related that they had not had any sexual activity in over 1 year. In talking about their past, she went on to explain that one of the things that she most liked about Nick when they first met was that he would not "pounce" on her like so many of the other men she had previously dated. When sexual encounters did occur, she would, in retrospect, usually have been the one to take the initiative (which did not concern her at the time since sexual events took place at a frequency that was ostensibly sufficient

for her). Neither had any difficulties with sexual function at that time. Sexual refusals on Nick's part began shortly before their marriage, but she attributed this to premarital jitters. In the following year or two, she found herself issuing fewer invitations since these were usually rejected. The level of physical affection between the two was never high but had diminished to the point where nowadays, they would rarely touch one another. They slept in the same bed but typically went to bed at different times and both regularly wore bedclothes. She began wondering if he still found her attractive, if he had found another woman, or if he was sexually interested in men rather than women. He assured her that none of these explanations was correct.

When he was seen alone, he explained that what Susan had described was indeed accurate. His sexual interest level was at best negligible and often nonexistent. Nowadays, he would think little about sexual matters at any time (home or work) and would masturbate about once each month. Even as a teenager, Nick found himself thinking much less about sexual matters than his friends.

Nick described himself as a restrained person and not anywhere near as outgoing and "tough" as Susan. He further contrasted himself to his wife in saying that he did not particularly like touching and definitely did not like to talk to her or anyone else about sexual problems.

He had been married once before for three years and then worked for three more on a mining operation in South America before meeting Susan. He said his first wife was very aggressive, that he was not particularly interested in sexual matters then either, and that intercourse was uncommon. In the three years of working for the mining company, sexual activity was infrequent in that intercourse took place on altogether three occasions with prostitutes (he had no sexual interest in men and had never thought about or engaged in atypical sexual activities), and, as now, he masturbated about once each month. Partner erections were generally problematic but varied in fullness depending on his interest level. Erections with masturbation were never a problem and neither was his ejaculation when alone. His ejaculation was variable when with a partner.

Nick's past history revealed that he was the eldest of three boys and his father was described as both alcoholic and often absent. His parents separated when he was about 7 years old. He saw little of his father afterward and remained very attached to his mother, who was described as caring and very religious. Nick's education was at a private (Roman Catholic) school for both his primary and secondary schooling. He recalled being sexually approached once at the age of 5 by an uncle but experienced no other sexual events in his childhood. He did not date until he was in college and, even then, described no long-term relationships before he married. He wondered about his ability to commit to such a relationship.

When seen alone, Susan talked of her love for Nick but also her re-

sentment (especially toward his mother, who she thought played a major role in his difficulties), her anger, and the anticipation that "things were not going to get better." From time to time, she thought about having an affair and indeed had some clear invitations, which she rejected. She was concerned about the "biological clock ticking" and "missing out" but was also explicit about her enjoyment of the life they had built together and was unsure if she really wanted to "give it up" by divorcing him and "starting all over again."

Nick and Susan were seen together in a treatment program that was intended to be directed at both their sexual experiences as a couple and also their marriage. Initially, the "sexual" focus was on diminishing her expectations of him by concentrating on the issue of touch, a matter that she had not fully realized was so problematic for him. This focus was accomplished by using the approach of encouraging them to hold hands and engage in other touching that was comfortable to both, and for the moment, not even thinking about engaging in sexual activity. He welcomed the idea, as did she. Susan was reassured that the sexual restraints would not be forever.

In the subsequent visit, it became clear that little touching had occurred in the interim. The reasons seemed to include primarily Nick's lack of motivation and apparent passivity as well as Susan's continued sniping. These observations allowed for discussion and apparent acceptance of the idea of not initially concentrating on sexual matters but rather a temporary redirection to dyadic issues, which, in fact, continued over the next two visits. (Nick was not thought to be accepting at this time of an examination of family-of-origin issues.)

Susan phoned to cancel the third scheduled visit the day before it was to occur and explained that her husband did not want to continue. Moreover, she felt that it would not be productive for her to carry on in his absence.

Comment

Given that Nick was a reluctant participant in this venture (his wife made the appointment and he came in only after she threatened to leave), a major issue was his substantial limitation in the areas of both psychological and physical intimacy. His lifetime lack of sexual desire was one issue, but he also had an intimacy problem that manifested in many ways, including sexually. The therapeutic target was for the couple to adapt more successfully to what seemed to be minimally changeable, namely, Nick's level of sexual interest. Adaptation would have meant sexual experiences that were at a frequency somewhere between what the two of them would have liked. (She would have liked a chance to become pregnant, an unappreciated aspect of this disorder.) That being said, and given his reticence

around the area of touch and talk, it seemed reasonable to begin treatment with a focus on these two issues and to delay attention to sexual matters. The intent was to decrease the level of conflict in their relationship, which, in turn, might provide an environment in which touching would become at least tolerable but hopefully enjoyable and that sexual events might take place if even at a low frequency. As much as the issue of his family of origin and, in particular, attachment to his mother seemed crucial, the beginning of this treatment process did not seem to be a propitious time for its consideration. This subject would have become more central as Nick became more trusting. However, even the initial focus on their marriage proved too much for Nick and he withdrew.

Case 2: Acquired/Situational HSDD

Richard, age 33, and Kate, age 27, had been married for 3 years and did not have children although this was in their future plans. During their courtship and in the first year of their marriage, sexual activity took place at least several times each week (minus intercourse before they were married due to their shared religious principles about premarital sex). Richard said that at the beginning of their relationship, "we couldn't take our hands off each other." In her teens, Kate had an episode of depression but had been psychiatrically well since then. About 1 year after marrying, she developed typical symptoms of hypomania and, after several months, became clearly manic. During that time, she became sexually indiscriminate, resulting in brief sexual liaisons with three other men apart from her husband. She was eventually hospitalized, diagnosed as having bipolar disorder, and treated with medications. She was discharged after 3 weeks.

Unfortunately she then fell into a period of depression for the subsequent 3 months. Kate's level of sexual desire increased during the time before her hospitalization, but when Richard came to realize that a part of her sexual interest related to her illness, his own level of sexual desire for her started to decrease as did their sexual activity as a couple. Nevertheless, he continued to have sexual thoughts and found himself masturbating at a level that was similar to that before marriage. When the two were seen some months later, and as she was emerging from her posthospitalization episode of depression, Richard plainly professed his continuing love for her but at the same time said (when seen alone) that his sense of sexual desire toward her was much less compared to the past. As she became less depressed she began to miss their sexual times together. He managed to finesse her interest and was unwilling to tell her that he was still frequently thinking about sexual matters and masturbating several times each week.

Weekly visits alternated between Richard being seen alone and the two of them together. She clearly understood and accepted that certain issues would be discussed individually with Richard and would not, at least

for the moment (and perhaps even later), be introduced in their conjoint visits. In the individual sessions, it became abundantly clear that Kate was a much more expressive person than Richard and that these personality facets derived from cultural and family-of-origin issues. Kate was the third of three children raised in an Italian family in which there was little restraint in talking of emotional matters. Richard, on the other hand, grew up as an only child in an English family in which talking about problems of any kind was discouraged.

An attempt was made to weave sexual and nonsexual issues into their conjoint sessions. Not only had sexual experiences ceased with her illness, but the couple became much less affectionate with each other. They were initially encouraged to resume touching in ways that they had once found enjoyable and natural (e.g., holding hands and hugging). At the same time, they were told that no matter how sexually aroused either one felt, this "exercise" should not go beyond exchanges of affection. The next time they were seen, they were both appreciative and Richard, in particular, said that he felt a sense of relief at having been told that they should just be affectionate (which they both wanted) without having to engage in sexual activity (which he wanted to avoid).

When he was seen alone we explored his earlier statement that "she was not the same person I married." He felt that his religious beliefs did not allow him to consider separation and divorce and the subject did not even arise. He previously had looked forward to having children but now worried about her capacity to be a caring and consistent mother. He felt guilty about having sexual thoughts about past girlfriends.

The sexual part of their treatment began slowly over several months with touching "exercises," initially with clothes on and then, in stages, with clothes off. Richard's thoughts during these sexual times together were used as "grist for the mill" when he was seen alone. A central concern seemed to be a sense of guilt that when Kate was hypomanic, he had "taken advantage" of her in a sexual sense since he now saw her sexual desire at that time to be a product of illness rather than a spontaneous feeling as in the past. He likened the sexual situation to experiencing sexual activity with a child, a thought that he abhorred. He was still not confident that she was well since she was continuing to require medications. His feelings about her sexual behavior with other men when ill were mixed. On the one hand, he recognized this as an aspect of her illness (she was now feeling very guilty about this issue); on the other, he was clearly angry and felt she violated a covenant between the two of them.

When seen together, it was evident that they cared a great deal about each other and continued to be affectionate. Richard was able to voice his concerns about Kate's psychiatric status and the effect this had on him sexually as well as his worries about her as a future mother. He revealed to her the fact that his mind was still sexually active and even the fact that he

masturbated from time to time (although he was not completely candid about the frequency). She found that information to be reassuring in that it told her that he was still quite sexually alive. She worried about whether he still loved her or if he had found another woman (the thought was unacceptable to him), or indeed, was interested in another man (he never had sexual thoughts about other men in his whole life). She tried to set his mind at rest about her psychiatric status and ability to function as a mother, and while his attitude became more positive in an intellectual sense, and in spite of her encouragement, their sexual times together were few and his feeling of sexual desire toward her continued to be muted.

When seen 1 year later, she was doing well psychiatrically (although still taking small amounts of medication), and the same was true of their relationship as a couple. Sexual activity had increased somewhat but Richard's desire for Kate was still far from what it had been in the past. They described having trouble conceiving a child and attributed this to the fact that intercourse was occurring so infrequently. They were seen again 1 year later and were distressed because conception still had not taken place despite any identified problems. They discussed the idea of artificial insemination using Richard's sperm and were referred to an expert in this area. They successfully conceived and, when seen 1½ years later, had a healthy child with them. The frequency of their sexual experiences had not changed, but they appeared to be a very contented twosome.

Comment

Many men who appear to be sexually disinterested are anything but when seen alone. Such was the case with Richard. He was candid with Kate about his need to masturbate, and while she was not pleased to hear this, saw this in a positive light insofar as his sexual desire was concerned as well as being reassured that he had not become attached to someone else. With evidence of sexual desire in at least one form, there is little need to engage in an elaborate and expensive physical and laboratory examination.

Richard's sexual enthusiasm for Kate diminished when she became ill, a transformation that is often seen by those who care for the disabled (physically or mentally) even in the context of protestations of continuing love. In this instance, Kate's psychiatric status had improved substantially and yet Richard's sexual distance remained. His guilt, excessive worries about Kate's mothering ability, family-of-origin issues, and expressive style were major contributions to Richard's lack of sexual desire for Kate. A fairly conventional sex therapy approach when the couple was seen together resulted in some changes in their sexual activity, but there was only a very modest increase in Richard's level of sexual desire (his passion had seemingly disappeared)—apparently not enough for Kate to become pregnant and hence the referral for insemination.

Case 3: Acquired/Generalized HSDD

Harold was a 55-year-old corporate executive who had been married to Charlene, age 52, a paralegal, for 27 years. He was referred to a sex therapist on his own by his family doctor because of a problem with his "libido." The therapist initially chose to see Harold and his wife together as a couple. With in-depth questioning, their main concerns turned out to be different than what had been stated by the referring doctor. While they both talked of having of a "libido problem," the meaning of this phrase for him was related to his erection difficulties, while the diminution of his sexual desire was of greater consequence to her. In the distant past, Harold had experienced transient erectile troubles the first few times they tried to have intercourse and on a few subsequent occasions over the years (usually when he was very tired or preoccupied with work troubles). He never had any difficulty with sleep-related or masturbation erections or with ejaculation.

When Harold was seen alone, he reported that over the past 5 years, he noticed that his erections were less firm (6 out of 10 on a scale of 0–10 where 0 was flaccid and 10 was fully erect) and that he had become much less sexually interested. He rarely had sexual thoughts or fantasies (unusual for him) and was not particularly interested in looking at other women. His morning erections were relatively unchanged. Vaginal entry was frequently problematic and because of a feeling of failure, coital attempts had just about ceased. The last time Harold recalled having a full erection under any circumstance was about 5 years ago. Apart from sexual issues, he confessed to being a worrier and having felt discouraged at work over someone else leapfrogging over him for a senior executive position.

Harold's medical status was such that high blood pressure (BP) and elevated cholesterol were discovered 3 years ago, and he was referred for consultation to an internal medicine specialist. Physical examination revealed him to be overweight but, apart from this and his high BP, was otherwise unremarkable. Charlene was apprehensive about his health, particularly since her own father died of a heart attack at the age of 57. This issue had become a source of tension between the two.

With appropriate permission in hand, the sex therapist phoned the family doctor, discussed the sexual concerns, and requested copies of the consultation report and recent lab information. Testosterone and prolactin had not been included in the blood testing, and after an explanation of the rationale with the referring doctor, these were tested and both found to be within normal limits.

Harold was put on a diet and given medications to lower his BP and his cholesterol. Sexual issues were not discussed at the appointments with either the specialist or his family doctor. Harold's reluctance to raise this subject changed when he began to suspect that the medications he was tak-

ing resulted in even more sexual troubles. He was quite sure that his erection difficulties preceded the decrease in desire but the sequence of events became quite cloudy with extensive questioning. His family doctor advised him to try using sildenafil (Viagra). He tried using it once but it "didn't work." On detailed questioning, he related that he had been given a sample box of four pills of 50 mg each, used one pill on one occasion, and described "minimal" change from what he was otherwise experiencing. At the present time, he talked about his concerns with cardiac side effects, an issue that had not previously been discussed and about which he was seemingly reassured. He was referred to a urologist who specialized in male sexual problems, and was advised to try sildenafil again but to increase the dose to 100 mg, to make sure that it was taken on an empty stomach, and to use it when alone on the first occasion. At the same time, he and Charlene continued to see the sex therapist, using a sensate focus program while simultaneously addressing her concerns about his health. Both were pleased about the idea of separate sessions for Harold where his work-related worries and mood could be addressed.

When they were seen again 2 weeks later, he reported that his erections with Charlene had improved to a level of 7–8 out of 10 and that, in spite of instruction to the contrary, they had attempted intercourse on two occasions. Vaginal entry was possible both times and while he did not ejaculate the first time, he did on the second. Charlene was quite pleased by the outcome of the treatment. In subsequent weeks and months, Harold was surprised to find himself thinking more about sexual matters, and he also found himself noticing and fantasizing about some of the women in the office where he worked.

Six months later he reported that he continued to use sildenafil, that his erections had not changed from his previous report, that he and Charlene continued to have intercourse about once every few weeks, and that his feeling of sexual desire was considerably greater than when they were first seen, but less than he recalled 5 years ago.

Comment

The connection between desire difficulties in men and erection problems is often uncertain. Clearly, the vector could go both ways. That is, a man with HSDD could experience ED as a result; likewise, a man with ED might well become less sexually interested. When faced with the conundrum of which is primary, one sensible approach would be to treat the man as if the central issue was ED since the care of someone with this disorder is often more successful, less complex, and less expensive than treating HSDD. Such was the case with Harold and Charlene.

While strongly suspecting that Harold's desire difficulties resulted from his concern about erectile function, one could not ignore the possible

contribution of conflicts with Charlene over his health as well as Harold's relatively recent tendency to fret over work and life accomplishments. He did not have all or even most of the components associated with a depressive disorder, but he was clearly glum. In an attempt to discuss these issues, it seemed reasonable to see Harold alone in individual psychotherapy. This facet of treatment proved to be a useful adjunct to the conjoint sex therapy.

SUMMARY AND CONCLUSIONS

Sexual desire disorders in men do not represent a single entity; they constitute the "final common pathway" of different disorders, the origins of which cover the spectrum from the psychological to the biological to the social, with many instances probably including pieces of two or three. In other words, the lack or loss of sexual desire in men is not a disease; it is akin to headache, nausea, anemia, and fatigue, none of which are diseases but rather symptoms of a health disorder that can have many different roots.

The man who could not care less about anything sexual and sees its importance as being greatly overrated is in a totally different category from the man who may be totally engrossed in the subject, but only when looking at a computer screen showing fetching women in various states of undress doing all sorts of sexual things that he finds exhilarating. These men are on the one hand joined by having an apparent disinterest in sex as far as the outside world is concerned but, on the other hand, are differentiated by having inner lives that are polar opposites.

The cost of HSDD in men can hardly be exaggerated. Sex in all its forms is so vital to men and their sense of masculinity that the loss can be overwhelming. In contrast, the man who has never thought much about the subject does not have too much to miss. He may feel differently from other men and, as a result, less adequate, and mystified about the importance others place on sex. More demoralized is his wife (in the case of a married heterosexual couple), who not only does not experience touch (that most fundamental aspect of human connections), but may well have anticipated a reproductive part to her life only to see this slip away in the incomprehensible fog of her husband's sexual inattention.

The lessons in the heterogeneity of sexual desire concerns involving men are at least fourfold: (1) that one must ask more than one question in the face of that difficulty, (2) that the clinician must search in many different corners to find an explanation, (3) that the treatment of this problem may well mean integrating several different approaches simultaneously, and (4) that the researcher must make an attempt to split the group into various subgroups and not simply lump all men with this concern together.

Even when the clinician digs deep in an attempt to understand why a man, in contrast to many of his peers, is not sexually eager, and even when

an explanation becomes apparent, it is so very difficult to alter the quantity of a man's sexual interest. There is precious little clinical research in this area to guide clinicians, so that as far as treatment is concerned one must apply the skills that one knows best, consult with other sexuality specialists, and use the wisdom and experience of other health professionals who are not necessarily expert in the this area. (To put this in different words and to borrow from the venerable cartoonist Al Capp, when it comes to sexual desire in men, clinicians do not have any Kickapoo Joy Juice.) Even then, when it comes to sexual desire concerns affecting men, the clinician must be careful to restrain expectations. Many in the population (including other health professionals) have yet to learn that the ability of sex therapists to deliver positive results is greater in some areas than others. Most of all, sex therapists must have humility in accepting their own therapeutic limitations. The care of some men with sexual desire difficulties can be a great test of this ability.

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CHAPTER 8

Treatment of Rapid Ejaculation

Psychotherapy, Pharmacotherapy, and Combined Therapy

STANLEY E. ALTHOF

On the face of it, rapid ejaculation would not appear to be a very distressing problem since it does not preclude sexual exchange or orgasmic release. Yet, it is one of the most prevalent complaints of men and (occasionally) of their partners. Although there are many behavioral interventions for delaying ejaculation, pharmacological treatments have become increasingly popular over the last decade. Nevertheless, as Althof points out in this chapter, sex therapy remains as viable and important as ever.

There remain a host of unanswered questions concerning rapid or premature ejaculation. Foremost among them is the question of how to define the problem. Should one count minutes of intravaginal thrusting, voluntary control of ejaculation, or the experience of personal distress about the condition? When does rapid ejaculation become a variant of erectile dysfunction? Who decides whether or not it is a genuine dysfunction? The man? His partner? The physician or therapist?

Similarly, there are many questions concerning etiology. Is rapid ejaculation a function of a man's biology or constitution, or is it a reflection of psychological issues or learned conditioned responses? To what extent is anxiety a major factor in either the development or maintenance of the problem?

Treatment can be challenging since most men do not feel comfortable discussing sexual matters generally or revealing sexual "secrets." Assessment of the man's relationship and personal history as well as the precipitating, maintaining, and contextual factors contributing to rapid ejaculation is helpful if the goal of treatment is not simply

ejaculatory control but rather sexual enhancement and the restoration of sexual confidence.

Althof offers cogent suggestions as to when to consider individual therapy, conjoint therapy, or pharmacotherapy alone in treating rapid ejaculation. He believes that overall, combined therapy "offers the best of all worlds" since pharmacotherapy can result in better ejaculatory control and confidence more quickly, while conjoint counseling can help reduce or eliminate the psychosocial obstacles that interfere with successfully delaying ejaculation.

Finally, Althof reminds the reader that despite one's best intentions and efforts, not every man who presents for treatment will be dramatically helped. Sometimes, referral to a different therapist or a different treatment modality may be sensible and sometimes neither psychotherapy alone, pharmacotherapy alone, or combined treatment is sufficient to overcome years of destructive interactions or the limited psychological resources of the man and his partner.

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Consider these questions:

- How serious is the problem of rapid ejaculation, really? No one dies from it; intercourse remains possible, as does a broad range of non-intercourse-focused sexual behaviors that bring pleasure and satisfaction to the man and his partner.
- Are complaints of rapid ejaculation simply signs of men and their partners searching for boundless intercourse or aspiring to some media-driven or cultural expectation? Who determines what "rapid" really means?
- Is rapid ejaculation a disease, a lifestyle condition, or a sexual dysfunction? Alternatively, might it simply be one end of a normal bell-shaped curve, like being short or overweight? What is the true prevalence of the disorder and what explains its pathophysiology and etiology?
- Why bother to treat the problem? Is it really distressing or bothersome to the man and his partner? Has the pharmaceutical industry created this condition because they will profit from offering men and couples the opportunity for extended-duration intercourse? Can psychological interventions be of demonstrable help over the long term?

This chapter addresses these controversial issues concerning definition, prevalence, etiology, the psychosocial impact of rapid ejaculation on the

man and his partner, and its treatment. Case vignettes portray the struggles of men and couples and their therapists as they seek solutions for this troubling dysfunction. Three distinct forms of intervention are examined: traditional psychotherapy alone, pharmacotherapy alone, and combined psychological and medical intervention.

The landscape has dramatically changed for patients seeking treatment for rapid ejaculation. Prior to the mid-1990s, psychotherapy or behavioral treatment was considered to be the treatment of choice for this troubling sexual dysfunction. By 1995, clinicians began successfully experimenting with the off-label administration of selective serotonin reuptake inhibitors (SSRIs) to delay ejaculatory latency (Waldinger, Zwinderman, Schweitzer, & Oliver, 2004). Recently, Dapoxetine, a novel, short-acting SSRI developed for the treatment of rapid ejaculation was reviewed by the U.S. Food and Drug Administration and failed to be approved. It is, however, seeking approval in Europe.

If new compounds do become available, clinicians in places where they have been approved will have medications for the treatment of premature ejaculation that are simple, safe, and efficacious. Some may then perceive psychotherapy/behavior therapy for rapid ejaculation as an obsolete and antiquated intervention. On the contrary, psychotherapy and alternative forms of psychological intervention will be more relevant than ever.

These days delaying men's ejaculatory latency is relatively straightforward, however, restoring men's sexual confidence and reversing the impact on the relationship is more complicated (Althof, 2005). One of the lessons learned from the "Viagra revolution" for the treatment of erectile dysfunction was that no matter how efficacious and safe the medical intervention, by itself, medications could not, in many men and couples, surmount the psychosocial obstacles that maintained the dysfunction and interfered with sexual life (Althof, 2002).

Psychotherapy remains useful either in its traditional form as the sole intervention for men or couples with rapid ejaculation or, in an updated rendering, where it is an integral aspect of a combined or integrated biopsychosocial intervention (Althof, 2003, 2005).

WHAT'S IN A NAME?: DEFINING PREMATURE EJACULATION

Premature ejaculation (PE), to use the generally accepted diagnostic label for this disorder, has been known by other names, including ejaculation praecox, and early, rapid, or uncontrolled ejaculation. In this chapter the terms "rapid ejaculation" and "premature ejaculation" are used interchangeably. Not only are the names confusing, but accurate and scientific diagnostic criterion sets are illusive. At present, three professional organizations—the American Psychiatric Association (DSM-IV-TR), World Health Organiza-

tion (ICD-10), and American Urological Association (AUA Guidelines on the Pharmacologic Management of Premature Ejaculation)—have published diagnostic criterion sets defining PE (American Psychiatric Association, 2000; World Health Organization, 1994; Montague et al., 2004). While there is some overlap between the three criterion sets, unfortunately there are also substantial differences.

The common denominators observed in all three sets are (1) ejaculatory latency, (2) voluntary control, and (3) presence of marked distress or interpersonal disturbance. According to ICD-10, ejaculation must occur "within 15 seconds of the beginning of intercourse." Both DSM-IV-TR and the AUA Guidelines are equivocal on duration. DSM-IV-TR states, "ejaculation occurs with minimal sexual stimulation before, on, or shortly after penetration" while the AUA Guidelines indicate that ejaculation occurs "sooner than desired either before or shortly after penetration." ICD-10 makes no mention of voluntary control, while DSM-IV-TR notes that ejaculation occurs "before the person wishes." All three criterion sets require the man to be distressed (ICD-10 offers a time frame of 6 months; no specific time frame is defined in either DSM-IV-TR or the AUA Guidelines). Finally, both ICD-10 and DSM-IV-TR require the clinician to make a judgment regarding the independence of this condition from other mental, behavioral, or physiological disorders.

Because the readers of this chapter are likely to be mental health professionals, the DSM-IV-TR criteria are presented below and reviewed in detail. Premature ejaculation (PE) is defined as:

- Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.
- The disturbance causes marked distress or interpersonal difficulty.
- The premature ejaculation is not due exclusively to the direct effects of a substance.

Specifiers:

- Lifelong versus acquired.
- Generalized versus specific.
- Due to psychological or combined psychological and biological factors.

After determining that the patient meets the diagnostic criteria for PE, the clinician is required to make three additional judgments: whether the dysfunction is lifelong or acquired, whether it is of a generalized or specific type, and whether it is due to psychological or combined biological and psychological factors. Lifelong PE, as the specifier suggests, characterizes a

man who has always struggled with the dysfunction, while acquired refers to an individual who previously had the ability to control ejaculation but who later developed the dysfunction. Approximately two-thirds of men have the lifelong form while one-third have the acquired type. The distinction between the lifelong and acquired forms may ultimately prove to be the most helpful in clarifying the etiology of the dysfunction. It may turn out that a subgroup of lifelong rapid ejaculators have a biological vulnerability, but not those with acquired symptoms (Cooper, Cernoskey, & Colussi, 1993; Gospodinoff, 1989).

Reporting on differences between primary and secondary premature ejaculators, Cooper et al. (1993) found that men with secondary premature ejaculation tended to be older with decreased libidos, coexisting erectile insufficiency, decreased erotic arousal, decreased penile sensitivity, and reduced frequency of erotic outlets. Men with primary premature ejaculation were a more homogenous group than men with secondary premature ejaculation and demonstrated more anxiety and emotional disturbance on psychometric testing than either controls or men with secondary ejaculation.

The lifelong versus acquired specifier may also turn out to be a predictor of who will benefit from pharmacological treatment over the long term. One study by McMahon (2002) demonstrates that after 12 months of SSRI treatment, men with lifelong PE no longer respond as well to treatment compared to men with the acquired form of the dysfunction.

> Jim, a 58-year-old businessman in his second marriage, typifies men with lifelong rapid ejaculation. He described never being able to last more than 15 seconds with any sexual partner. He had tried masturbating prior to lovemaking and tried to distract himself with nonsexual thoughts. He had read books about premature ejaculation and diligently practiced the exercises to no avail. This "disability" was a great source of shame for him, and he felt it had greatly interfered in his relationships prior to marriage and in both of his marriages. His wife, Claire, was supportive and praised Jim for going "all out to please her after his orgasm." They appeared to have a good relationship and neither partner had significant psychological problems. They had come for consultation after reading that SSRIs were helpful to men with rapid ejaculation. He seemed like an ideal candidate for pharmacotherapy and did well with it.

Acquired PE calls upon the clinician to explore the forces that generated the new symptom, which may reflect recent psychosocial stressors or be a consequence of an illness, medication, or surgery. For instance, acquired rapid ejaculation may be a consequence of erectile failure. Men develop performance anxiety regarding their erectile reliability and hurry intercourse, thinking that they have limited time to "complete the act."

With this mindset, an additional dysfunction appears and men become even more anxious about sexual interactions.

"Generalized" refers to a man who manifests the conditions with all partners versus the specific type, where the man has a variable pattern of normal ejaculation with some partners and rapid ejaculation with others. Such a pattern would strongly suggest that psychological factors are responsible for the rapid ejaculation.

> John, a 6′2″ well-muscled, 30-year-old, never-married police officer sought consultation because he had developed rapid ejaculation with his new partner of 6 weeks. John prided himself on his masculinity and said he could not understand why this was happening to him now.
>
> There was a bragging quality to John as he detailed his sexual history. He had slept with many women and had never suffered from rapid ejaculation. Most of his prior relationships were of relatively brief duration. John enjoyed being single and sleeping around.
>
> The essential question in my mind was what was different now. With some embarrassment John revealed that he was intimidated by Kim. She was a beautiful, successful woman, the CEO for a small corporation, and he felt "dominated" by her. I asked if he had ever been in a relationship with any other woman where he felt dominated. At first he said no, then he laughed and recalled that many years ago there was such a woman and yes, he also suffered from rapid ejaculation with her. We immediately knew which issue to focus on.

The last specifier attempts to define the etiology as totally psychological or a combination of mixed psychological and biological factors. In practice this is difficult to determine as the etiology of rapid ejaculation remains incompletely understood.

Problems with the DSM-IV-TR, AUA, and ICD-10 Criterion Sets

There are serious problems with all three diagnostic criterion sets. None of them guide clinicians to objectively diagnose the dysfunction. All the definitions suffer from excessive vagueness and subjectivity (e.g., "shortly after penetration"?), in part, because no large-scale normative studies concerning ejaculatory latency, control, and distress were available to the authors of the criterion sets. In fact, in the last edition of *Principles and Practice of Sex Therapy*, Derek Polonsky (2000) quipped that the subjectivity of the definitions reminded him of Justice Potter Stewart's definition of pornography: "I know it when I see it."

The lack of acceptable diagnostic criteria plagues researchers as well as clinicians. This lack of precision results in published studies including subjects with markedly different intravaginal ejaculatory latency times (IELTs) as the group they define as having rapid ejaculation. Specifically,

subjects with IELTs between 1 and 7 minutes make up the premature ejaculation groups in various published studies. Ironically, PE subjects in one study (those with a 7-minute IELT) could serve as controls (non-PE subjects) in studies that employed a 1- or 2-minute inclusion criterion (Grenier & Byers, 1995; Rowland, Strassberg, deGouveia Brazao, & Slob, 2001)! Standardized, more objective criterion sets would obviate this problem. Even with objective data, every now and then we see the following type of case:

> Frank, a 35-year-old, single factory worker came in asking for a drug to prolong his ejaculatory latency. His girlfriend was complaining that he ejaculated too quickly and that she was unable to reach orgasm. Upon inquiry Frank stated that his IELT was 20 minutes. I was astounded that he believed he had rapid ejaculation. He was obviously distressed and hurt by his girlfriend's comments and very much wanted to please her.
>
> I asked how long he thought the average man lasted during intercourse. Forty minutes, he responded. He said the guys at work talked about intercourse that lasted between 30 and 60 minutes. He had difficulty believing me when I told him that the average man lasted between 5 and 10 minutes. He was not relieved to hear me say that he did not have rapid ejaculation. He still wanted to know how he could prolong his ejaculation and was upset that we were not willing to give him medication.
>
> I urged him to consider coming to see me with his girlfriend but was not surprised that he did not follow through.

This vignette raises the not infrequently seen dynamic of women who blame men for their struggles with orgasm. They label them as rapid ejaculators and thus disguise their own dysfunction. On the other hand, Frank's girlfriend may have held false beliefs about how easily and regularly women achieve orgasm with intercourse. She may not have known that only one-third of women regularly achieve orgasm, and with intercourse that is not generally as prolonged as what she had with Frank.

Recent Perspectives on Defining PE

Objective data concerning IELT, voluntary control over ejaculation, sexual satisfaction, and distress have only recently become available. Patrick et al. (2005) studied 1,587 subjects who were screened by experienced clinicians into two groups: subjects with and without PE according to DSM-IV-TR criteria. These men and their partners were given stopwatches and sexual logs and instructed to record their IELTs over a period of 4 weeks. The

men and their partners also independently completed single-item patient-reported outcome measures on voluntary control, sexual satisfaction, and distress.

Median IELT was 1.8 minutes for the PE group and 7.3 minutes for non-PE subjects. However there was considerable overlap between the two groups in the intervals between 2 to 4 minutes, suggesting that time alone may not be the best criterion for diagnosing PE. Interestingly, the item regarding voluntary control of ejaculation proved to be even a better predictor of PE/non-PE status than IELT. The men with PE manifested greater distress and less sexual satisfaction than men without PE.

The results of this study suggest that time alone should not define PE; rather the diagnosis should be multidimensional. Information about voluntary control, sexual satisfaction, and distress was an important discriminator between the two groups. While 95% of the non-PE subjects had IELT times that exceeded the median time of 1.88 minutes, only 50% of the PE subjects met this threshold.

PREVALENCE

Most articles on rapid ejaculation begin by asserting that it is the most common male sexual dysfunction, affecting approximately one in three men. Several recent cross-sectional, international, epidemiological studies support the 20–30% prevalence figure for this disorder (Jannini & Lenzi, 2005; Laumann et al., 2005; Rosen, Porst, & Montorsi, 2004; Montorsi, 2005).

All these studies, however, have employed patient self-report or patient dissatisfaction with rapidity of ejaculation during intercourse, rather than a diagnosis by a trained clinician. Reporting dissatisfaction with ejaculatory latency or labeling oneself as premature is not the same as meeting any of the published criterion sets. It may indeed be a problem for the subject; he may, however, not have a sexual dysfunction. In my opinion, these figures are likely to be an overestimate of the true prevalence of rapid ejaculation.

Supporting this view that the prevalence figures are an overestimate is the lack of congruence between patients presenting for treatment of PE and the reported prevalence of the disorder. Far fewer patients present for treatment than would be expected with a true prevalence of around 30%. This phenomenon may have several explanations in addition to overestimating the true prevalence, including men not being aware of treatment options, and men being too embarrassed to seek treatment or not knowing where they might obtain treatment. Additionally, there is likely to be a subgroup of men who are not distressed or simply don't care.

PE Is a Disorder of the Young

It has always been assumed that rapid ejaculation is a dysfunction of the young, with diminishing prevalence with age. This notion presumes that with age men habituate to the exciting sexual sensations or that there is a slowing of the ejaculatory reflex. This long-held belief was recently challenged by publication of two data sets demonstrating that the prevalence of premature/rapid ejaculation was constant across age groups ranging from 18 to 70 (Laumann, Paik, & Rosen, 1999; Rosen et al., 2004). These studies are limited because they did not follow men longitudinally to assess changes in IELT with age. Nonetheless, it appears the belief that the prevalence of PE diminishes with age is not supported by current data. From a cross-sectional perspective, PE appears to affect a broader age range of individuals than ED, and the prevalence of PE appears to be higher than that of ED in any given age bracket studied.

ETIOLOGY

For years the prevailing opinion was that rapid ejaculation was a psychological or learned condition. However, a series of biological investigations has begun to unravel the physiological underpinnings of the ejaculatory process, leading theorists to speculate about organic contributions to this disorder (Gospodinoff, 1989; Grenier& Byers, 1995; Metz & McCarthy, 2003).

At this juncture, unlike in erectile dysfunction, where a coherent story of smooth muscle relaxation/contraction mediated by nitrate oxide has been elucidated, the pathophysiology of PE remains incomplete and yet to be determined.

Although the exact biological mechanisms remain unknown, in the future we may be able to categorize PE into different organic and psychological subtypes (Metz & McCarthy, 2003). At present, the data do not permit this. Even if we were able to unequivocally state that a man's PE was due to exclusively biological factors he would still manifest a psychological response that would worsen the condition. Additionally, his partner is also likely to be psychologically affected by the dysfunction, even if the condition is due exclusively to organic factors.

The most promising biological causes hypothesized include: the role of serotonin receptors, an individual's genetic predisposition, and increased penile sensitivity or nerve conduction abnormalities. In support of the serotonin receptor hypothesis, based on studies of rodents, Waldinger, Berendsen, et al. (1998) report that activation of the 5-HT_{2C} receptor delays ejaculation while activation of the 5-HT_{1A} receptor speeds up ejaculation. Assuming congruency between rodent and human neuroreceptors, Waldinger

et al. speculate that rapid ejaculation may be understood as a hypofunction of the 5-HT_{2C} receptor or a hyperfunction of the 5-HT_{1A} receptor. Because of safety concerns this work can not at present be performed on humans, so it remains only a highly intriguing theory. Additionally, it is not likely that this hypo or hyper function of the serotonin receptors explains the underpinnings of rapid ejaculation in all men; it might, however, account for a significant subset.

Supporting the genetic vulnerability hypothesis is another study by Waldinger, Rietschel et al. (1998), who reported that 91% of a small sample of his lifelong PE patients had a first-degree relative who also suffered from this dysfunction. Based on this observation Waldinger et al. speculate that genetic factors may contribute to the development of lifelong rapid ejaculation. It is important to note that this hypothesis applies only to the lifelong form of rapid ejaculation.

Regarding the heightened penile sensitivity and/or nerve conduction hypothesis the findings of several studies have been contradictory. Some support this notion; others show no relationship between PE and either heightened penile sensitivity or rapidity of the bulbocavernosus reflex (Gospodinoff, 1989; Mirone et al., 2001; Fanciullacci, Colpi, Beretta, & Zanollo, 1988).

The psychophysiological data of Rowland et al. (2000), comparing rapid ejaculators and normal controls, have demonstrated that rapid ejaculators take substantially longer to ejaculate with masturbation in comparison to intercourse (1.5 vs. 4.5 minutes)—a difference not observed in the control group of non-PE men. Rapid ejaculators also experienced less enjoyment from their orgasms than controls and were more vulnerable to penile vibratory stimulation, with no differences noted between the two groups with visual stimulation alone. Rowland et al. (2000) also concluded that rapid ejaculators either ejaculate prior to full sexual arousal or, alternatively, they underestimate their level of somatic arousal. Rowland's conclusions have important treatment implications in terms of men's lack of awareness of their sexual arousal.

Psychological Theories

There are multiple psychological explanations as to why men develop PE. Unfortunately, none of the theories evolve from evidenced-based medicine studies; rather, they are the products of thoughtful synthesis by clinicians from several schools of thought. While untested, the theories are thought provoking and have been helpful to clinicians over the years.

In 1927, Karl Abraham, a German psychoanalyst, speculated that PE is due to a combination of the man's unconscious hostile feelings toward women and his passive pleasure, as a child, in losing control of his urination (passive urethral eroticism), which in adulthood transforms itself into

his passive pleasure in giving up control of ejaculation. Thus, ejaculation into the woman's vagina was equated with "soiling" or "debasing" her. The man takes his sexual pleasure, unconsciously soils her, and in so doing deprives her of sexual pleasure. Simultaneously he gives himself over to the passive pleasure of letting go of his ejaculation without any attempt to control his sexual excitement or delay ejaculation.

A second psychoanalytic explanation focuses on the man's unresolved excessive narcissism during infancy, which results in his placing exaggerated importance on his penis. This hypothesis might explain the selfishness observed in some rapid ejaculators who seem unconcerned with pleasuring their partners. The psychoanalytic language of "unresolved infantile narcissism" or "excessive focus on the penis" may obscure the essential notion of some men's selfishness as lovers.

In 1943, Bernard Schapiro introduced the notion that premature ejaculation was a psychosomatic disorder. In his view, premature ejaculation is a bodily symptom that expresses the man's psychological conflict, akin to psychosomatic explanations for headache, backache, and stomach pain. Schapiro speculated that men with PE had specific biological organ vulnerabilities that directed the expression of the individual's psychological conflict. In his view because men with PE had "weakened" genitourinary systems they became rapid ejaculators rather than expressing their psychological conflict through another organ system (e.g., headache).

Psychodynamic theorists consider anxiety to be the primary etiological agent in precipitating the symptom of rapid ejaculation. However, anxiety is not a singular concept; it is employed to characterize at least three different mental phenomena. Anxiety may refer to (1) a phobic response, like being fearful (i.e., afraid of the dark, wet, unseen vagina); (2) an affect, the end result of conflict resolution where two contradictory urges are at play (i.e., the man is angry at his partner, but feels guilty about directly expressing his hostility); or (3) anticipatory anxiety, commonly referred to as performance anxiety, where preoccupation with sexual failures and poor performance leads to deteriorating sexual function and avoidance of future sexual interactions

Conceptualizing PE in more of a behavioral/learning perspective, Masters and Johnson (1970) emphasized the concept of "early learned experience." By reviewing the case histories of men with PE, Masters and Johnson noted that many men described first sexual experiences characterized by haste and nervousness, for example, making love in the backseat of an automobile or an encounter with a prostitute. Masters and Johnson speculated that based on their initial experiences the men became conditioned to ejaculate rapidly. It is not known whether these early conditioning experiences are unique to men with PE (Perelman, McMahon, & Barada, 2004).

Kaplan (1989) considered "lack of sexual sensory awareness" to be

the immediate, here-and-now cause of rapid ejaculation. She believed that men fail to develop sufficient feedback regarding their level of sexual arousal. Such men experience themselves as going from low levels of arousal to ejaculation without any awareness.

Absent from any of these theories are compelling notions differentiating the lifelong and acquired forms of PE. Obviously more work remains to be done in clarifying the psychological causation(s) of this sexual problem.

The Role of Performance Anxiety

Performance anxiety per se does not generally cause the initial episode of rapid ejaculation; however, it is pernicious in maintaining the dysfunction. By the time patients present for psychological intervention the initial precipitating event often is obscured because of the intensity of the man's performance anxiety. A further complication of performance anxiety is that it distracts the man from focusing on his level of arousal, rendering him helpless to exert voluntary control over sexual arousal and ejaculation. In fact men believe that focusing on their level of arousal will only cause them to ejaculate even more rapidly.

IMPACT ON THE MAN AND COUPLE

Premature ejaculation impacts both individual and relationship quality of life (QOL). Qualitative research with 28 men ages 25–70 with self-reported PE illustrates this point (Symonds, Roblin, Hart, & Althof, 2003). The subjects were asked what impact the condition had on their self-image, sex life, relationship with their partner, and everyday life. The majority of men (68%) reported a decrease in sexual self-confidence. Moreover, half of the single men reported either avoidance of relationships or reluctance to establish new relationships. Men in relationships reported distress at not satisfying their partner, with some worrying that their partner would be unfaithful to them because of their PE.

Embarrassment regarding discussing PE was the primary reason for not consulting a physician, cited by 67% of respondents. Interestingly, almost half thought no treatment existed (47%).

Hartmann, Schedlowski, and Kruger (2005) characterize PE patients as preoccupied with thoughts about controlling their orgasm, with anxious anticipation of a possible failure, thoughts about embarrassment, and thoughts about keeping their erection. In contrast, he found that functional men focused on sexual arousal and sexual satisfaction.

Intimacy is also affected in men with PE. Men with PE scored lower on all aspects of intimacy (emotional, social, sexual, recreational, and in-

tellectual) and had lower QOL (lower levels of satisfaction in all areas) than sexually functional men (McCabe, 1997).

PE also has a negative effect on the partner's quality of life. A recent study showed a relationship between PE and lower partner sexual satisfaction in heterosexual couples (Byers & Grenier, 2003). Partners are not just distressed because of the quality of the man's sexual performance; they are also upset because the condition and the man's associated distress often lead to a rapid and unwanted interruption of intimacy. Women are also angry with their PE partners because they do not feel that their concerns have been genuinely "heard" by the man or that he is unwilling to "fix" the problem. Men likewise believe that their partners do not understand the degree of frustration and humiliation that they routinely experience. This disconnect between the men and their partners is the basis for considerable relationship tension. Thus, for men in stable relationships, PE should be recognized as a couple issue. All these studies suggest that the psychosocial impact of PE on the patient and partner has profound psychosocial consequences.

EVALUATION

Although clinicians conceptually separate evaluation and treatment processes, patients do not. For them the "cure" begins with the first encounter. The patient is, of course, correct; the attentive therapist is aware that the psychotherapeutic relationship and all its transference ramifications are initiated with the first handshake and entry into the consulting room.

Attend to the Therapeutic Relationship before Attending to the Data

The establishment of a respectful, comfortable, and healing relationship with the patient(s) is the primary goal of the evaluation session. Too often the secondary goal of gathering data displaces the more human process of relating to one another. The man and his partner are likely to be anxious and uncomfortable; they are about to share aspects of their intimate life with a stranger.

Talking about sexual matters does not come naturally to most people. The therapist must first set them at ease before progressing into the more difficult material. When couples seem ready to work, one can ask, "What brings you in?" Others may need more soothing, so asking, "How is it for you to come in today and talk with me?" may be helpful. For the very anxious patient, it may be advisable to start by asking, "Did you have any trouble finding the office?"

My office overlooks the Florida Intercoastal Waterway. Patients often

begin by commenting on the view. We briefly discuss the boats, birds, or manatees and then, when they are ready, focus on the sexual and interpersonal currents of their lives.

Look for the Early Resistances

Infrequently, even when the presenting problem is sexual, there are first meetings at which sexual issues are not discussed. This is significant and challenges the therapist to assess whether the resistance belongs to the patient or therapist. I still recall my reluctance to ask an elderly European gentleman about his sexual life because he very much reminded me of my father. Unknowingly I was avoiding taking a sexual history. At 15 minutes into the hour this man asked, "So, when are you going to ask me about sex?" He was right. I laughed to myself, recognizing the countertransference, and was able to proceed.

Patients' reluctance to share sexual material may be due to a number of factors. The old analytic maxim "resistance before conflict" is good advice. Inquiry should shift from descriptions of the couple's sexual life to understanding what prevents the man or woman from discussing this subject. When the first hour passes without directly addressing the sexual problem, begin the next session by inquiring about the patient's reluctance to talk about sexual matters.

> Rob, a 55-year-old married male, was "sent to see me by his wife" for rapid ejaculation. When I asked about their sexual life Rob deflected the question and talked at length about his business endeavors, his athleticism, boating, and the children. He seemed to ignore the social cues of my trying to redirect him. Instead, he launched into a long monologue on his wife's unjust perception of him as a failed businessman. Only when I reflected how bad it must feel "to have been sent to see me by his wife," and her perception of him as a disappointment both as a breadwinner and lover, was Rob able to discuss their sexual life. He was trying to protect his fragile self-esteem and not reexperience with me the humiliation he felt at the hands of his wife.

In most ordinary clinical interviews sociocultural and religious prohibitions against talking about sexual life are encountered. These include: "In our family, such matters were never discussed" and "I grew up thinking it was wrong to talk about sex with anyone." Sometimes the gender of the interviewer is the focus of the resistance. "I can't talk about this with a male/female doctor." Acknowledging the patient's discomfort and giving permission and reassurance often overcomes resistance stemming from these sources. If the therapist's gender continues to be an unyielding source of resistance, referral should be made to a colleague of the opposite-sex.

The clinician can also ask the patient what the therapist can do differ-

ently to facilitate the discussion. Some patients are well aware of what sets them at ease; others will simply appreciate your willingness to acknowledge and ask about their discomfort.

Patients' expectations regarding treatment also contribute to resistance. Couples do not know what to expect. Some are afraid that the therapist will physically examine them or watch them engage in sexual behavior. Others may have concerns about the therapist being sexual with them or asking them to engage in sexual behaviors that they consider unconventional. The following vignette illustrates one couple's fear:

> On the night before her first appointment Monica dreamt that she came to my office and was greeted by a receptionist who looked like a witch. The witch had no teeth and green eyes and told her that the doctor required her to undress before he would see them. After telling me her dream she asked if I was planning to watch her and her partner have sex.

The Secret: The Pitfalls from Collusion

A stronger, more persistent source of resistance initially stems from patients' reluctance to reveal aspects of their lives that are embarrassing, shameful, or hurtful to themselves or their partner. These secrets from the therapist may have their origins in fragments of traumatic childhood sexual experiences, awareness of unconventional fantasies, extramarital relationships, or conflictual young adult life events that have not been shared with others, such as the suicide of a brother, periods of sexual promiscuity, a visit to a prostitute, having been raped, or a homosexual encounter.

Levine (1988) lists three categories of secrets: (1) secrets from oneself; (2) secrets from the partner; and (3) secrets known to both partners but kept from the therapist. Secrets from the self are due to repression or suppression and often emerge during the course of treatment. Examples include "I had an inkling that my sexual attractions were to men, but I tried to push this out of my mind and live a straight life" and "I think I really never loved my partner." Secrets from the partner or secrets from the therapist are of a different order (i.e., ongoing and past affairs, cross-dressing, childhood sexual abuse, and alcoholism) and almost always lead to therapeutic impediments.

Some patients rationalize that these events, feelings, or fantasies are unrelated to the current problem and therefore they do not need to be shared. Conversely, others are keenly aware of the impact of this secret on their psychological and sexual life but lack sufficient trust, courage, or motivation to address these problematic life dilemmas.

Honesty between patients and therapist is the cornerstone of treatment. Conscious avoidance and withholding of information compromises

the therapeutic process. My current policy is not to begin couple treatment if one partner asks me not to talk about a relatively current and important issue, for example, a 2-year affair that ended 2 months ago. I have less difficulty agreeing to maintain a secret such as "Twenty years ago on an out-of-town business trip I had a one-night affair." My rational is that I do not see a brief remote affair as necessarily relevant and that disclosure of the event to the partner may prove to be more destructive than helpful. Earlier in my career, when I agreed to keep important secrets in an attempt to be "flexible," this often proved to be an error and resulted in unexpected therapeutic failures.

Assessment: What to Ask

Each therapist needs to develop his or her style and method of assessing PE. What follows is my method.

I begin by asking patients when the PE began and whether there was ever a time when he had control over ejaculation. I chart the course of the problem and ask specifically about average IELT, degree of voluntary control, distress, and sexual satisfaction. I want to know why he or they have chosen to seek treatment at this point in time.

I move on to take a sexual history to identify if there are any coexisting sexual dysfunctions and learn whether the patient has PE with all partners or only specific partners. Then I ask patients to recount in detail a recent sexual encounter. This helps to clarify the degree of performance anxiety, the narrowness or broadness of his sexual repertoire, his cognitions and affect, what happens after he ejaculates, and the responses of the partner to his dysfunction. I attempt to ascertain whether he attends to or has an awareness of his level of sexual arousal. I inquire as to the strategies he has employed to delay ejaculation and whether or not they were successful. I also ask if he was previously in sex therapy, marital therapy, or individual treatment and what that experience was like for him.

The next portion of the assessment focuses on his interpersonal relationship and the impact of PE on the couple's sexual and nonsexual intimacy and overall relationship. Questions about the partner are broached, such as the following: Does she suffer from any sexual dysfunctions? Does she engage in strategies to help delay his rapid ejaculation or does she seem to encourage his ejaculating rapidly? Is she willing to participate in treatment? These questions allow the therapist to form preliminary judgments regarding the partner's willingness to help with treatment versus her potential to sabotage it.

Lastly, I try to ascertain the patient's interpersonal style, presence or absence of Axis I or II problems, and limitations or strengths regarding treatment. All these data should help me to develop preliminary hypotheses

as to the predisposing, precipitating, maintaining, and contextual factors (Althof et al., 2005) and what resistances might interfere with treatment.

THE FIRST DECISION: INDIVIDUAL OR COUPLE TREATMENT, PHARMACOTHERAPY, OR COMBINED PSYCHOLOGICAL AND PHARMACOLOGICAL THERAPY

The evaluation concludes with the therapist offering the patients his or her treatment recommendations. There are several distinct possibilities: individual therapy for one or both partners, conjoint or couple treatment, pharmacotherapy alone, or combined pharmacological and psychological treatment.

It seems odd that combined pharmacological and psychological treatment of sexual problems has not established itself as a mainstream intervention for either mental health clinicians or subspecialty physicians who treat sexual problems (e.g., urologists or family practice physicians). Generally mental health clinicians offer psychological interventions and medical practitioners offer pharmacological treatment. Yet, several well-controlled studies demonstrated that patients diagnosed with diverse psychiatric conditions (depression, schizophrenia, posttraumatic stress disorder, etc.) benefit significantly more from combined psychological and pharmacological approaches than from either modality alone (Keller et al., 2000; Nathan & Gorman, 2002). Why shouldn't this also be true for sexual medicine? I hope that, in the future we will have evidence-based algorithms that guide combined therapy (Althof, 1998, 2003, 2005; Perelman, 2003, 2005; Rosen, Leiblum, & Specter, 1994). What follows is a discussion of psychotherapy alone, pharmacological treatment alone, and combined therapy.

When to Offer What

Psychotherapy alone is best reserved for men and couples for whom the precipitating and maintaining factors are clearly psychological and the psychosocial obstacles are too great to surmount with pharmacotherapy alone. Examples of these psychosocial obstacles include: (1) patient variables such as the degree of performance anxiety or presence of depression; (2) partner issues such as how she copes with the sexual dysfunction or that his rapid ejaculation obscures her sexual dysfunction (e.g., anorgasmia); (3) interpersonal nonsexual variables such as a chronically unsatisfying relationship; (4) contextual variables including lack of privacy; and (5) each partner's expectations from treatment (e.g., "he should last 20 minutes because it takes me that long to have an orgasm").

Individual psychotherapy is the default choice for single men not in relationships. In addition to treating the sexual dysfunction, therapy must address these men's often-seen reluctance to enter into new relationships for fear of humiliating themselves and disappointing the woman. Psychotherapy can only go so far without the presence of a partner. Obviously, without a partner the patient cannot sexually practice what he has learned nor work through salient interpersonal dynamics. For these men treatment is sometimes divided into two phases, treatment when there is no partner and later resumption of treatment when they establish a new relationship.

For men in relationships, individual psychotherapy is recommended when the psychological variables supporting the dysfunction are thought to be more intrapsychic rather than interpersonal, for example, fear of penetrating a dark, wet, warm vagina or excessive fear of or hostility to women. These are generally products of unresolved childhood issues that continue to interfere in the man's adult sexual life. Individual psychotherapy may also be the treatment of choice when the relationship is deemed too chaotic or unworkable, or when the partner refuses to participate. Individual treatment in these situations is of course limited given the limitations of the interpersonal environment.

Conjoint psychotherapy is recommended for men with either lifelong or acquired forms of PE where both partners are relatively psychologically healthy and motivated to pursue treatment. Ideally, the precipitating and maintaining factors can be elucidated, the impact of the dysfunction on both partners can be clarified, and interventions directed at him, her, and both of them can be initiated.

Pharmacotherapy alone is recommended when the man has severe lifelong premature ejaculation, is sexually experienced, is in a satisfying relationship, and has reasonable expectations regarding treatment outcome. These men must understand that pharmacotherapy alone will not "cure" the problem; the rapid ejaculation will return as soon as they stop taking the medication. They must therefore be willing to continue on the medication for the foreseeable future.

Combined therapy offers the best of both worlds. Pharmacotherapy will rapidly delay ejaculation and allow the man to regain some sexual confidence. Coaching will help the man or couple maximize gains from pharmacotherapy. It seeks to help men and couples overcome the psychosocial obstacles that interfere with making effective use of the pharmacological intervention. The man can be taught to attend to sensations rather fear his arousal. He can learn to pace his arousal and expand his sexual repertoire without fear that it will lead to rapid ejaculation. In time he can be slowly weaned from pharmacotherapy and implement what he has learned in psychotherapy. Not all men will be able to give up the pharma-

cological intervention; some, however, will be pleased that "on their own" they have triumphed over adversity.

PSYCHOTHERAPY ALONE

Present-day psychotherapy for rapid ejaculation is an integration of psychodynamic, systems, behavioral, and cognitive approaches within a short-term psychotherapy model (Althof, 2005; Kaplan, 1989; Levine, 1992; Masters & Johnson, 1970; McCarthy, 1990; Metz & McCarthy, 2003; Semans, 1956; Zilbergeld, 1999). The guiding principles of treatment are to learn to control ejaculation while understanding the meaning of the symptom and the context in which it occurs. Psychotherapy and behavioral interventions improve ejaculatory control by helping men and couples to: (1) learn techniques to control and/or delay ejaculation, (2) gain confidence in their sexual performance, (3) lessen performance anxiety, (4) modify rigid sexual repertoires, (5) surmount barriers to intimacy, (6) resolve interpersonal issues that precipitate and maintain the dysfunction, (7) come to terms with feelings or thoughts that interfere with sexual function, and (8) increase communication. Psychodynamically oriented therapists view the dysfunction as a metaphor in which the couple is trying to simultaneously conceal and express conflicting aspects of themselves or the relationship. In symbolic terms, the dysfunction contains a compromised solution to one of life's dilemmas.

Alternatively, behavior therapists understand the dysfunction as a conditioned response or a maladaptive response to interpersonal or environmental occurrences. They provide exercises or homework to help the man comfortably attend to his sensations and learn to pace his arousal.

Men fear focusing on their sexual excitement, believing it will cause them to ejaculate even more quickly. They attempt to diminish or limit their sexual excitement by resorting to wearing multiple condoms, applying desensitization ointment to the penis, repeatedly masturbating prior to intercourse, not allowing partners to stimulate them, or distracting themselves by performing complex mathematical computations while making love. These tactics, however creative, curtail the pleasures of lovemaking and are generally unsuccessful. These men typically describe themselves as having two points on their subjective excitement scale—no excitement and the point of ejaculatory inevitability. They fail to focus on their arousal and are unable to perceive or linger in midrange sexual excitement. In treatment, men are instructed to focus on their sexual arousal. By utilizing graduated behavioral exercises, they are taught to identify and become familiar with intermediate levels of sexual excitement. Successively, beginning with masturbation and moving progressively through foreplay and in-

tercourse, they master the ability to linger in this range, thereby delaying ejaculation.

In addition to teaching the men sexual skills and resolving the interpersonal and intrapsychic issues related to rapid ejaculation, it is also helpful to address the cognitive distortions that help maintain the dysfunction. Rosen et al. (1994) in discussing erectile dysfunction list eight forms of cognitive distortion that may interfere with sexual function. These forms of distortion are just as applicable to rapid ejaculation and include: (1) all or nothing thinking ("I am a complete failure because I come quickly"); (2) overgeneralization ("If I had trouble controlling my ejaculation last night, I won't be able to this morning"); (3) disqualifying the positive ("My partner says our lovemaking is satisfying because she doesn't want to hurt my feelings"); (4) mind reading ("I don't need to ask, I know how she felt about last night"); (5) fortune-telling ("I am sure things will go badly tonight"); (6) emotional reasoning ("Because a man feels something is true, it must be"); (7) categorical imperatives ("should," "ought to," and "must" dominate the man's cognitive processes); and (8) catastrophizing ("If I fail tonight my girlfriend will dump me").

Psychoeducational interventions also aim to rework the behavioral repertoire of the man or couple, referred to as their sexual script (Gagnon, Rosen, & Leiblum, 1982). Men with rapid ejaculation limit foreplay because they fear becoming too excited. Sex becomes very mechanical and rigid; yet these solutions do not help the man to delay ejaculation. By modifying rigid and narrow scripts therapists may help couples establish a more satisfying sexual life.

Resistance

No therapy ever progresses without some resistance on the part of the patient or couple. It is to be expected. Resistances seek to keep the status quo. It is not easy for patients to give up comfortable, yet maladaptive behaviors. Yet with confrontation, interpretation, and gentle humor patients can be encouraged to relinquish resistances and "try on" new behavioral and interpersonal routines.

I encourage patients to abandon their resistances and seek to adopt alternative behaviors by comparing this to a dance student learning a new step. Old steps are automatic, as if they are engrained in our brain; learning to perform the dance differently is initially awkward and doesn't "feel natural." Yet with practice, patients can become as proficient in the new step as they were with the old.

Levine (1992) posits five sources of resistance: (1) when the PE and associated problems maintain a sexual equilibrium and cover up the female partner's sexual disorder or concern; (2) when the individual or couple har-

bors unrealistic expectations about sexual performance; (3) when there are major relationship problems; (4) when male or female deceit is present; and (5) when PE is the consequence of a major health problem.

Case Illustrations of Psychotherapy

What follow are two vignettes that characterize different aspects of psychological treatment. The first portrays a middle-aged couple who both were motivated and committed to overcoming his rapid ejaculation. The second vignette describes a complicated drama where rapid ejaculation was the least of this couple's problem.

Case 1: Joseph

Joseph, a 45-year-old married architect with lifelong rapid ejaculation, came for consultation at the urging of his wife, Susan. She had become increasingly frustrated with the lack of intimacy in their marriage and was totally "disgusted" with the quality of their sexual life. She was tired of hearing him apologize after ejaculating and simply wanted him to do something, anything, to fix it.

In conjoint treatment, Joseph sheepishly admitted that he was afraid of vaginas. He joked about being "a real Freudian case." He wasn't exactly sure why he developed this fear, but he never felt comfortable with the warmth and wetness of Susan's vagina. He was glad that he could finally talk about this hidden fear and over time it dissipated. Susan was surprised; this was a part of Joseph she didn't know. It precipitated intense anger at Joseph, which expressed itself in demeaning and excessively critical comments. It was as if Susan expected to know every private corner of Joseph's mind. This resistance gave way to my interpretation that her anger served as an obstacle to Joseph sharing his subjective life with her. I also spoke about zones of privacy and that none of us can ever know the other completely.

As you can imagine, Joseph also had significant performance anxiety, fearing that he would come quickly and anger Susan. Joseph had no sense of feeling sexually aroused. From his perspective he entered the vagina and then ejaculated.

Susan talked about hating hearing Joseph's apology after ejaculated. She also hated when he turned away from her after coming. She wanted to be held or for him to talk to her. She wanted more from Joseph and felt that the sexual problem had over the years created increasing distance between them. Conjoint treatment had three initial foci: (1) talking with Joseph regarding his fear of vaginas, (2) instructing him on how to focus in on his arousal and control it, and (3) addressing the relational and intimacy issues.

I suggested that they temporarily suspend attempts at intercourse.

They were both agreeable to this. Susan talked about feeling simultaneously angry at all the years Joseph did nothing and happy that he was finally addressing the problem.

In terms of behavioral exercises I asked Joseph to imagine sexual arousal on a scale from 0 to 10, where 9 is a point of ejaculatory inevitability. I explained to him that I wanted to teach him to linger in the midrange of excitement, somewhere between 5 and 7. I asked him to go home and masturbate, imagining his arousal on the 0–10 scale. When he reached 6 he was to stop and allow his arousal to dissipate to a 3 or 4. Then he was to start masturbating again and stop at 6. I told him to do this four times before allowing himself to ejaculate. He was to practice these exercises at least four times per week.

After several weeks of talking about his fears, abstaining from intercourse, and practicing masturbating to midlevel arousal we moved on to having Susan masturbate him to midranges of arousal. She was told to manually or orally stimulate him until he asked her to stop. Joseph's task was to concentrate on his level of arousal and ask Susan to stop when he reached a 6. Then, as he had previously, he was to allow his excitement to diminish and allow it to build up to 6 several times before achieving orgasm. Susan was a supportive and committed partner and understood the purpose of the exercise. She was told that she could ask Joseph to pleasure her in any noncoital fashion. She did so on several occasions.

Following Joseph's mastering his excitement with manual or oral stimulation I suggested that the couple have two minutes of intercourse without thrusting. This was a test to see if Joseph's fear of the wet and warm vagina would interfere with his ability to concentrate on arousal. I urged Joseph not to apologize should he ejaculate, but rather to hold Susan and continue being emotionally intimate with her. Susan greatly appreciated this suggestion. Joseph did surprisingly well; he only ejaculated once out of six attempts and remembered not to apologize. The couple moved on to have intercourse with thrusting and again Joseph was instructed to stop the exciting movements when he reached a level of 6 on the 0–10 arousal scale. He was to follow the same pattern of stopping, allowing his arousal to diminish and then resuming thrusting until he reached 6. They were to do this several times before he could ejaculate.

All along we had also been discussing how they could deepen their level of intimacy. Joseph's fears and Susan's anger were identified as roadblocks to intimacy. With little help from me, as they worked together on the sexual problem each was able to be more intimate with the other. Within 4 months, Joseph had achieved moderate to good control and both felt that their relationship had significantly improved. I continued to see them every 4 months for 2 years to ensure that they sustained their gains. At 18 months we saw each other for several weekly sessions to again address the intimacy issues.

Case 2: Carl

Carl, a self-centered 26-year-old, married health care professional sought treatment for lifelong rapid ejaculation. He took no responsibility for his dysfunction, projecting the blame to his wife, Cindy, for being too attractive. He harshly reproached her, saying, "You get me too excited." In addition to his conspicuous narcissism he also was severely compulsive, having to change his underwear and shower several times daily. He dismissed my suggestion to consider taking SSRI medication that could simultaneously diminish his compulsivity and delay ejaculatory latency. He insisted that he did not need any psychotropic medication.

The marital climate was dominated by jealousy of Cindy's professional success. Cindy was depressed and overwhelmed; her mother had recently passed away and she had two young boys under age 3.

None of my interventions were successful. Carl refused medication and Cindy had little energy available to devote to conjoint therapy. The couple never made time to complete behavioral assignments; they wanted a quick, simple fix to all their problems. After 6 weeks we mutually agreed to terminate.

Interestingly, Cindy came to my office 8 years later complaining of anorgasmia. Now divorced and thriving professionally, she was a single mother of two young teenage boys. She described the painful process of her marriage disintegrating as she helplessly watched Carl spiral downward professionally propelled by his cocaine abuse and sexual addiction to prostitutes. Whether true or not, Carl told her that he never ejaculated rapidly with prostitutes, only with her.

Cindy continued in treatment for approximately a year and a half. She had begun a new relationship and was scared of allowing herself to be vulnerable to another man. Her sexual symptom served to create distance and protect her from feeling too close to her boyfriend.

Psychotherapy Outcome Studies

Evidenced-based medicine has become the gold standard for judging the efficacy of psychological or medical interventions. Studies at the highest level of evidence-based medicine require moderate to large sample sizes with designs being randomized, placebo-controlled and double-blinded. Sex therapy treatment outcome studies can be characterized as uncontrolled, unblinded trials; none meet the requirements for high-level evidenced-based studies. The literature consists of reports on small to moderately sized cohorts of subjects who received different forms of psychological interventions with limited or no follow-up. In most studies, active treatment was not compared to placebo, control, or wait list groups.

Masters and Johnson (1970) reported on 186 men who were seen in

their quasi-residential model utilizing multiple treatment techniques, including the squeeze technique sensate focus, and individual and conjoint therapy as well as sexual skills and communication training. They reported "failure rates" of 2.2% and 2.7% immediately posttherapy and at 5-year follow-up, respectively. Never before or since has any clinical center been able to replicate either the initial, or posttreatment, efficacy rates reported by Masters and Johnson. For example, only 64% of men in Hawton, Catalan, Martin, and Fagg's (1986) study and 80% of Kaplan's cohort (1983) were characterized as successful in overcoming rapid ejaculation immediately posttherapy.

All studies with long-term follow-up noted a tendency for men to suffer relapses. In writing about the problem of relapse in treating all forms of sexual dysfunction, Hawton, Catalan, and Fagg (1992) reported that recurrence of or continuing difficulty with the presenting sexual problem was commonly being reported by 75% of couples; this caused little to no concern for 34%. Patients indicated that they discussed the difficulty with the partner, practiced the techniques learned during therapy, accepted that difficulties were likely to recur, and read books about sexuality. In spite of the decrease in IELT over time, patient sexual satisfaction remained very high!

The concept of relapse prevention has begun to be incorporated into sex therapy. McCarthy (1993), in discussing relapse prevention, suggests that therapists schedule periodic "booster or maintenance" sessions following termination. Patients remark that knowing that they will be seen again in 6 months keeps them on target because they know they will have to "report" on their progress. The follow-up sessions can also be used to work out any "glitches" that have interfered with their progress.

PHARMACOTHERAPY

Pharmacological treatment of rapid ejaculation is accomplished by both daily and "as needed" dosing schedules of SSRIs or clomipramine (a tricyclic antidepressant). In the first instance patients ingest a tablet daily; taking the medicine bears no relationship to planned sexual activity. Patients who use medications on an "as-needed" basis take the tablet several hours prior to the planned sexual encounter. There is also a third approach where patients start with daily dosing for 1 month and then move to as needed dosing.

The SSRIs paroxetine (Paxil), sertraline (Zoloft), and fluoxetine (Prozac) and the tricyclic antidepressant clomipramine (Anafranil) have all been successfully employed to treat rapid ejaculation. It is believed that all have similar mechanisms of action. The dose range for each drug is paroxetine, 20–40 mg; clomipramine, 10–50 mg; sertraline, 50–100 mg; and fluoxe-

tine, 20–40 mg. Ejaculation delay is observed within the first week and tends to improve over several weeks. Side effects from these medications are dose related and include fatigue, yawning, nausea, gastrointestinal upset, and excessive sweating. There is some controversy over whether these medications cause impulsive behaviors and increased suicidal ideation. Given the seriousness of these side effects patients on pharmacotherapy for rapid ejaculation should be closely monitored. While infrequent, some men report diminished libido and erectile dysfunction after starting on these medications. Side effects are seen in the first week but generally diminish over the course of 2 to 3 weeks. Finally, these drugs should not be abruptly discontinued. Doing so may lead to an unpleasant "withdrawal syndrome."

Greater success has been achieved with daily dosing than with "as needed" schedules. However, men prefer "as needed" schedules for several reasons including cost and convenience, and because sexual activity for most men is not a daily event. Additionally, some men are averse to the idea that they are taking psychiatric medications to treat a sexual problem.

There are reports that PDE5 inhibitors can also be of benefit to men with rapid ejaculation. There is controversy over whether or not they truly benefit men with rapid ejaculation. This discussion is beyond the scope of this chapter.

Pharmacotherapy delays ejaculation six- to twentyfold. Thus a man who ejaculates in 30 seconds might be expected to achieve an IELT ranging between 3 to 10 minutes. While men are satisfied with the efficacy of the intervention they tend to discontinue its use within a year. By doing so, they return to their original baseline.

COMBINED TREATMENT: COACHING

The psychological aspects of a combined medical–psychological treatment are different from psychotherapy alone and are generally referred to as coaching. Such interventions are more directive, advice oriented, educational, and technique focused. They target the psychosocial obstacles created after the onset of the dysfunction, such as avoidance of foreplay, restrictive sexual patterns that are resented by partners, and unwillingness to discuss the problem, which itself creates a barrier. The goals of coaching include (1) identifying and working through the resistances to medical intervention that lead to premature discontinuation, (2) reducing or eliminating performance anxiety, (3) gaining sexual confidence, (4) understanding the context in which men and couples make love, and (5) helping patients to modify maladaptive sexual scripts.

Combined treatment may be especially helpful when the treatment effects of pharmacotherapy are modest. By lessening the psychosocial obsta-

cles that interfere with treatment and offering patients methods to delay ejaculation the impact of pharmacotherapy can be enhanced.

> Robert, a 50-year-old unhappily married man with lifelong rapid ejaculation, wanted a pill to fix his problem. He didn't think that the marital unhappiness caused the sexual problem (I agreed with him), and also didn't see how addressing the marital issues would help the sexual problem. Given this was our first meeting I didn't want to chase him away by strongly confronting him, but I nonetheless offered a gentle rebuttal to his perspective. I asked him to talk with his wife about using the medication and judge her reaction.
>
> Robert returned and seemed taken aback by his wife's comments about prolonging lovemaking. She had told him she preferred to have their lovemaking over with quickly. She had told him that it was hard for her to have sex with him because she was so angry. Robert and I were then able to explore how his withdrawal from his wife and his tendency to demean her contributed to her not wanting to be with him sexually.

NOT EVERYONE CAN BE HELPED

In spite of our most diligent efforts, it is not possible to help all individuals who present for treatment of rapid ejaculation. For some, none of the interventions—psychotherapy alone, pharmacotherapy alone, or combined treatment—overcome early trauma, the aftermath of years of destructive interactions, or limited psychological resources in the man or the couple.

There are instances in which patients achieve profound psychological gains, yet their control over ejaculation does not improve. Similarly, the man may demonstrate significantly improved IELT but have the relationship issues remain.

Psychotherapy and pharmacotherapy have their limitations. We cannot help everyone; not all patients want their problem resolved. Some patients may do better with another therapist or a physician, but there are some who will not benefit from any treatment. At these times, the therapist should discuss the limitations of his or her method of intervention and discuss any and all other reasonable options for ejaculatory delay. While these cases are discouraging, in general the majority of men and couples achieve modest gains sexually, psychologically, and relationally in treatment.

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CHAPTER 9

Treatment of Delayed Ejaculation

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One of the most challenging of male sexual disorders is that of delayed ejaculation (DE). The man who cannot readily ejaculate either alone or, most typically, with a partner, feels thwarted, anxious, and sexually incompetent. Contrary to popular belief, if his partner is a woman, she, too, feels deprived and distressed, particularly if she wants to conceive. Often, the problem has existed for years, if not decades, and treatment is initiated only when it has led to relationship tensions.

As Hartmann and Waldinger point out in this chapter, there has been a paucity of research focusing specifically on DE since the problem tends to be the least common of male sexual complaints. Clearly, both neurobiological and psychological factors play a role in the etiology and pathogenesis of DE but much remains to be known as to why men differ so dramatically in ejaculatory latency and why men capable of ejaculating with masturbation are unable to ejaculate with a partner or during intercourse.

DE is usually viewed as analogous to female orgasmic dysfunction. Most men with DE experience sexual desire and erection, but cannot orgasm during intercourse. There are a variety of psychological theories concerning the etiology of DE. Psychodynamic theories view DE as an inhibition caused by fears surrounding loss of control and other psychological conflicts, such as incest or castration fears, hostility and anger, or excessive reliance on paraphilic stimuli. There is little data supporting these speculations. Behavioral theories attribute the problem to excessive indulgence in and reliance on idiosyncratic masturbatory techniques. Apfelbaum's provocative and original perspective on DE views it as an example of automatic functioning in the absence of genuine arousal. The man with DE is regarded as a "workhorse" who is trying too hard to please a partner without himself feeling sexually aroused.

Treatment approaches to DE are varied and usually require the skilled application of many interventions, systemic, psychodynamic, and cognitive-behavioral. Often, exploration of early experiences and beliefs concerning sexuality is important as well as graduated behavioral exercises in which the man is encouraged to ejaculate in the presence of his partner, and then with partner stimulation, and finally, with intercourse. The man is taught that erections alone do not signify readiness for intercourse and that direct communication of his sexual wishes and feelings is essential. Treatment is most successful when an integrated approach is adopted, involving both the man and his partner in a flexible format. Often, underlying conflicts, especially unconscious dyadic or interpersonal ones, must be explored so that the man develops some understanding of his fears, past traumatic experiences, or destructive relationship interactions that might be reinforcing his problem.

While in the future, safe and effective drugs may be developed that will facilitate ejaculation, to date the only successful studies using pharmacological compounds have been done with rats and it is unlikely that what works with rats would work with dysfunctional humans with psychological inhibitions! Treatment of DE demands patience, support, and ingenuity on the part of the clinician. As Hartmann and Waldinger illustrate in their fascinating case example, therapy of DE typically involves a skillful combination of pharmacotherapy and sex therapy interventions as well as attention to the intrapsychic and interpersonal conditions associated with this challenging condition.

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In comparison to all other male sexual dysfunctions, delayed ejaculation (DE) has received the least attention. Erectile dysfunctions have been the focus of clinical and scientific interest for more than 20 years, especially since the introduction of phosphodiesterase inhibitors in 1998. Similarly during the past few years premature ejaculation has received more and more attention, again parallel to the development of new pharmacological treatment options. In contrast, DE remains the least observed and least understood of all sexual dysfunctions. This disorder's lack of "popularity" is based essentially on two assumptions, both of which we prove unfounded in this chapter. The first assumption says that this disorder is rare and therefore deserves little attention. The second assumption refers to these

patients' therapy prognoses, which are usually rated as significantly gloomier than the prognoses of all other sexual dysfunctions. In this chapter we discuss both these assumptions and other myths surrounding this disorder.

It is impossible to provide an evidence-based review for this disorder, since the literature contains almost no randomized clinical trials. Therefore, our summary of the etiological and treatment literature as well as our recommendations for treating DE basically rest on expert opinion, anecdotal and case study information, and our own clinical experience. Evidence supporting the different psychological or partner-related hypotheses regarding causative factors has been based on a few individual case studies rather than systematic investigations of larger patient samples. As Rowland et al. (2004) have recently pointed out, so little is known about patients with DE that hardly any normative data exist on general aspects of their sexual response, such as whether they demonstrate normal erectile response and arousal in response to psychosexual stimulation. Hence, it is not surprising that in the absence of any commonly accepted biological or psychological etiology, standardized and empirically validated treatment procedures for this disorder have not been fully developed.

TERMINOLOGY

To point out the similarity with female orgasmic disorders, the inhibition or failure of orgasm in men is classified as male orgasmic disorder in DSM-IV. This terminology is not precise enough, however, due to the fact that premature ejaculation is not taken into consideration at all, and thus only one form of male orgasmic disorder exists.

Although ejaculation and orgasm usually occur simultaneously, they are two separate phenomena. It is therefore unfortunate that in DSM-IV no clear distinction was made between orgasm and ejaculation, with retarded ejaculation categorized under the heading of orgasmic disorders (DE = male orgasmic disorder) whereas premature ejaculation, inconsistently, was not defined as premature orgasm. Using synonymous terminology for ejaculation and orgasm, however, is not in keeping with current neurobiological research indicating that orgasm and ejaculation seem to be mediated by different neural circuits and different transmitter systems (Waldinger & Schweitzer, 2005).

Considering this important difference in men, the inhibited or absent orgasm should be identified as inhibited male orgasm as in former DSM versions or, even more exactly, as male orgasmic disorder—delayed or inhibited type. DSM-IV defines male orgasmic disorder as "persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the

person's age, judges to be adequate in focus, intensity, and duration" (American Psychiatric Association, 1994, p. 509). Apart from the inconsistent terminology, the DSM-IV criteria entail additional problems for the clinician, who is confronted with sophisticated and demanding judgments: can the sexual excitement phase in his or her individual patient be classified as "normal" and "adequate in focus, intensity, and duration"? We discuss these criteria in the section on diagnostic issues. Finally, in DSM-IV there is no formal distinction between delayed or retarded ejaculation and the complete failure of ejaculation.

Here, the term "delayed ejaculation" will be used because it represents a correct contrast with rapid ejaculation and also entails no implications about etiology. Completely absent ejaculation is referred to as failure of ejaculation. A simple but adequate definition of DE would be that a man finds it difficult or impossible to ejaculate despite the presence of adequate sexual stimulation, erection, and conscious desire to achieve orgasm.

SYMPTOMATOLOGY

DE is an involuntary inhibition of the male orgasmic reflex and can be seen as analogous to female orgasmic dysfunction. It can also be described as a dissociation of emission and orgasm, two processes that are normally fully integrated. DE can be lifelong, or primary (e.g., congenital anorgasmia), or it can be an acquired, or secondary, problem. It can occur in every sexual encounter or it can be intermittent or situational. Some men with secondary DE can masturbate to orgasm; others, for a variety of reasons, will or cannot masturbate. Some men lose their masturbatory capacity secondary to emotional or physical trauma and some men have reported intermittent nocturnal emissions, while others are either unaware of—or do not have—nocturnal orgasms. In men with DE, the erotic flow from desire to sexual excitement and on to orgasm is inhibited or blocked.

The most prevalent form of DE is coital anorgasmia. The man is able to achieve an orgasm through masturbation as well as by manual and oral stimulation from the partner, but not through sexual intercourse. In practice, several varieties of this sexual problem can be found: men who have difficulty in achieving an orgasm from masturbation and noncoital stimulation; men who only achieve orgasm with masturbation; men who are sometimes able to orgasm after prolonged and intensive coital thrusting; men, who during sexual intercourse may reach the orgasmic threshold but then cannot reach the finishing line; and others who have a strong feeling that they will never achieve a coital orgasm. Normally, neither sexual desire nor erectile attainment is significantly impaired, although, as is true for all sexual disorders, these impairments may develop if the DE exists for a long time.

In summary, there is a spectrum of severity with respect to the degree of ejaculatory delay that, in a classification by Kaplan (1974), ranges across (1) mild forms, in which the male can achieve an intravaginal orgasm under certain conditions, (2) moderate forms, in which the man is able to ejaculate in the presence of others via various methods except vaginal intercourse, (3) severe forms, in which the man can achieve orgasm only when alone, and (4) most severe forms, in which the patient has never been able to ejaculate, either alone or in the presence of others.

Two widespread misconceptions surround DE (McCarthy & McCarthy, 1998): (1) the assumption that only complete coital orgasmic inhibition is a serious problem in a sexual partnership, and (2) the myth that DE has advantages due to the fact that the man is capable of prolonged sexual intercourse and thus can satisfy his partner enormously. Both assumptions are mistaken because they don't go beyond superficial sexual myths. The second assumption, often called the "blessing in disguise" assumption, is a typical example of male glorification of performance over pleasure.

As a matter of fact, even an orgasmic inhibition where the man is able to ejaculate after extended coital thrusting is experienced by both partners as very cumbersome and less pleasurable. The sexual act is overshadowed by the man desperately trying to achieve an orgasm, which in turn leaves little room for intimate pleasure. Most patients see this as "hard work" and not as an expanded satisfying sexual interaction. The man will break off the sexual intercourse when his erection declines after a certain time or when resignation occurs, preventing any further increase in sexual arousal. Most women experience the prolonged intercourse as "work" too, since vaginal lubrication lessens or disappears and unpleasant sensations or even pain may result.

Some women feel responsible for their partner's lack of orgasm and reproach themselves. Other women miss the shared (if not necessarily simultaneous) sexual climax. They feel the excessive control of the partner, his disability to "let go," as a marked impairment of their sexual experience. When the man with coital orgasmic inhibition also refuses his partner's manual or oral stimulation and is able to achieve orgasm only by self-stimulation (on his own or in the partner's presence), the woman feels unneeded and rejected. For both partners, the orgasmic inhibition can cause a loss of sexual motivation and sexual interest, thus placing an enormous burden on the relationship.

Many men with DE feel unhappy and concerned, especially when they have experienced ejaculatory difficulties since their first sexual encounters. Many men have become preoccupied with ejaculation and fearful of their partner's disapproval. As a consequence, intercourse has become predictably less pleasurable and they primarily engage in sexual activity in order to satisfy their partner and to reassure themselves of their masculinity and ability to perform. Some men eventually fake orgasms, others may experi-

ence secondary ED, loss of desire, aversion, or feelings of disgust (Campden-Main & Sara, 1985).

EPIDEMIOLOGY

The few available prevalence data from nonclinical community samples indicate that the problem of inhibited male orgasm does not seem to be as rare as generally assumed. In the U.S. National Health and Social Life Survey (Laumann, Gagnon, Michael, & Michaels, 1994; Laumann, Paik, & Rosen, 1999) approximately 8% of the male respondents admitted to suffering from the "inability to achieve an orgasm" over a period of at least 2 months during the previous year. In the analysis of several surveys, Nathan (1986) reported a prevalence of 3–4% in a "non-geriatric male population," while Spector and Carey (1990) found a range of 1–10% prevalence for this disorder. In a study of 250 men, Frenken (1980) came to the conclusion that 2% of this sample had severe and 6% a mild form of DE. In two more recent studies (Frankel, Donovan, & Peters, 1998; Blanker et al., 2001) an association between reduced ejaculation and age was found. In a French community-based sample (McFarlane, Botto, & Sagnier, 1996) of 1,568 men, 3% of those 50 to 59 years old reported "ejaculatory difficulty" every time, while this prevalence doubled in the subsequent age decades, reaching 12% in men 70 to 79 years old. Thus, DE, like other sexual dysfunctions, is likely to become more prevalent with the aging of the world population.

In clinical samples, the percentage of male patients with symptoms of inhibited male orgasm is between 3 and 9% (Dekker 1993; Rosen & Leiblum 1995; Hauch 2005). DE is thus the least common male sexual disorder for which professional help is sought. However, in interpreting these figures it must be acknowledged that in some percentage of DE cases, the sexual dysfunction may be mislabeled (both by the man himself and by the physician) as an erection or desire problem (McCarthy & McCarthy, 1998).

CASE ILLUSTRATION: PAUL AND MIRIAM, PART 1

The case history of Paul and Miriam is typical of the treatment of DE with sex therapy and, at the same time, unusual: typical because it reflects the complex and multifaceted nature of the disorder, unusual due to the many psychopathological aspects that are deeply rooted in both partners' histories and the resulting relationship dynamics, and due to the long and meandering course of the treatment. This case also illuminates the demands that the treatment of DE makes on the experience, flexibility, and methodologi-

cal repertoire of the therapist. Hence, the example of Paul and Miriam clearly demonstrates that the treatment of DE requires a multidimensional approach and an integration of the medical/somatic and the psychotherapy/sex therapy perspectives.

The Constellation at the Start of Therapy

Paul, age 31, was referred to us for cotreatment in sex therapy from the special andrological unit of our urological clinic. Paul was a good-looking, slightly stocky Mediterranean type with dark eyes and rather thin hair. As a master painter with his own business, he owned a small workshop and was financially well off. Paul reported that his life would be great if not for his sexual problem. From the first session onward his "sexual problem" proved to be a complex, multifaceted psychosexual disorder. At the start of therapy, Paul was about to marry Miriam, with whom he had lived in an intimate relationship for 2 years. Miriam, 30 years old, was a nurse who after completing further training was employed as a social worker. Paul said that both had an excellent relationship, because, among other things, Miriam had an "enormous understanding" of his sexual difficulties.

Miriam was quite a tall woman whose feminine figure and long hair stood in contrast to her tomboyish manner. She seemed intellectually to have somewhat of an advantage over Paul and was clearly more articulate. Due to her training, she was more familiar with a psychotherapy setting and initially adopted the role of co-therapist. The couple had known each other for many years, as Miriam had been married to a friend of Paul's in her first marriage. Only when this friend had started an affair with another woman did Paul and Miriam discover their love for one another.

At first, the sex in the relationship had been "quite catastrophic." Paul could barely allow himself to be touched by Miriam, and his penis was especially sensitive. Sexual intercourse was unthinkable. Since then, things had improved markedly and it was currently sometimes possible to insert the penis into the vagina. However, during coitus, Paul often lost his erection. Miriam said that she could sense when Paul became stressed and, predictably, shortly after this, his erection would disappear. A further problem was Paul's complete inability to reach orgasm in Miriam's presence. This occurred with both coitus and every form of oral and manual stimulation during foreplay regardless of whether the stimulation was provided by Miriam or by Paul himself.

Paul's masturbation, which he practiced almost daily, was unproblematic with respect to both erection, which was easy to achieve and reliable, and orgasm. Paul also had an idiosyncratic pattern of masturbation: He did not take his penis in his hand, but rather rubbed it against the mattress or his clothes while lying prone. In the past, his rare attempts to masturbate with his hand had been unsuccessful. Paul attributed his masturbation

pattern, among other things, to the high pain sensitivity of the glans penis, and also said that his foreskin could hardly be retracted during an erection, which caused pain during coitus, especially with the woman on top. In the urological examination there were no signs of phimosis, but there were signs of frenulum breve, with higher pain sensitivity as a possible consequence. Any organic cause of the erectile dysfunction was ruled out by the urological examination.

An additional problem for both partners concerned Paul's fetish-oriented sexual fantasies, which involved women wearing wet T-shirts and short, tight jeans. The naked female body had never been particularly arousing for Paul and a slight aversion existed toward the female genitalia. This was confirmed by Miriam, who reported that Paul never "voluntarily" touched her genitals, and that when she explicitly asked him to, he would become ill at ease and awkward.

At the start of therapy Miriam reported that she herself had no problems with sex and a "normal" ability to become aroused and reach orgasm. In her first marriage, sexuality had been initially satisfying, but later she increasingly lost her desire and felt overtaxed by the sexual demands of her then partner. She mentioned having certain difficulties relinquishing control and "really letting go" in the presence of a man, and said that she had no problems with her partner's sexual fetishes: she did not mind wearing the clothes he liked her to wear.

Both partners agreed that Paul's sexual symptoms had markedly improved over the course of their relationship. They reported that he was now capable of inserting his penis and its rigidity did not immediately abate. However, Paul lost his erection during intercourse. Paul's fear of pain during penile insertion had also diminished, although it was still impossible for him to ejaculate with partner contact. Miriam was most concerned about the impact of Paul's problems on her likelihood of becoming pregnant—her goal for treatment.

Sexual History

Paul

Paul grew up with both parents as the younger of two children (sister 5 years older). His father was the owner of a gas station and a car mechanic with his own business, and his mother worked part time at the gas station but mainly in the household. For Paul she was the first person he would talk to when something was on his mind, and at the same time a dominant figure. Paul reported that in his childhood, there were never any major conflicts or fights, and that his parents generally tended to "sweep problems under the carpet." When conflicts did arise, his parents would often simply not talk to each other, even for quite long periods of time.

Paul said that he had been a shy, anxious, and reserved child until he was 11 or 12. He had been very mother-oriented and used to live in his own private (dream) world. His parents worried that he was socially too withdrawn but this changed when he turned 13 and found a new group of friends, with whom he "hung out" and felt more comfortable. At puberty, Paul had his first depressive reaction. He said he could no longer see the good in anything or find his place in the world. He felt alienated, dismal, and dejected. A few sessions with a child psychologist had, however, helped him substantially. After an unsuccessful attempt to enroll in one high school, he finally attended a less academically oriented school, and then decided to start a painting apprenticeship. Later, he obtained his master painter certification with considerable effort, and since then he has been successfully running his own business.

Sex was not treated as a taboo subject in Paul's family but it was not spoken about openly either. Although Paul always made a good impression on girls because of his looks, he was extremely shy and used to marvel at girls from a distance. He was never brave enough to approach them. During puberty, Paul noticed that he found women in skintight clothing, especially jeans and T-shirts and shiny clothing, extremely arousing, while women's naked bodies and, in particular, the female genitalia hardly interested him at all.

Paul processed these impulses and fetishist arousal patterns in a very conflicted way, which led to a fixed cognitive expectancy pattern, that "normal sexual intercourse" was not possible for him, as he would automatically fail. His first sexual encounter, a chance meeting in a disco, reportedly went "disastrously," so that he avoided subsequent attempts. He masturbated in the idiosyncratic way described above. Whenever he did attempt sex, he experienced high anxiety, lack of genital arousal, and the expectation of failure. He resigned himself to being only a "good friend" to women and living alone. His psychological state, however, was fragile, and characterized by self-blame, self-doubt, and feelings of hopelessness. Not until starting his relationship with Miriam did a change take place. He could openly express himself and his openness was reciprocated with understanding, affection, and patience.

Miriam

In contrast to Paul, Miriam came from a socially marginal family. Her childhood was characterized by her father's alcoholism, frequent and intense fights between her parents, and periodical material deprivation. As the elder child (one brother 4 years younger), Miriam was always particularly affected by the situation and tried to protect her brother. When he was drunk, her father repeatedly struck her mother and also demanded sexual acts of her, sometimes in front of Miriam. When her mother (who

was described by Miriam as a jumpy, impulsive, hysterically structured personality, who could never provide Miriam with security or refuge, and who also consumed alcohol) finally left her husband, the situation did not improve. Her mother began liaisons with a series of frequently changing partners, often with alcoholic men. When Miriam was 7 years old, she was sexually abused by one of these men, an event that not only critically affected Miriam's life, but also affected the middle and late phases of therapy. Miriam was forced to perform fellatio on this man. At the start of therapy, Miriam had no memory of this event. When Miriam grew older and entered puberty, her mother treated her like a close friend, which was somewhat flattering for Miriam, but also psychologically burdensome.

In puberty and adolescence, Miriam developed normal sexual interest, even though sexuality never had a special meaning for her. She remembers her first petting experiences as well as her first sexual intercourse with her first steady boyfriend as rather neutral, neither particularly pleasant nor particularly unpleasant. She had always had problems reaching orgasm in the presence of a partner, but it was possible when masturbating, although she seldom did so. Her main fear was that her partner might witness her being very aroused, losing control, and perhaps looking "funny." For this reason, she always tried to let her long hair fall over her eyes and face during sex.

Miriam described sex with her first husband as being initially pleasant and satisfying, although she often acquiesced to sex "for his sake." After a while, she began to rebuff her husband's requests for frequent sexual intercourse. She was deeply hurt and insulted to discover that her husband had been having extramarital relationships and found consolation and encouragement with Paul. Miriam began to feel greater trust and affection for Paul although this was not accompanied by strong sexual feelings. She was mainly interested in someone she could trust and depend on to be faithful. Initially she had been sexually attracted to Paul's shyness and inexperience, and it felt good to be the experienced lover. However, this was short-lived and Paul's sexual problems began to trouble her as well. Miriam said that she could probably live without sexual intercourse, or at least without genital intercourse, which seemed to her to be "something for men," but added that intimacy and tenderness were very important to her.

To be continued . . .

ETIOLOGY AND DIAGNOSTIC ISSUES

There are a number of different psychological theories regarding the etiology of DE. Most of these models have been derived exclusively from clinical experience and thus suffer from a lack of empirical evidence. Due to the fact that nearly all sex therapists and even the larger centers specializing in

sexual medicine have access to only a limited number of DE patients, generalizations about DE are based on limited numbers of patients and almost no methodologically sound studies. Dekker (1993) pointed out that the scientific understanding of the psychophysiological processes involved in male orgasm is still too rudimentary to develop established theories of orgasmic dysfunctions. However, as a starting point and search mode for the diagnostic evaluation of DE patients, many of the existing psychological assumptions are still useful and are therefore listed in the following short overview. We first turn to some issues of more general importance for the etiology of male sexual problems and then focus on factors specific to DE.

General Psychological and Psychopathological Aspects of Male Sexuality Related to DE

While a comprehensive male sexual psychology is beyond the scope of this chapter, this section focuses on common developmental lines and problem spheres that, from a clinical perspective, constitute the backdrop of many male sexual dysfunctions.

Blocked Perception of the Inner World

Therapeutic work with sexually dysfunctional men is often difficult due to the fact that their relationship with their sexuality is marked by self-remoteness, which in turn, reflects the expression of a blocked perception of the inner world of thoughts and emotions. This tendency to externalize feelings, especially negative ones like fear or shame, explains why for many patients an organic explanation and a pharmacological treatment approach is more attractive than a psychological approach and psychotherapy or sex therapy. In first consultations, it is always quite impressive to learn what enormous emotional stress or dramatic life events a patient may have experienced that have a direct temporal connection with the emergence of his sexual dysfunction. However, many of these patients firmly refuse to acknowledge this connection, but rather believe that some unknown organic factor must have caused the problem. Many men believe that their sexual response can (and should) be automatic, which is a defense against their own vulnerabilities and needs. The individual basic conditions for a satisfying sexuality are blurred and their history reveals only rudimentary sexual competence at best.

This problem is associated with the characteristics of male development described in the previous section, which can cause a denial of inner processes and "inner genitality" (Schmauch, 1996) and which can be seen as the result of a male upbringing that basically consists of a process of toughening up and battling against physical and mental weakness. During adolescence this process continues in the form of rigid adjustment demands

exerted by peer groups. With the observable loss of traditional puberty in male adolescents, hitherto having served as a second chance for obtaining autonomy as a young adult (not only but especially in the sexual sphere), the young man is confronted with adult male responsibilities and role expectations without a proper transitional space, complicating the development of a viable access to the inner world.

Inhibition of Erotic Intentionality or Absence of an Erotic World

The loss of an erotic world, apart from the pressure to perform and the fear of failure, is the most significant problem of male sexuality. The differentiation of everyday reality from erotic reality is an extremely useful tool for the analysis, understanding, and treatment of male sexual problems (Davis, 1983). It is based on the fact that people who are engaged in sexual behavior or erotic imagery experience the world in a way that differs profoundly from the world experienced during everyday life. Sexual excitation changes our consciousness and our perception of the world and can be understood as a "reality-generating activity." Given this differentiation, most people live a divided life and experience the everyday world and the erotic world as clearly divided spheres. But the two worlds can mix: during boring tasks or under pressure erotic thoughts can suddenly appear. On the other hand, falling out of the erotic world can happen unintentionally, with one's thoughts going back to everyday problems. For many people crossing the border between these two worlds and sliding into the erotic reality is a problem. The step into the erotic world is experienced as dangerous or risky and cannot be permitted. Others love to live in the erotic world and will go there—in their imagination or in reality—whenever they can.

Using this concept for analyzing problems of male sexuality, it becomes apparent that our patients have difficulties with the relationship between everyday reality and erotic reality. Basically, many men, especially in long-lasting partnerships, would like to avoid entering the erotic world. Sexuality is "handled" in everyday reality—creating an erotic atmosphere or crossing the border between the two worlds is seen as unnecessary and exhausting. However, this phenomenon goes beyond pure convenience and extends the level of deep-rooted problems. In one group of sexually dysfunctional patients, it seems as if the inner erotic world has become impoverished and can no longer be employed for creating sexual excitement. The head is empty—everything has to be applied externally. Under the premises of this model, the increasing prevalence of male sexual desire and erection disorders—keeping in mind that erectile dysfunctions are essentially disorders of arousal—is at least partially based on the fact that there is no success in the erotic codification of stimuli or interactions. Actually, everything could be possible but nothing will work. There are no sparks—sexuality can no

longer provide a special kick because somehow the intensity needed to fuel the fire is missing. Certainly, the naturalistic modernization of sexuality, in a one-sided view often described as sexual liberation, has its part here. Its message that sexuality is no longer "a big deal" but only a pleasure or excitement like so many others has obviously weakened and not invigorated sexual motivation.

Another important factor that may contribute to the development of male sexual problems is the negative connotations associated with male sexuality associated with public discussion of sexual offences, violence against women, and sexual abuse. The identification of male sexuality as a problem, as a potential source of harassment, renders every frontier crossing, every identity change, a risk that cannot be taken—either consciously or unconsciously. No "walk on the wild side" anymore, but instead frozen ideals of harmony and mutuality. The attempt to destroy or to deny the aggressive facets inherent in sexuality leads to a "strangulation" of sexuality (Schorsch, 1989), to an erosion of the power and vitality of the sexual life. On an unconscious level, however, sexuality and aggression cannot be divided—a constellation that in the end results in the new "splittings" mentioned above. As a consequence, the subjective erotic world is in danger of becoming stunted and inaccessible—at least for the sexual partnership—although a kind of autosexual occupation with sexual fantasy, pornography, or Internet sex may still be possible for the man.

The factors and processes delineated above constitute the broader framework that translates into behavioral problems often encountered in clinical practice. Thus, many men with the problem of DE have not learned to make requests for their most arousing type of erotic stimulation, especially if they are used to automatic erectile functioning and not needing stimulation. Sex easily becomes mechanical and the couple loses the rhythm of giving and receiving pleasure-oriented touching. In these cases, many men develop secondary erectile dysfunction or avoidance behavior (McCarthy & McCarthy, 1998).

Psychological Concepts and the Etiology of DE

In her highly influential theorizing, Kaplan (1974, 1987, 1995) compared the etiology of DE with constipation or with blocked micturition, where vegetative reflexes, normally under voluntary control, can be inhibited by emotional arousal or psychological conflicts. This causes an automatic defense reaction, excessive control, and the inability to release the behavioral sequence. In Kaplan's experience, the causes of emotional arousal or the qualities of psychological conflict are nonspecific and it is therefore impossible to identify a specific etiologic constellation that would allow a clear differentiation of DE from other sexual disorders like erectile dysfunction. According to Kaplan, the man with an orgasmic inhibition unconsciously

holds back and tries to avoid the emergence of anxiety by increasing his control efforts whereas the man suffering from erectile dysfunction either totally avoids the unconsciously dangerous sexual encounter or, more often, is flooded by anxiety when his defense mechanisms fail. In both cases, a loss of erection results.

Other authors have tried to derive specific causes of DE from their clinical experience. Some of these assumptions refer to negative experiences like unwanted pregnancy, traumatic sexual experiences, or sexually transmitted diseases. Other assumptions focus on more immediate behavioral factors like deficient sexual stimulation, inhibitions about requests involving one's own sexual wishes and needs, the fear of getting caught while indulging in sexual activities, distorted attitudes and expectations, or learning deficits.

In contrast to other sexual dysfunctions, where immediate causes like fear of failure or spectatoring are considered the deciding factors by most sex therapists, most explanations of the causation of DE continue to draw on in-depth explanations claiming that deep-rooted conflicts or unconscious fears or fantasies play the key role for this dysfunction. The common final pathway of these factors is the irrational fear of ejaculating intravaginally. The wide array of possible conflicts and fantasies that has been described can only be briefly listed and assigned to some broader categories here.

- *Incest fears*: Psychosexual development has not been successfully completed and the oedipal constellation could not be solved constructively. On an unconscious level, every sexual intercourse is an incestuous situation draped with taboo, forbiddance, and the fear of punishment.
- *Castration fears*: Fear of castration is related to incest fears but can also have different sources, stemming partly from earlier developmental phases. Castration fears can be meant in the literal sense that the penis may get injured or damaged in the vagina ("vagina dentata"), but in most cases they can be understood in a broader sense as fears of self loss or fears of death (orgasm as "little death").
- *Fears of hurting the woman*: These fears are, in a sense, the counterpart to castration fears and are interpreted by psychoanalysis as a defense against castration fears. In this line of thinking, the penis acts as a dangerous weapon; sexual intercourse and especially orgasm and ejaculation are experienced by the man as very threatening and harmful for the woman. Here, as in other constellations, the symptom has a protective function, in this case for the woman.
- *Fears of loss of control*: The letting go, the altered consciousness, and the loss of control associated with orgasm are the source of strong fears. A lot of different factors can be involved, such as fear of embarrassment, shame due to a restrictive sexual upbringing, or conflicts resulting

from a masculine stereotype, where the man isn't allowed to show emotions and always has to be in control.

- *Hostility and anger*: According to these assumptions, men with DE exhibit marked feelings of hostility, anger, or rage toward women. These feelings can be traced to different sources related to unresolved conflicts from psychosexual development and can be hidden behind overtly caring and gentle behavior toward women.
- *Fear of sperm loss*: Some men have the conviction that every ejaculation entails a loss of vitality, causing an enormous weakening or even something worse, and that therefore, ejaculations should be avoided. In Western culture, this idea is probably of minor importance compared to Islamic or some Asian or African cultural groups.
- *Paraphilic impulses*: Periodic paraphilic impulses or a distinctive fixation on certain paraphilic stimuli or fantasies can basically be involved in every sexual dysfunction. However, some theories of the etiology of DE maintain that these factors are of particular importance in patients with DE. As sexual excitement is dependent on specific stimuli for these men, the sexual arousal possible in partner sex may be sufficient for reaching an erection (especially if paraphilic fantasies are used), but not for a coital orgasm.

It is easy to see that the majority of these concepts are highly speculative and hardly amenable to empirical verification. As a matter of fact, some of the available questionnaire studies indicated a higher degree of hostility and anxiety in patients with DE (Dekker, 1993). But these studies had significant methodical limitations and their results did not allow a clear interpretation regarding the cause and effect status of these characteristics.

From a more behavioral perspective, Perelman (1994) thinks that high-frequency masturbation plus idiosyncratic masturbatory techniques are among the most frequent causes of DE. He maintains that, in many cases, the man has conditioned himself to ejaculate only in response to a particular, often very vigorous, touch by his own hand on a particular spot of his penis. The result can be a completely conditioned sexual dysfunction (see the case of Paul and Miriam).

An innovative and distinctly original model of the causation of DE with important implications for the treatment of this disorder was developed by Apfelbaum (2000). Apfelbaum maintained that DE is essentially a subtle and specific desire and excitement problem, masked by a dysfunction. For Apfelbaum the most frequent form of coital orgasmic inhibition was a "partner anorgasmia," due to the fact that most DE patients experience difficulty in reaching a sexual climax only in the presence of a partner. Responsible for this partner anorgasmia is a phenomenon that Apfelbaum called the "autosexual orientation" of the man who can only allow and

relish his own masturbatory self-stimulation. The partner-related arousal and desire difficulty will be "masked" through the robust, automatic (or even "premature"), and prolonged erections of the patient. These erections, however, are not an expression of true sexual desire and sexual excitement, but are rather "desynchronized" and will primarily be used by the man to fulfill his partner's expectations. Apfelbaum offered no plausible explanation for this high grade of genital reactivity but disagreed with assumptions that men with DE harbor strong (conscious or unconscious) feelings of hostility or rejection against women. Instead, he saw these men as persons who are not able to be selfish enough, who cannot take care of their own needs and wishes, and who are unable to stand up for their own satisfaction. They live under the yoke of conscientiousness, of self-control, and of fulfilling their duties as well as under continuous pressure to satisfy and please the partner. Dominated by this omnipresent feeling of not being able to give enough, the man, through his sexual symptom, conveys the impression to his partner that she cannot do anything good for him, either. Her resigned withdrawal thus closes the circle of "autosexuality."

Apfelbaum's arousal-deficit model of DE could be confirmed by a recent psychophysiological study, as Rowland, Keeney, and Slob (2004) found that, regarding self-reported sexual arousal, men with DE indicated significantly lower levels than each of the other three groups: functional counterparts, men with ED, and men with PE. This factor, more than actual erectile response, appeared to characterize men with this dysfunction. The cause for this lower arousal was not explained in the study. Factors involved may include physiological ones such as low penile sensitivity and/or hyporesponsivity or elevated threshold of the ejaculatory reflex, as well as the psychological ones described above. Again, cause and effect relationships between psychological or relationship factors and self-reported sexual arousal remained elusive. We return to Apfelbaum's approach in the treatment section.

Diagnostic and Differential Diagnostic Aspects

The evaluation of psychological factors in patients with DE does not substantially differ from the usual diagnostic procedures established for sexual dysfunctions. The symptomatology must be clarified by means of a detailed sexual history, preferably with inclusion of the partner, which forms the basis of a proper diagnostic classification including the usual formal criteria like lifelong versus acquired, and situational versus global.

The main goal of the diagnostic assessment is to determine the conditions under which orgasms are possible or impossible for the individual patient. As usual, the level of immediate, here-and-now causative factors should be explored first, through a detailed analysis of the patient's thoughts and feelings during sexual encounters. Important aspects include:

- What are his "start conditions"? Does he experience enormous pressure to succeed right from the beginning or does this pressure emerge later during intercourse?
- What is his degree of spectatoring?
- What is the relationship between subjective sexual arousal and penile erection?
- Does he want and receive sexual stimulation from his partner?
- Are there sexual fantasies and can they be used without feelings of guilt?
- Can the patient monitor his own feelings and emotions during the sexual contact with his partner or is he totally focused on satisfying her?
- Does he have the feeling that his partner becomes frustrated, bored, or annoyed during prolonged intercourse or that she is doing it "just for his sake" (mercy sex)?
- Are there apprehensions in connection with the experience of orgasm/ejaculation or with the loss of control of which the patient is aware?
- Can the partner achieve a coital orgasm, and if so, how quickly?
- Does the patient continue intercourse after his partner's orgasm?

Another focal point to be addressed during the evaluation process relates to how the patient masturbates. Again, the inner processes, the masturbatory technique, and especially the erotic imagery involved should be explored. Are there sexual fantasies (possibly paraphilic) about which the patient feels conflicted and which he tries to suppress?

Examination at the level of immediate causes is followed by an evaluation of more deep-rooted intrapsychic or dyadic variables. Given the low degree of specificity of these factors, the clinician should consider the above-mentioned categories and scrutinize them in a comprehensive manner. It should be determined if feelings of anger or hostility toward the partner can be identified or if they should be interpreted as a sign of more fundamental conflicts. In most cases, hypotheses can be derived from sexual history, which may then be assessed more closely by targeted questioning. However, these psychodynamically complex issues, predominantly unconscious to the patient, often are revealed only in the course of a longer therapeutic process. Therefore, the investigator should not try to enforce rapid clarification.

In terms of differential diagnosis, DE causes no particular problems. Attention should be paid to differentiating DE from ED, since some men lose their erection and don't ejaculate and may regard this as ejaculatory inability. As with all sexual dysfunctions, it should be determined if DE is secondary to a psychiatric illness (depression, anxiety disorder, obsessive–compulsive disorder) or is caused by drugs or medication (see below).

NEUROBIOLOGY OF LIFELONG DE

In the last two decades, the results of animal research have contributed to a greater understanding of the neurobiology of ejaculation. Studies with male rats have shown that a cluster of specific areas and pathways in the central nervous system (the brain, brainstem, and lumbosacral spinal cord) is highly specialized in mediating ejaculation (Baum & Everitt, 1992; Coolen, Peters, & Veening, 1996; de Jong et al., 2005). Numerous animal studies have shown that an increased serotonergic neurotransmission in the synapse between neurons leads to DE (Ahlenius & Larsson, 1984; Foreman, Hall, & Love, 1992). Moreover, activation of specific serotonin (5-hydroxytryptamine [5-HT]) receptors by 5-HT molecules leads to either rapid ejaculation or DE. For example, activation of 5-HT_{2C} postsynaptic receptors gives rise to DE, whereas activation of 5-HT_{1A} postsynaptic receptors facilitates ejaculation.

Recently, our group developed an animal model for both premature ejaculation (PE) and DE (Pattij et al., 2005). Like humans (Waldinger et al., 2005), where a biological continuum of intravaginal ejaculation latency time (IELT) has been found in a random cohort of men in the general population, male rats can be matched in homogenous groups of individuals that persistently display sluggish, normal, or rapid ejaculation (Pattij et al., 1995; Waldinger & Olivier, 2005). Remarkably, it appeared that sluggish-ejaculating rats fail to get an ejaculation after many penile thrusts and show a stable pattern of DE from their first sexual encounters with a female rat. As this resembles basic characteristics of men with lifelong DE, further research in this subgroup of rats may lead to more insights in the neurobiological background of lifelong DE in men.

Drug Treatment of Lifelong DE

Currently there are no drug treatment for lifelong DE. Based on animal data, a potential ejaculation-facilitating drug might be a selective 5-HT_{1A} receptor stimulating agent. However, there are no such drugs for safe human use available. Other pharmacological options might consist of compounds that activate dopamine receptors, oxytocin receptors, or noradrenaline receptors. However, no well-controlled studies with these drugs for DE have been published yet.

NEUROBIOLOGY OF ACQUIRED DE

In cases of acquired DE one should always look for both psychological and somatic factors that may cause the dysfunction. Many medications (SSRIs, tricyclic antidepressants, antipsychotics, alpha-sympathicolytics) as well as

alcohol (either directly during acute consumption or chronically) can impair ejaculation through central and peripheral mechanisms. A moderate but acceptable delay in ejaculation occurs with aging. Androgen deficiency, traumatic or surgical spinal injuries with damage to the lumbar sympathetic ganglia and the connecting nerves, abdominoperineal surgery, lumbar sympathectomy, and neurodegenerative disorders may lead to delay or failure of ejaculation.

Somatic Treatment of Acquired DE

If medications are responsible for acquired DE, one should try to switch the ejaculation-delaying drug to one that has less or preferably no such effect. However, this is not always possible. In case of androgen deficiency, further investigations into the cause and treatment are indicated. In case of damage to vital nerves, the chance for spontaneous recovery is small and this should be explained to the patient.

CASE ILLUSTRATION: PAUL AND MIRIAM, PART 2—THE COURSE OF SEX THERAPY

Phase 1: Paul—Progress and Obstacles

Due to the deep-rooted and complex nature of Paul and Miriam's psychosexual problems, an integrative therapy plan was constructed in which pharmacotherapy and sex therapy interventions were combined. Initially, the classical sex therapy sensate focus exercises were recommended to reduce the mutual avoidance behavior and revitalize the intimacy and physical contact. At the explicit wish of the couple, a PDE5 inhibitor was temporarily administered to improve Paul's erection problems and to relieve the fear of failure. Paul's main problem, his inability to reach orgasm in the presence of Miriam, was then treated with a program of gentle desensitization and a gradual approach. It was arranged that if any resistance or blocking occurred, the deeper intrapsychic and dyadic conflicts would be focused on and, if necessary, dealt with, possibly in individual one-on-one sessions. In the initial phase of therapy the couple had great difficulty becoming comfortable with the sensate focus exercises. Strong resistance and avoidance behavior emerged, mainly from Paul, who, despite thorough instruction, could not let go of his massive fear of failure and performance anxiety. As Paul also avoided intimacy and physical contact, and Miriam perceived Paul as "disinterested" and "bored" when he petted her during their rare sensate focus exercises, Miriam began to feel disappointed and angry. The avoidance behavior and Paul's petting problems with Miriam were primarily based on anxiety and were dealt with successfully in therapy. Paul also agreed to reduce his masturbation frequency and to alter his

masturbatory pattern. He was advised to use massage oil and to stimulate the penis softly with his hand. Paul was also asked to practice a kind of monitoring of his sexual arousal, during masturbation as well as during partner contact, using an inner scale from 1 to 10.

In the following sessions, Paul and Miriam reported success with the sensate focus exercises. They enjoyed the affectionate touching and intimacy and were eager to move on to more erotic touching and penile insertion. This was also accomplished without great difficulty, although stronger inner resistance and intrapsychic conflict became more evident in both partners. Paul displayed some aversion toward Miriam's genitals, which made it difficult for him to stimulate her. In addition to his inexperience, his underdeveloped knowledge of the anatomy and physiology of the female genitals made his stroking awkward and clumsy, and he was unable to give Miriam pleasure. Hence, an "exploratory tour" was arranged, in which Miriam was to show Paul how and where she would like to be touched. The "dosage" of this exercise was, however, left up to Paul, who was instructed to pay careful attention to his feelings and his personal limits, and not to overtax himself.

Miriam, on the other hand, found it easy to be active and the "giver" in these exercises, but found it difficult and unpleasant to be passive and be stimulated by Paul. She also reported how embarrassing it was to her to be seen as sexually aroused. At the same time, she said that she was increasingly angry that Paul seemed to be counting on her to take the initiative and to pamper him.

The assigned exercises, especially the examination and stimulation of Miriam's genitalia, were problematic for Paul. Miriam became impatient and angry and accused Paul of "only thinking of his penis" and of being egoistic and self-centered. Paul reacted to Miriam's accusations with concern and accepted all blame. It turned out that Paul was basically a very emotional and "soft" person who easily cried in emotional situations. For this reason his father had accused him of being a "crybaby" and "no real man," which affected Paul deeply. He had taken it upon himself to become a tough, "rugged" guy who did not let his feelings show. He was now only gradually managing to show more of his feelings to Miriam, and sometimes to take the initiative sexually and pamper her. In this phase of the therapy, after completing Sensate Focus I and II, the couple asked to have pharmacotherapy for the erectile dysfunction. It was Miriam especially who hoped that Paul's fear of failure during their sexual contact would diminish and that both would be relieved of sexual anxiety. The PDE5 inhibitor administered (vardenafil) had a good effect on Paul immediately. He reliably achieved good, long-lasting erections. The feeling of being able to count on obtaining and maintaining his erections and possibly ejaculating was a completely new experience for Paul; it motivated him and relieved him of many of his fears. Miriam too appeared relieved by the improve-

ment in Paul's erection problems and was able to enjoy her own sexual feelings with less inhibition. Both appeared quite impatient about tackling the "final problem" of Paul's DE.

A program of slow desensitization and gradual approach was agreed upon, in which Paul initially learned to reach orgasm by manual self stimulation. After that, Miriam was to participate in the stimulation more actively before these new experiences were attempted in intercourse. The classical sex therapy procedure for DE was applied, in combination with Apfelbaum's approach. This involved dealing with several aspects of Paul's experience, including his attitude toward sexuality in general, his own and Miriam's expectations of a man's sexual performance, and his attitude toward control and loss of control.

A hierarchy of stages was set up, in which the first stage was Paul stimulating himself manually to the point of orgasm with Miriam in the next room. In the second stage the door to the next room was left open, while in the third stage Miriam was present in the room. During the first stage Paul experienced substantial problems, as he found it embarrassing that Miriam knew he was stimulating himself. This strong distraction made the buildup of sexual arousal difficult. The therapy sessions revealed that Paul's parents did not tolerate any privacy or intimacy and disregarded Paul's personal boundaries. He was allowed to neither lock his bedroom nor the bathroom door, and when he did it, he heard cynical remarks ("no one wants to take your penis away from you"). Paul only masturbated in the highest secrecy, as fast as possible, in constant fear of being discovered, and without actually touching his penis. It was a big problem for him to "do away with" the ejaculate without being noticed. However, he was still certain that his parents "knew about him," which caused intense shame. Miriam's patience and caring along with working through these early experiences in therapy helped Paul successfully progress through the first three stages of the desensitization hierarchy. Not every time, but increasingly often, he managed to reach orgasm. However, transferring this progress to sexual intercourse proved difficult, as Paul regularly reverted to his old performance anxiety and fear of failure during coitus. This distracted him and he tensed up, and then, despite his attenuated sexual excitement, he tried to reach orgasm anyway with great mental and physical effort. Around this time, Miriam and Paul came to a session with the news of Miriam's pregnancy.

Phase 2: Miriam—Inhibited Sexual Desire, Sexual Abuse, and Trauma Therapy

Miriam had pursued her pressing desire for children parallel to the therapy. She did not want to wait until Paul was capable of intravaginal orgasm, and she was sure that she was not capable of becoming pregnant easily, so

she had contacted a center for reproductive medicine. Several attempts at a homologue insemination were ineffective, but an *in vitro* fertilization finally produced the desired results. Although the difficulty of resolving the ejaculatory problem at the same time that Miriam was pregnant was discussed, Miriam was not prepared to give up her plans. She promised Paul that she would definitely participate in treatment until his problems were solved. Paul was ambivalent toward the fertility treatment as well as toward the pregnancy. He was looking forward to the child on the one hand, but was afraid that Miriam would lose interest in sex therapy and that the child would become the exclusive center of attention.

Miriam did cooperate with the therapy, but her sympathy for and patience with Paul's DE declined considerably, as did the frequency of sexual contacts. The subsequent increase in Paul's tension lead to a stagnation of the sexual progress, which made Paul angry at Miriam, especially concerning her expectation that he should "finally start to function properly." The following therapy sessions focused on the expectations, disappointments, and attitudes of both partners, which meant that the sexual symptom was temporarily put aside. It turned out that Paul and Miriam both felt strong shame about being visible to the other during orgasm. Various therapeutic interventions aimed at this problem were developed for the couple to try. In alternation, one of the two was to look at the other quite consciously during coitus and give feedback on how attractive it looked to be immersed in sexual pleasure and arousal. A second intervention involved play-acting a "film orgasm" that was quite exaggerated and theatrical, like the performances in pornographic films. Both interventions proved to be very difficult for the couple. Strong resistance and avoidance was provoked and Paul did not achieve any substantial progress in his DE symptomatology. In consideration of the approaching birth of the child, the therapy was interrupted for several months.

Some time after the birth of their son, Ben, Miriam and Paul returned to continue the therapy. Both were now very happy as parents. Paul's doubts about Miriam's motivation to continue working in therapy appeared to be justified, although not in the same way that Paul might have expected. Once during sexual intercourse, Miriam had a flashback of her childhood sexual trauma, and the memory of this past event suddenly resurfaced. She reported that she felt like a "chunk of meat" being abused by a man, or perpetrator. She "outed" herself to Paul and confessed that she had in fact never desired sexual contact and that everything she had done had been for his sake and to avoid jeopardizing the relationship. She was now no longer prepared nor able to continue, but rather had come to see that she needed to process these traumatic experiences in order to get in touch with her own sexuality. Paul reacted to Miriam's statements with concern and helplessness. He tried to empathize, understand, and to respect her feelings. It was obvious that Miriam's sexual abuse could not be

dealt with in the context of the sex therapy, so the couple therapy was interrupted, and Miriam began seeing a female psychotherapist, who then referred her to a specialist in trauma therapy. Using eye movement desensitization and retraining, the traumatic experiences (the perpetrator was a former partner of her mother who was now dead) were uncovered and made accessible to conscious processing. Miriam was psychologically unstable for a long period of time and distanced herself from Paul. She could no longer imagine living together with him nor, by any means, having sexual relations with him. Finally she decided to break up with him.

To be continued . . .

SEX THERAPY FOR DE

In their review of empirically validated treatment for sexual dysfunction, Heiman and Meston (1997) bluntly concluded that "inadequate data" on the topic of delayed orgasm in men prevented any conclusion regarding treatment efficacy for this disorder. Although there are no large-scale controlled-outcome studies of a standardized treatment regime for DE patients, a variety of psychotherapeutic techniques have been suggested, many on a purely anecdotal basis. In first-generation sex therapy, the decisive treatment approaches and interventions were derived from the basic assumptions underlying these models, which were delineated in the etiology section of this chapter. Two antithetical points of view for understanding and treating DE have evolved: the inhibition model and a desire deficit model (Segraves & Althof, 2002).

Classic Models for the Treatment of DE

The Inhibition Approach

In the inhibition model, advocated by the founders of classic sex therapy like Masters and Johnson (1970) and Kaplan (1974), two different explanations and starting points for therapy can be distinguished. One, which is more behaviorally oriented, assumes that the man is not receiving enough or adequate stimulation to reach the orgasmic threshold, which may be increased for unspecified reasons. As a matter of fact, it would be more appropriate to classify this line of thinking as an "inadequate stimulation approach" rather than an inhibition approach. In contrast, psychodynamically oriented approaches claim that the symptom can be traced back to an inhibition of the orgasmic capacity as a conscious or unconscious expression of the man's deep-rooted underlying conflicts centered on aggression and hostility toward women. In her dual-level model of immediate and deep-rooted causes of DE, Kaplan tried to combine both concepts, propos-

ing that in all cases immediate behavioral factors like inadequate stimulation or fear of failure are operative and that sometimes, but not in all cases, they are caused by more profound psychodynamic conflicts. According to these different models, treatment efforts either aim to increase sexual arousal through prolonged, intense stimulation or by interpreting the man's unconscious impulses and defense mechanisms or by a flexible combination of both.

The Desire-Deficit Model

In the desire-deficit model developed by Apfelbaum (2000), ejaculatory inhibition is seen as an excitement and desire disorder disguised as a performance disorder. In this view, intense and goal-oriented stimulation is regarded as a demanding, coercive strategy that is bound to heighten rather than decrease performance anxiety. Apfelbaum argued vehemently against what he understands as an almost "aggressive attack" against the symptom and as an enforcement of coital orgasm for any price and he explicitly links this critique to the therapeutic principles proposed by Kaplan (1974, 1987). In Apfelbaum's view, the arousal and desire deficits masked by the ejaculatory dysfunction should not be therapeutically "bypassed" or attacked with intense stimulation but must be uncovered and clarified, and the man must be encouraged to be aware of and take the responsibility for his refusal to achieve coital orgasms. The term "counterbypassing" was coined by Apfelbaum for this therapeutic technique. Generally, treatment is aimed at having the man acknowledge his lack of desire to have intercourse and his lack of arousal during intercourse. As most DE patients have the conviction that they are withholding the "correct function" from their partner and should be more giving, attitude changes and reinterpretations of common myths and distorted beliefs surrounding this dysfunction comprise a central component of this treatment approach.

Are the Two Models Really Antithetical?

It is beyond doubt that Apfelbaum's thinking has expanded our understanding of the phenomenon of DE and has given us a new frame of reference for evaluating and treating these patients. He showed us that the sustained erections of the delayed ejaculator cannot be taken as a sign of subjective arousal but can instead mask a subtle desire and excitement deficit that is partner specific in a number of cases. He warned us against a "furor therapeuticus" one-sidedly aimed at "forcing" the patient to become coitally orgasmic at all costs. In addition, he pointed the finger at other problems of the inhibition model and opened new horizons for our thinking.

On the other hand, there are a number of problems inherent in Apfelbaum's approach, both on theoretical and practical grounds. In our

view, his model is based on the analysis of one subtype of patients with DE and his conclusions are hardly transferable to other subtypes that are characterized by more pronounced signs of psychopathology, differing in its nuances and origin. In a significant percentage of patients with DE, we encounter (more or less attenuated) features of obsessive–compulsive disorders, affective disorders, anxiety disorders, paraphilias, or various personality disorders (see case of Paul and Miriam). For these men, their DE is indeed the expression of inhibited arousal and desire with respect to sexual intercourse or partner sex. However, this desire deficit is embedded in a more profound intrapsychic or interpersonal psychopathology that has to be adequately addressed, regardless of the treatment concept advocated by the individual therapist.

In addition, it is highly questionable whether the *key diagnostic sign* of DE is "that only the patient's own touch is erotically arousing, and his basic sexual orientation is 'autosexual' (masturbatory) rather than heterosexual or homosexual" (Apfelbaum, 2000). While it is true that many patients with DE exhibit an idiosyncratic masturbatory pattern, it is not in agreement with our clinical experience that these patients "invariably report enjoying masturbation more than sex with a partner." Instead, they are simply more successful in reaching orgasm through masturbation, often their only way to reach an orgasm at all. Therefore, the term "autosexual" does not seem to be appropriate for them since their behavior can be better understood as a creative form of compensation and does not constitute a true sexual orientation. As a matter of fact, these men long to experience their full orgasmic capacity together with their partner and feel pressured by this wish rather than by their partner or by some external standard prescribing coital orgasms as the ultimate goal.

From a practical perspective, the main goal of sex therapy in Apfelbaum's approach is to encourage the man to openly express his feelings, to focus his awareness on his lack of subjective arousal, and to overcome the performance demands. To achieve these goals, the therapist triggers or gives new interpretations to convictions commonly found in patients with DE and their partners. With this strategy that in our view is basically a "reframing approach," the therapist tries to pave the way for a new kind of sexual experience. However, we do not share Apfelbaum's optimism that "typically it is possible to establish the basic insights in an hour or two" as the effect of reinterpretations may be impressive on a cognitive level but simultaneously tends to be limited by more deep-rooted psychodynamic or dyadic factors, especially in cases where unconscious conflicts are operative. Another limitation relates to the fact that in his therapies Apfelbaum usually employed his body work concept with specially trained surrogate partners as co-therapists. While this approach may have had particular advantages for patients with DE, its principles are probably not easily transferable to other, more conventional settings.

Overall, for understanding and treating DE the inhibition model represented by Kaplan and Apfelbaum's desire deficit or reframing approach do not seem to be antithetical. In clinical practice with real-life patients both have their place, depending on the individual case or subtype of DE as well as on the stage of the treatment process. In his pointed comments on Kaplan's approach, Apfelbaum's critique seems excessive in some respects. For instance, it is unclear why a prudently planned guided stimulation technique should be "by far [the] most aggressive attack on a symptom to be found in the field of sex therapy" or why therapeutic interventions aimed at maximizing arousal and minimizing inhibition should constitute a "coercive demand strategy." Ironically, by his pronounced arguing against Kaplan's theorizing, Apfelbaum remains constantly associated with her work and is not able to really transcend the boundaries of first-generation sex therapy. In our view, both concepts reflect a part of the truth, and Apfelbaum and Kaplan seem to have focused basically on two different sides of the same conflict inherent to the phenomenon of DE: while Kaplan mainly looked upon the drive side (aggression, hostility, unconscious forces), Apfelbaum mainly considered the defense side (feelings of guilt, control, excessive giving tendencies). As a matter of fact, both concepts can be reconciled and both sides have to be integrated to get a full picture and the therapist should have command of a broad repertoire of treatment interventions that, beyond all ideological ditches, have to be tailored to the specific needs of the individual patient. Therefore, in the following section we try to leave the two traditional approaches behind and describe those strategies and interventions that have proven to be useful in treating patients with DE problems.

CASE ILLUSTRATION: PAUL AND MIRIAM, PART 3—THE COURSE OF SEX THERAPY

Phase 3: Miriam and Paul—Separation, Reunification, Achievements, and Unfulfilled Hopes

Paul was surprised and shocked by Miriam's decision, but soon adjusted to the new reality. It was his goal to solve his sexual problem of DE, if need be without Miriam, and promptly went in search of a new partner. He met Yasmin through a "lonely hearts" advertisement. She was a divorced woman his age who quickly fell in love with him. Paul described Yasmin in comparison to Miriam as much softer and gentler. He said that she expected less and pressured him less during sex than Miriam had. However, it became clear that he still had strong feelings for Miriam and missed her greatly. Paul did not have any erection problems with Yasmin and did not need to use a PDE5 inhibitor at all. He could reach a climax after a certain amount of time by manual or oral stimulation, although only in the dark.

Once after a party, when both were slightly inebriated, Yasmin stimulated Paul orally and then inserted his penis quickly into her vagina. For the first time in his life, Paul ejaculated intravaginally. Although he was very pleased, this experience was not the long-awaited breakthrough, and the DE was not completely resolved. Following this, Paul could almost always ejaculate after manual or oral stimulation, but only rarely during intercourse. As Yasmin was satisfied, Paul did not seem to pay much attention to the remaining DE either.

After several months of separation, it became clear to Miriam that she wanted to return to Paul. She tried hard to regain Paul's affection, and finally she succeeded in getting him to break up with Yasmin. The couple reunited, but after an initial euphoric phase, the old problems reemerged. Paul felt more pressure with Miriam than he had with Yasmin, and he could not ejaculate during intercourse with her. His ability to maintain an erection also deteriorated. Miriam emphasized that she no longer minded Paul's sexual problems, but she was also no longer prepared to go along with his wishes, such as his clothing fetish. Instead, she recommenced her trauma therapy, as she was convinced that she still had not unearthed all of the details of the traumatic events in her past. She became active in supporting sexually abused women and founded an antistalking group. Her sexual desire declined continually, and she often rebuffed Paul's initiatives. She left therapy and Paul also decided to discontinue therapy. In the final sessions, the various aspects of his sexual dysfunction were analyzed again, and the psychodynamic and biographical features became clear to him, as did the relationship and interactional factors. He talked about his relationship with Miriam quite pessimistically, but felt quite sure of himself and well enough equipped to be able to enjoy his sexuality and to overcome his DE.

In a follow-up session a year after the end of therapy, Paul reported that he and Miriam had truly ended their relationship. Miriam had met another man and Paul was currently seeking a new partner.

Commentary

The case of Paul and Miriam is not atypical of a multiple-modality treatment in a more complex multiple etiologic case of DE. It is also a good example of a case where it is hard to decide whether DE treatment was a success or a failure. Regarding the symptom itself, advances and limitations seem to be counterbalanced: Paul learned to ejaculate in the presence of a partner and was even able to ejaculate intravaginally, but not with Miriam and only under specific, not easily reproducible circumstances. He also succeeded in overcoming his erection problems, first with and then without the aid of pharmacotherapy. On the other hand, the achievements concerning his ejaculatory dysfunction remained fragile and unreliable, highly de-

pendent on the specific conditions of the sexual situation encountered by Paul.

The case of Paul and Miriam also exemplifies that the partner's intrapsychic conflicts may be evoked by the man's improvement and by the fact that a female partner might feel that she has to "service" her husband. In both partners, the sexual dysfunction (Paul) or the intrapsychic conflicts (Miriam) could be traced to traumatic experiences that proved to be much more severe for Miriam. As a consequence, the relationship was burdened by unresolved conflicts and deep-rooted wounds in both partners.

Paul and Miriam's case indicates that the prognosis for DE is related to its severity (including whether it is primary or secondary) and to the existence of concomitant individual psychopathology and dyadic discord. It also demonstrates the possible benefit of combining sex therapy with pharmacotherapy, which enabled Paul to overcome his erectile problems, thus opening the way for addressing his DE.

A PRACTICE GUIDE TO USEFUL TREATMENT INTERVENTIONS FOR DE

Guided Stimulation Techniques

As noted earlier in this chapter, DE represents an involuntary and unconscious conditioned inhibition. As with other psychosomatic disorders the ultimate goal of treatment is the extinction of this inhibitory process or the "inhibition of the inhibition." In patients with DE, guided stimulation techniques aim at distracting the man from his excessive control and increasing the stimulation necessary for achieving orgasm during partnered sexual activities generally and sexual intercourse specifically. In terms of behavioral treatment, there are two basic principles and techniques: *in vivo* desensitization aimed at intravaginal ejaculation, starting out from the existing individual sexual arousal and ejaculatory capacity, together with guided stimulation using tactile genital play and fantasy to distract the man from his fears of failure and abandonment.

In working out the individual hierarchy the specific inhibitory factors have to be identified and subsequently modified gradually and systematically. To this end, the couple is instructed to perform a series of sexual tasks designed to desensitize the patient step by step. Thus, from his initial orgasmic capacity, the behavior is gradually shaped toward the goal of intravaginal ejaculatory competence. During this process, the level of sexual arousal should be closely monitored by the patient. With more effective physical stimulation and with the help of erotic fantasies, subjective arousal should increase. The man should be helped to relinquish his need for control and the compulsive urge to achieve orgasm. The desensitization process has to be flexible and creative: if initially the patient is only able to

reach an orgasm in the absence of his partner, the patient is asked to stimulate himself while his partner is not at home. The next step could be that the partner is somewhere in the house or in the apartment, then in an adjoining room. All steps are planned and analyzed with the couple, to whom the therapeutic purpose is made completely transparent. If the initial desensitization hierarchy is successful, individual intermediate steps are planned until orgasm is possible in the partner's presence and finally during sexual intercourse. As an adjunct, the so-called bridging maneuver can be employed, a technique commonly used for treating female orgasmic disorder (Kaplan 1975). The patient will be manually or orally stimulated by his partner until he is close to climaxing; then the penis is promptly inserted into the vagina, where the orgasm is experienced. If necessary, the sexual arousal can be further enhanced with additional stimulation of the penis shaft or testicles.

It is important, that the patient is given permission to freely enjoy his sexual arousal and to create, together with his partner, his "ideal conditions." To reach that goal, the man is instructed to be "selfish" in experimenting with his sexual wishes and to "use" his partner only for this purpose. In doing this, the patient should observe trigger points for his orgasm for later transference to other situations. Another important principle is that the patient should engage in sexual intercourse only when he is sufficiently aroused, independent of his erection. If destructive cognitions return, he should talk about them with his partner or distract himself with fantasies to avoid reverting to a state of inhibition. Sometimes paradoxical interventions can be of great help, like "forbidding" the patient to achieve a climax during intercourse.

Sex therapy involves a combination of psychotherapeutic modalities, preferably in the format of a conjoint therapy, combined with specifically structured sexual experiences. In a number of DE cases, underlying conflicts, especially unconscious dyadic or interpersonal ones, must be explored. If hostile or aggressive impulses are involved, patients may harbor strong feelings of guilt and exhibit rigid defense mechanisms that must be explored and dealt with. Therapy should foster the patient's insight into his fears, past traumatic experiences, or the destructive partner interactions reinforcing his dysfunction. Treatment cannot follow a preconceived routine but must be continuously adapted to the patient's specific needs.

Reframing and Attitude Change

Reframing approaches, mainly represented by Apfelbaum, have been described earlier. Generally, treatment is aimed at having the man acknowledge his lack of desire for coitus and lack of arousal during intercourse and partnered sexual activities. As most patients with DE believe they are withholding "correct functioning" from their partner and think they should be

more giving, attitude changes and reinterpretations of common myths and distorted beliefs comprise a central component of this treatment approach. Apfelbaum recommends transferring the principles used for the treatment of female orgasmic inhibition to its male counterpart to make the patient aware of his unconscious "refusal" without "overdriving" him therapeutically. The symptom's reinterpretation of a (unconsciously motivated) "inability to give" into a developmentally understandable "inability to take" combined with a therapeutic focus on the man's strong conscientiousness, perfectionism, and excessive control are central steps in this treatment approach. In this view, the patient with DE is a classic example of someone who is unable to take, to be selfish, or to have coital orgasms for himself, which is one important reason for his overcontrol. The patient's sexual mind-set is to satisfy his partner. Becoming quickly erect, the man usually does not ask for additional stimulation and thus maintains the same low to moderate arousal level, blocking the erotic flow toward higher levels of arousal and orgasm.

According to Apfelbaum, the interpretation that the patient is desperately trying to achieve an orgasm "for his partner" is helpful and opens up new therapeutic opportunities. An important treatment technique is the continuous monitoring of the level of subjective sexual arousal to make it clear to the patient that his subjective arousal (despite good erections) is not adequate, thus improving the probability that the possibilities of increasing the stimulation can be better and more coherently integrated in the therapeutic interventions.

As many partners share the man's belief system and most partners take their man's ejaculatory unresponsiveness as rejection, the reframing interventions have to include the partner and should be custom-fitted to her attitudes and expectations. It is especially helpful to introduce the idea that the patient is trying "too hard" to have an orgasm for his partner, which in most cases eases the tension and enables the woman to be more tolerant and less demanding.

Cognitive-Behavioral Interventions

To some extent, cognitive-behavioral approaches like the ones put forward by McCarthy and McCarthy (1998) or Perelman (2001, 2004) have already combined a number of basic features of both the inhibition and the reframing concepts. From his analysis of a larger group of patients with DE, Perelman (2004) highlighted two factors as predisposing toward and/or maintaining DE: high-frequency idiosyncratic masturbatory patterns and a disparity between the man's inner world of erotic imagery and the actual sexuality with his partner. For overcoming this disparity, the man or, preferably, the couple is instructed to integrate masturbation fantasies into

their sexual interactions, thus reducing guilt and increasing the likelihood of orgasm. Perelman recommends a simple technique for making the man aware of and eventually changing his problematic masturbatory style: the man is instructed to switch hands while masturbating. This immediately makes him more aware of exactly what types of and what intensity of stimulation he needs to become aroused and reach orgasm. The man is thus able to see that, if his own left hand could not produce an orgasm, it is no surprise that his partners have also failed.

In their refined treatment approach for DE patients, McCarthy and McCarthy (1998) employ a wide array of psychotherapeutic techniques. From a cognitive-behavioral vantage point, the basic therapeutic strategy is to identify inhibitions and fears and develop sexual scenarios and techniques to overcome them. While some can be mastered or modified so they no longer interfere with the erotic flow, others have to be accepted and worked around. The principal behavioral change strategies are to increase erotic stimulation and identify and use orgasm triggers. However, interventions targeting cognitions or changes in attitude are at least equally important. The man is encouraged to ask his partner for increased intimacy and eroticism. Cognitive-behavioral treatment strategies involve a three-part combination: (1) being an intimate sexual team, (2) comfort with pleasuring, and (3) increased erotic stimulation.

1. If the couple manages to work as an intimate team, the performance pressure on the man will be significantly reduced. Mutual involvement in the cycle of pleasuring is the key factor in the increased verbal and physical intimacy that can overcome inhibition and sexual isolation.

2. For those patients who automatically get erections, the erection may erroneously signify readiness for intercourse, even if the level of subjective arousal is too low. The major treatment strategy is to give support and permission to enjoy pleasure and view ejaculation as a natural culmination of arousal. It is a gradual process of encouraging the man to be direct in requesting stimulation and experiencing and savoring erotic feelings. By gaining confidence and being more "selfish," he will experience more intense levels of subjective sexual arousal culminating in orgasm.

3. The two key techniques are multiple stimulation and being aware of orgasm triggers. Examples of multiple stimulation include using fantasy during partner sex, testicle stimulation during intercourse, stimulating the partner's breast or anal area during intercourse. Orgasm triggers are highly individualistic and can be identified during masturbation. Depending on the individual case, the goal of intravaginal ejaculation must be approached in a stepwise manner. Patients are instructed not to initiate intercourse until they are highly aroused. Fantasies can be a bridge to heighten arousal.

Systemic Strategies

Systemic approaches can add some effective components to the treatment repertoire for DE. In a systemic perspective there are no techniques or assignments but only "tools" that the therapist should have at his or her disposal.

Clarifying the Therapy Goals and the Client's Objectives

In considering the goals of therapy, clients should be asked to consider "what's at stake," that is, what are the consequences for each partner if the symptom disappears, and what are the consequences if it lingers. Subtle and latent fears are often connected to the elimination of the symptom: What would happen if the man was no longer sexually "handicapped" by his DE? Would he want to "catch up" on lost experience? Would he cheat on his partner? Addressing questions such these is not just important, but can also be very enlivening for the therapeutic process as it helps to develop and particularize future scenarios in a lively way and thus promotes change. The therapist needs to be aware of contradictory objectives from the couple and must not be swayed to adopt just one of the partners' positions on change.

Testing Possible Sexual Realities

For a sexual problem as stubborn and unyielding as DE, it is important that the therapist understand the couple's "erotic framework." Typically, couples wish to have their sexual problem removed by a "microsurgical procedure" that does not affect the foundations of the relationship or the personalities of the partners. An effective way of bringing the couple out of their cozy, but also insipid and boring comfort zone is to make their erotic scripts more fluent and dynamic. The gentle elucidation of their erotic dark area can enable both partners to develop their own sexual profile and to discover each other in a new way. In patients with DE, it is especially apparent that an exaggerated consideration for the partner serves as a way of veiling one's own lack of courage toward one's sexual fears. In some cases, traumatic experiences and emotional barriers would lead to a hesitancy to risk intimacy or to a loss of access to one's self. Changing the focus from the couple's interpersonal conflicts to each partner's intrapsychic conflicts and fears can be helpful.

The process of discovering possible erotic worlds will almost always lead to defensive reactions, fears, and the activation of unconscious guilt. In these phases it is important that the therapist adopt an emotional holding function to provide the couple with a safety net. The key question here should be: Which of your own (sexual) fears have been sheltered by your partner's sexual problems?

A very effective therapeutic tool in this context is the "ideal sexual scenario" (ISS) described in detail by Clement (2004). It serves to make available to the therapeutic process the sexual profile and the already accessible erotic potential of both partners, as well as the unlived, or underlying potential that cannot be accessed by simple questions. For this approach, each partner is instructed to imagine being completely egoistic in sex, without having to be considerate of the other. Which script of an ideal sexual encounter trimmed to one's own individual needs would each partner create? This ideal scenario, containing ample detail and less concerned with feelings than concrete actions, should be written on a piece of paper and enclosed in an envelope. Initially one's partner does not find out what was written down. The envelope is brought to the next session, but it is up to each individual to open it or not. The exercise can also be extended in such a way that each partner is asked to write down what he or she imagines might be in the other's ISS.

Even more significant than the content of each ISS is the way each partner approaches this exercise, since it reveals the dramaturgy of sexuality in the relationship and its concealed fears. While some couples can not bear the "secret" of the envelopes, and, contrary to instruction, show each other the scenarios before the next session, other couples prefer never to open the envelopes at all. Still other couples compose an obviously rosy plot devoted to tenderness and mutuality and maintain that all possible needs are already satisfied by the present sexual relationship and that no "exotic" desires exist beyond them. According to our experience, the ISS provides abundant links to further therapeutic work and is particularly useful for the treatment of couples affected by DE.

TOWARD AN INTEGRATED TREATMENT OF DE

Lifelong or chronic delayed ejaculation remains one of the least prevalent and least understood of all the sexual disorders and confronts both researchers and clinicians with many unresolved problems. With respect to research issues, both neurobiological and psychological factors play a role in the etiology and pathogenesis of DE. However, much remains to be known about why men differ so dramatically in ejaculatory latency or why men capable of ejaculating with masturbation are unable to ejaculate intravaginally. Both the neurobiological vulnerability and the biographical, psychodynamic, or interpersonal factors responsible for this dysfunction need to be elucidated in future studies on larger samples. It should be noted that any neurobiological vulnerability may, in turn, be the result of psychological or environmental stress factors that negatively interfered with the development of the neural circuitries necessary for successful ejaculation in a specific phase of brain plasticity. Therefore, only an integration of

psychosocial and neuroscientific research methods will pave the way to a better understanding of this disorder.

DE is certainly challenging to clinicians. The case history described in this chapter is typical of a complex multiple etiologic case of DE and illustrates the need for a multiple-modality treatment approach. Although ejaculation in male rats can be facilitated by certain compounds, it does not automatically follow that these drugs will have the same effect in patients with DE. Overall, treatment of DE should reflect an integrated approach combining pharmacotherapy and sex therapy and addressing medical, intrapsychic, and interpersonal contributions.

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CHAPTER 10

Erectile Dysfunction

Integration of Medical and Psychological Approaches

RAYMOND C. ROSEN

Erectile dysfunction (ED) continues to be one of the most common and distressing of male sexual complaints. As Rosen points out in this chapter, ED is highly prevalent among aging men, with approximately 50% of men older than 60 voicing complaints about the quality or reliability of their erections. However, it is younger middle-aged men who are more likely to seek treatment and often, their first stop is their primary care physician rather than a sex therapist. Often, though, they find their way to a mental health clinician when treatment is less than successful.

There have been significant changes in the assessment and management of ED since the first publication of this book. Nowadays, the three major PDE5 inhibitors—tadalafil, sildenafil, and vardenafil (Cialis, Viagra, and Levitra)—are often first-line treatments, despite the fact that there are often other critical issues that may thwart the successful use of these medications. As Rosen acknowledges, although PDE5 inhibitors are generally safe and well tolerated, they may prove ineffective if significant relationship issues, desire deficits, partner sexual dysfunctions, or other medical conditions are ignored. In fact, the dropout and discontinuation rates with medical treatment of ED are quite high. Successful outcome in clinical trials obscures the fact that participants in these trials have been screened to rule out depression or major relationship issues. Nevertheless, oral medications often prove an extremely helpful adjunct to the treatment of erectile disorders.

Comprehensive assessment of the medical, psychological, and relationship factors contributing to the genesis of ED is often neglected when men are seen in a busy primary care practice. Determining whether the erectile problems are situational or generalized, lifelong or acquired is important as well as interviewing the man alone and with his partner. Evaluation of *patient factors* such as performance anxiety or sexual inhibition, *partner factors* such as low self-esteem or dysfunction, *relationship quality and satisfaction*, and *contextual issues* such as financial or extended family stresses sheds light on variables that may need to be addressed in treatment.

Increased genital tactile stimulation is often a critical ingredient in achieving good erections and this becomes especially important when treating older men. Often, a female partner is unaware of the physiological necessity of direct stimulation and may misattribute a man's lack of erection to sexual disinterest or her loss of sexual appeal. At the same time, menopausal or sexual desire and arousal problems may interfere with a partner's sexual responsivity or receptivity. It is for this reason that it is so important to assess individually and together the patient with ED and his partner.

Given the aging of the population, ED problems will certainly be encountered by anyone engaged in the practice of sexual medicine. As Rosen points out, practice patterns have changed dramatically over the last decade. While medical intervention with PDE5 inhibitors has revolutionized the treatment of ED, the most successful outcome is likely to result with an integrated or combined treatment approach, regardless of the specific etiology of the problem. Sex therapy interventions, relationship emphasis, and sensitivity to psychological issues of the man and his partner all contribute to positive overall treatment satisfaction.

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Erectile dysfunction (ED) is among the most common sexual problems in men, affecting more than half of all men above the age of 50, including married and single men, professional and working-class men. It is associated with a wide array of medical and psychological risk factors and consequences and can have negative, or even in some cases devastating effects on a man's self-esteem, quality of life, and partner relationship. Recent epidemiological studies have highlighted the association between ED and broader indices of cardiovascular health and psychological well-being, suggesting that ED may be an early marker for cardiovascular and other disease states (Thompson et al., 2005; Rosen, Wing, Schneider, & Gendrano, 2005). At the same time, the availability of safe and effective oral therapies has led to a dramatic increase in the number of men seeking treatment. It is estimated that there are currently 25–30 million men worldwide taking PDE5 inhibitors, and an additional 50 million or more who are potential candidates for treatment.

The first large-scale, community-based studies of ED were reported in the early 1990s in the United States. These studies included the Massachusetts Male Aging Study (MMAS; see Feldman et al., 1994), Olmstead County Study of Urinary Symptoms and Health Status (Panser et al., 1995), and National Health and Social Life Survey (NHSLS; Laumann, Gagnon, Michael, & Michaels, 1994). These well-known U.S. studies laid the foundation for current epidemiological concepts and findings in this area. All three studies observed a strong effect of aging on ED, using different measurement and sampling approaches. The presence of medical comorbidities, particularly cardiovascular disease and depression, was also identified as predictive of ED in each of these studies (Rosen et al., 2005).

The NHSLS included in-depth sexual behavior interviews with a nationally representative sample of men and women (N = 1,749 women; 1,410 men) in the United States ages 18–59 (Laumann et al., 1994). A single-item question was used to evaluate the presence or absence of sexual problems (e.g., "Which of the following problems have you had for several months or more during the past year?"). Erectile dysfunction was defined as difficulty achieving or maintaining erection, and ranged from 7% of men under the age of 30 to 18% of men older than 50. ED was significantly related to overall health, and was strongly associated with both emotional stress and a history of urinary problems, for example, lower urinary tract symptoms (LUTS). Unfortunately, the absence of men older than 60 in the sample limits the assessment of aging effects and related comorbidities (Laumann, Paik, & Rosen, 1999).

Evidence from these and other epidemiological studies supports several broad observations (Rosen et al., 2005):

1. ED is highly prevalent in aging men, affecting approximately 50% of all men older than 60. For many men, ED first manifests in their 40s and 50s, but increases markedly in frequency and severity after age 60.
2. The degree of bother associated with ED is inversely related to aging, as men older than 70 typically report a lesser degree of bother than their younger counterparts. Consequently, distress and treatment seeking are usually higher in younger and middle-aged men.
3. The prevalence and incidence of ED are highly correlated with the presence of known risk factors and comorbidities. In particular, cardiovascular comorbidities (e.g., hypertension, hypercholesterolemia), diabetes mellitus, and the metabolic syndrome have all been associated with ED in multiple cross-sectional and longitudinal studies. Most recently, depression and LUTS have been added to the list of significant medical comorbidities and risk factors.
4. Lifestyle factors, including smoking, obesity, and exercise, are also significant predictors of ED.

5. A complex and often interactive set of variables and determinants can lead to ED, as illustrated by the case vignette below.

Bill K is a 49-year-old married stockbroker with a history of coronary artery disease and recent coronary bypass surgery. He has been married for the past 18 years and reports a satisfying sexual relationship with his wife for most of their relationship. The patient complains of increasing erection difficulties and loss of libido since undergoing coronary bypass surgery 2 years ago. He is currently maintained on cholesterol-lowering and antihypertensive medications, in addition to intermittent use of benzodiazepines for anxiety. He reports increasing marital distress and is concerned that his wife may be having an affair with a colleague at work. The patient has experienced moderate success in achieving erection with sildenafil (100 mg), but has not attempted sexual intercourse with his wife for several months. His sexual desire is markedly reduced and he notes that his wife is avoiding him sexually and emotionally. The patient feels anxious and helpless about his situation.

THE VIAGRA REVOLUTION AND BEYOND: NEW TREATMENT CHOICES AND OPTIONS

Major changes have taken place in the clinical management of ED since approval of sildenafil (Viagra) and two other PDE5 inhibitors, tadalafil and vardenafil (Cialis and Levitra) since 1998 (Rosen & McKenna, 2002; Rosen, 2005). The approval and availability of these three landmark drugs has greatly increased the number of men seeking treatment for their condition, and has significantly altered the medical and psychological management of the disorder. Historically the province of urologists and sex therapists, ED is now managed predominantly by primary care practitioners. Costly and potentially invasive diagnostic procedures, such as penile cavernosography or cavernosometry, once the mainstay of urologic assessment of ED, are seldom performed nowadays. Nocturnal penile tumescence (NPT) testing, another common procedure of the 1980s and early 1990s, is infrequently recommended. Instead, new management guidelines emphasize the need for a brief sexual and medical history, physical examination, and standard laboratory tests to rule out diabetes, dyslipidemia, or hypogonadism (Lue et al., 2004). Specialized diagnostic testing is reserved for more complicated or treatment-resistant cases. In reality, most middle-aged men with ED receive a prescription for Viagra, Cialis, or Levitra with little or no psychological evaluation. Further diagnostic studies are usually reserved for those patients who fail to respond to an initial trial of a PDE5 inhibitor (Lue et al., 2004).

Despite these important benefits, some disadvantages and risks associ-

ated with the widespread use of sildenafil have been identified. Although PDE5 inhibitors are generally safe and well tolerated, there may be specific medical risks for selected subpopulations. For example, concomitant nitrate use is a strong contraindication for all three current PDE5 inhibitors. Patients with high-risk cardiac conditions (e.g., unstable angina, recent heart attack) may be at risk for sexual activity, although PDE5 use per se is not contraindicated in these patients (DeBusk et al., 2000; Kostis et al., 2005). Patients with sickle-cell disease or those using other erectogenic agents (e.g., intracorporal injections) may be at risk for priapism. Due to sildenafil's effects on phosphodiesterase enzymes in the eye, patients with ophthalmological disorders (e.g., retinitis pigmentosa or NAION) should be carefully evaluated prior to treatment with PDE5 inhibitors. Given the enormous numbers of individuals now using sildenafil, and likely increases in these numbers in the near future, there may be unanticipated medical risks in selected subgroups of users. As increasing numbers of prescriptions for PDE5 inhibitors are obtained via the Internet, there are also risks associated with a lack of adequate medical screening or supervision in these individuals.

While all three PDE5 inhibitors are effective in restoring erections in about 75% of men who use the drugs, differences have been observed in patient preferences or the pattern of side effects associated with the drugs. Some studies have suggested that sildenafil (Viagra) or vardenafil (Levitra) may be associated with a firmer or more satisfying erection, whereas other studies have suggested that tadalafil (Cialis) is preferred by many patients due to the longer-lasting effects of the drug. One recent study, in particular, showed that the majority of patients preferred tadalafil due to the increased sense of spontaneity and reduced time pressure with this drug compared to sildenafil (Dean et al., 2005). Further studies are needed to confirm this finding.

From a psychological or interpersonal perspective, PDE5 inhibitors may facilitate better erections in the male but fail to address key individual or couple issues (Althof et al., 2005; Leiblum, 2002; Perelman, 2005). At times, use of oral medications serves only to reveal or highlight other sexual problems, such as lack of sexual desire or premature ejaculation. Sexual problems in the partner or other couple issues may come to light following successful (or unsuccessful) use of oral medications (Rosen, 2000). One follow-up study of patients being treated with sildenafil found that about one-fourth of the sample were unable to sustain initial improvements with the drug (Pallas, Levine, Althof, & Risen, 1999). Many of these individuals appeared to have difficulty in resuming or maintaining an active sexual relationship.

Despite the efficacy and overall safety of PDE5 inhibitors (Padma-Nathan, 2003; Rosen & McKenna, 2002), increasing evidence suggests that a substantial proportion of men with ED discontinue treatment or fail

to seek help. A recent large-scale, multinational study of more than 25,000 men in eight countries (MALES) found that 58% of men with erection problems had discussed their problem with a health professional, although fewer than half of these men received a prescription for sildenafil or other medication, and only 16% were continuing to use the drug at the time of the study (Rosen et al., 2004). Multiple reasons were cited for the high rate of discontinuation, including lack of education or counseling from physicians, fear of side effects, partner concerns, and distrust of medications. Failed expectations may be another important reason for patient dropout from medical therapy, as many men or their partners are disappointed at the lack of change in the quality of the sexual relationship. For these reasons, the importance of combined medical and psychological treatment approaches has been emphasized.

Leiblum (2002), Perelman (2005), and others have noted additionally that success rates with PDE5 inhibitors may be significantly lower in couples for whom there has been chronic sexual or marital conflict, lack of desire in one or both partners, or significant psychiatric illness in either partner. These individuals are generally excluded from clinical trials of sildenafil, and the efficacy of the drug in such cases is essentially unknown. PDE5s may also lose efficacy over time due to other factors, such as progression of the underlying disease state or development of tolerance to the pharmacological effects of the drug (El-Galley, Rutland, Talic, Keane, & Clark, 2001). Several authors have recommended combined use of sildenafil and sex or marital therapy interventions, particular in cases of low desire, sexual initiation difficulties, or the presence of other sexual dysfunctions in either partner (Weeks & Gambescia, 2000; Perelman, 2005). Large-scale trials of combination drug and sex therapy have not been performed to date. Despite their overall effectiveness in restoring erectile function for many men, PDE5 inhibitors should not be regarded as a panacea or "magic bullet" for achieving sexual happiness.

At a societal level, positive and negative consequences have also been noted (Rosen & McKenna, 2002). On the one hand, the availability of PDE5 inhibitors has legitimized sexual dysfunction as an appropriate topic for medical assessment and intervention. Many millions of men with ED have been encouraged to acknowledge their sexual problem and to seek medical help. The large majority of these individuals have experienced the benefits of improved erection with the use of one of the three drugs. Physicians and other health care providers have been made aware of the prevalence of sexual problems and the potential benefits of screening and diagnosis. And the public at large has received an unprecedented amount of new information about male and female sexual function. On the other hand, some authors have raised concerns about potential risks associated with the "medicalization" of male sexuality and the increasing role of the pharmaceutical industry in this area (Bancroft, 2002). There are also in-

creasing reports of recreational uses of PDE5 inhibitors, often in combination with other drugs of abuse (e.g., methamphetamines, cocaine), although there are no good estimates currently of the use of the drug in this context (Swearingen & Klausner, 2005). It is also uncertain to what degree PDE5 inhibitors are capable of improving sexual function in otherwise healthy or functional individuals.

Whereas current management guidelines recommend sex or marital therapy (Althof et al., 2005) or the use of vacuum pump devices (VCDs) as alternative first-line therapies, these are far less widely used at present. The simplicity and ease of use of an oral medication are major advantages, particularly for primary care physicians with little training or interest in the management of sexual dysfunction. Referral to a sex therapist or mental health professional is likely to occur only when requested, when couple or psychological issues present a major obstacle to treatment, or when oral medications fail. Referrals for other urological treatments (e.g., intracorporal injection, penile implant surgery) are similarly reserved mostly for oral therapy failures nowadays.

Wincze and Carey (2001) have noted that health care providers continue to address ED and other sexual problems based on a "false dichotomization" of sexual dysfunction into organic and psychogenic classifications. It is assumed if there are mostly organic factors present, as in the case vignette above, that a medical model is preferred. In contrast, Wincze and Carey have argued recently that in most cases, including those with organic factors, an integrated management approach is preferable. This integrated treatment approach should be used since "even when the etiology is clearly organic, the best solution may be partly or completely psychological in nature" (p. 162). Other authors have similarly recommended more extensive use of a combined or integrated model of treatment for both organic and psychogenic factors in ED (Weeks & Gambescia, 2000; Leiblum, 2002; Perelman, 2005).

DIAGNOSIS AND CLASSIFICATION

Diagnosis of ED has historically been based on the self-reported ability of the man to achieve and maintain erection sufficient for sexual performance (Lue et al., 2004; Hatzichristou et al., 2004). The disorder is further classified as organic or psychogenic, based on the presence of specific organic factors, including vascular, hormonal, or neurogenic determinants. If these factors are present to a significant degree, and if the patient's history is suggestive of a temporal association between onset of symptoms and the patient's medical condition, an organic diagnosis is suggested. Psychogenic ED has traditionally been used as a diagnosis of exclusion, which may be given in the absence of specific organic factors.

TABLE 10.1. Classification of Psychogenic Erectile Dysfunction

I. Generalized type
  A. Generalized unresponsiveness
    1. Primary lack of sexual arousability
    2. Aging-related decline in sexual arousability
  B. Generalized inhibition
    1. Chronic disorder of sexual intimacy
II. Situational type
  A. Partner related
    1. Lack of arousability in specific relationship
    2. Lack of arousability due to sexual object preference
    3. High central inhibition due to partner conflict or threat
  B. Performance related
    1. Associated with other sexual dysfunction(s) (e.g., rapid ejaculation)
    2. Situational performance anxiety (e.g., fear of failure)
  C. Psychological distress or adjustment related
    1. Associated with negative mood state (e.g., depression) or major life stress (e.g., death of partner)

An expanded classification system for psychogenic ED has been proposed (Lissa & Rosen, 1999) (see Table 10.1). This proposed classification is intended to broaden the previously limited focus of psychogenic ED, particularly in regard to the potential role of inhibitory or excitatory factors. The proposed typology incorporates both clinical features (i.e., generalized vs. situational ED) and hypothesized etiological mechanisms (i.e., central excitation vs. inhibition) of psychogenic dysfunction. This new classification is intended to broaden the scope and depth of psychological assessment in sexual dysfunction treatment.

In addition to the clinical subtypes of generalized versus situational, psychogenic erectile dysfunction should be characterized as lifelong (primary) or acquired (secondary). Primary psychogenic ED refers to the lifelong inability to achieve successful sexual performance, while secondary psychogenic ED occurs after a period of satisfactory sexual performance. Primary psychogenic ED is relatively rare and is usually associated with a chronic pattern of sexual or interpersonal inhibition. Psychogenic ED may also be classified as secondary to substance abuse disorder (e.g., alcoholism) or another psychiatric disorder (e.g., depression, generalized anxiety disorder).

Additionally, it is important to include the presence of other male sexual dysfunction in the diagnosis. For example, recent studies have suggested that up to 30% of men with ED also report symptoms of premature ejaculation (Fisher et al., 2004). Rapid or premature ejaculation may develop as a secondary response to psychogenic ED or may precede the erection difficulty in some cases. In either event, the diagnosis should reflect

the presence of concomitant ejaculatory and erection difficulty. In older men, it is not uncommon for men with ED to report loss of orgasm and ejaculation, as well as decreased sexual desire (Rosen et al., 2004). Again, these concomitant or comorbid symptoms of sexual dysfunction should be included in the diagnosis.

PATIENT EVALUATION IN THE POST-VIAGRA ERA

Along with new treatment approaches for ED, fundamental changes have occurred in the clinical assessment and evaluation of the disorder. Due in large part to the increasing management of ED by primary care physicians, in addition to the widespread use of PDE5 inhibitors, little attention is paid nowadays to detailed sexual history taking or the use of specialized diagnostic testing (e.g., nocturnal penile tumescence, penile cavernosography). Medical and psychological testing for ED, once the mainstay of the diagnostic approach, are rarely used in most settings. Instead, focused symptom evaluation, along with the use of brief screening questionnaires such as the International Index of Erectile Function (Rosen et al., 2004), is the preferred approach in most primary care settings. In fact, s*elf-report of sexual symptoms is the cornerstone of ED assessment at the present time* (Hatzichristou et al., 2004). Although partner assessment is acknowledged as also important in most clinical guidelines and recommendations, partners are seldom included in the clinical evaluation in most medical settings.

Given the strong evidence of an association between ED and various medical risk factors (e.g., diabetes, coronary artery disease), recent guidelines have emphasized the importance of a comprehensive medical history and physical examination for all men with ED (Lue et al., 2004). Specific guidelines for the medical evaluation of men with ED were recently published by the 2nd International Consultation on Sexual Dysfunction in Men and Women. According to these guidelines, the first step in the process is a detailed sexual and medical history. History taking should be aimed at characterizing the severity, onset, and duration of the problem and evaluating the need for specialized testing. A physical examination and selected laboratory testing should be performed on all patients with complaints of ED. Although this screening is not different from a routine physical examination, special emphasis is placed on review of genitourinary, endocrine, vascular, and neurologic systems. The physical examination may corroborate aspects of the medical history (e.g., poor peripheral circulation) and may occasionally reveal unsuspected physical findings (e.g., Peyronie's plaques, small testes, prostate cancer). The physical examination also provides an opportunity for patient education and reassurance regarding normal genital anatomy (Lue et al., 2004).

Selective laboratory testing is recommended in all cases. This includes

investigation of the hypothalamic-pituitary-gonadal axis via assessment of androgenic status, particularly if sexual desire is reduced. There is disagreement about the relative value of the various testosterone assays, including total, free, and bioavailable testosterone. However, strong consensus exists that at least one of these assays should be performed (Lue et al., 2004; Rosen et al., 2004). Standard serum chemistries, complete blood count (CBC), and lipid profiles may be of value and should be obtained if not performed in the past year. Finally, a serum PSA test should be performed, based upon the patient's age and relative risk status.

Specialized diagnostic procedures, such as nocturnal penile tumescence and rigidity (NPTR) testing or other specialized vascular or neurologic procedures, may play a role in selected cases. For example, these procedures may be of value in evaluating young patients with pelvic or penile trauma who may be candidates for reconstructive vascular surgery. Patients with complicated diabetes or other endocrinopathies may benefit from further endocrinologic studies. Patients with a history of cardiac disease or significant cardiovascular risk factors should be evaluated for potential cardiac risk associated with sexual activity. Consensus guidelines have recently been established for evaluating cardiac risks associated with sexual activity (Debusk et al., 2000; Kostis et al., 2005).

Results of the initial evaluation and specialized testing should be carefully reviewed with the patient and patient's partner, if possible, prior to initiating therapy. Potentially modifiable risk factors, such as cigarette smoking or alcohol abuse, should be addressed. Prescription drugs such as antihypertensives or antidepressants may be implicated in the patient's erectile difficulties and should be altered when medically indicated. Patients with specific endocrine deficiencies such as hypogonadism should be placed on hormone replacement therapy prior to initiation of direct therapies for erectile dysfunction. Additionally, sexual problems in the partner, such as a lack of lubrication, hypoactive sexual desire, or dyspareunia (painful intercourse), should be addressed. Patients and partners should be fully informed about the range of treatment options available, and the risks and benefits associated with each should be addressed.

Over and above the standards for medical evaluation of ED, several authors have recommended a combined medical/psychological approach to evaluation in all cases (Weeks & Gambescia, 2000; Wincze & Carey, 2001). An integrated approach to assessment has also been proposed by Althof et al. (2005), based on their comprehensive review of psychological and interpersonal factors in ED. Included in their model are the need for assessment of (1) patient factors, such as performance anxiety or sexual inhibition; (2) partner issues, such as low self-esteem or sexual performance problems; (3) quality of the overall relationship; and (4) sexual and contextual variables, such as financial stresses and family dysfunction. Each of

these fours areas should ideally be addressed in every case and treatment strategies initiated in each area as indicated.

PSYCHOLOGICAL FACTORS IN ED

Psychological determinants of ED have traditionally been divided into immediate and remote factors (Kaplan, 1974; Rosen & Leiblum, 1995). Immediate factors include performance anxiety or fear of failure, lack of adequate stimulation, and relationship conflicts. Performance anxiety has been emphasized as a specific cause of psychogenic ED in patients with or without medical illness (Rosen, Leiblum, & Spector, 1994; Rosen & Leiblum, 1995). As described first by Masters and Johnson (1970), performance anxiety includes the adoption of a "spectator role" in which the individual's attention is focused predominantly on sexual performance and away from erotic stimulation. This cognitive distraction from sexually arousing cues was viewed by Masters and Johnson as central to arousal difficulties in both sexes and formed the basis of their "sensate focus" approach to treatment. Among the remote or early developmental causes of arousal disorders, various authors have emphasized the role of childhood sexual trauma, sexual identity or orientation issues, unresolved partner or parental attachments, and religious or cultural taboos.

Cognitive components are important to consider in all cases of ED (Wincze & Carey, 2001; Althof & Leiblum, 2005). In considering the role of cognitive or attitudinal factors, traditional male attitudes to sexuality need to be considered. Men with erectile difficulties (and their partners) are often resistant to psychological explanations or interventions. As noted by Zilbergeld (1992), men with ED typically experience both shame and guilt in association with their sexual dysfunction, and organic explanations of the disorder are obviously more appealing. Thus patients frequently present with the request: "Tell me it's not all in my head, Doc!" For this reason, most men (and their partners) are more likely to accept a referral for psychological or couple counseling when it is combined with medical treatment for the disorder (Rosen, 2002). This attitude may be responsible, in part, for the large initial success of oral medications for ED. However, the high discontinuation rates may be reflective of unaddressed psychological or interpersonal issues (Rosen et al., 2004).

Several laboratory studies have specifically addressed the role of cognitive factors and anxiety in psychogenic ED. For example, some studies have shown that increasing the intensity of distracting stimuli presented in conjunction with erotic stimulation markedly reduces sexual arousal in both men and women. Furthermore, the effects of anxiety on sexual arousal in men have been shown to be mediated largely by the effects of cognitive factors. Overall, studies in this area suggest that it is

not anxiety per se that is responsible for initiating or maintaining sexual arousal difficulties; rather it is the alterations in perceptual and attentional processes that occur in sexually dysfunctional men and women. This is an interesting psychological observation, which may help to explain the lack of long-term success in some men using PDE5 inhibitors (Rosen et al., 2004).

Bancroft and Janssen (2000) have proposed a new theoretical model for understanding psychogenic factors in ED. Psychogenic arousal in men, they propose, depends upon a delicate balance between central excitatory and inhibitory mechanisms. Based upon laboratory and questionnaire studies, two partially independent inhibitory factors have been identified. These include (1) performance anxiety, and (2) fear of negative consequences. Whereas excessive inhibition may be associated with erectile or other sexual dysfunctions, insufficient inhibition alone could lead to development of high-risk sexual behaviors. Other authors, such as Byrne (1994), have proposed that erotophobia (aversion or fear of sexual experience) or erotophilia (attraction to sexual experience) underlie the personality dimension of male sexual dysfunction.

Along with individual psychological factors, couple and relationship issues have been associated with ED by many authors (Rosen & Leiblum, 1992; Althof & Leiblum, 2005). Communication difficulties, lack of intimacy or trust, and power conflicts are common causes or concomitants of sexual arousal difficulties in both sexes. Loss of sexual attraction has also been implicated in some studies. Relationship conflicts may be a consequence as well as a cause of ED for many couples.

The role of sexual stimulation is another important area to be addressed, particularly for older couples (Rosen, 2005; Perelman, 2005). With aging, most men require increased physical and mental stimulation in order to achieve adequate erection. This aspect of normal aging may not be understood or appreciated by the patient, his partner, or the health care provider. Increased genital stimulation may be necessary for some men to achieve an adequate erection and may augment the effects of pharmacological therapy (Rosen, 2005). Among older men, in particular, there is an increasing need for direct, tactile stimulation of the penis, along with a decreasing responsiveness to psychogenic forms of stimulation. Thus, the older male may require extended manual or oral stimulation of the penis in order to achieve adequate erection for intercourse. The female partner is frequently unaware of this important physiological change in her partner, and may misattribute his lack of arousal to sexual disinterest or her loss of sexual attractiveness to her partner. When informed of the need for change in this area, older couples frequently have difficulty in modifying or adapting their traditional sexual script. Many of these couples have minimal experience of foreplay or nonintercourse forms of sexual stimulation (Perelman, 2005).

PSYCHOLOGICAL/SEX THERAPY APPROACHES

Traditional sex therapy approaches to ED have typically emphasized four major areas of intervention: (1) anxiety reduction and desensitization; (2) cognitive-behavioral interventions; (3) increased sexual stimulation; and (4) interpersonal assertiveness and couple communication training. A fifth component of relapse prevention has also been advocated by some therapists (McCarthy, 1993; Wincze & Carey, 2001). Although various studies have supported the use of one or more of these interventions in the treatment of psychologically based erectile difficulties, few studies have attempted to isolate the effects of individual treatment components or to evaluate the long-term outcomes associated with psychological treatment (Mohr & Beutler, 1990; Hawton, Catalan, & Fagg, 1992; Althof & Leiblum, 2005). Additionally, planned comparisons of the effectiveness of psychological treatment with medical or surgical interventions have been lacking, as have studies of the cost-effectiveness or impact of treatment on health-related quality of life (Spilker, 1990). Of note, one recent study of a PDE5 inhibitor (vardenafil) for treatment of ED in middle-aged men in stable partner relationships showed marked improvements in aspects of both the female partner's sexual function and overall relationship satisfaction (Fisher et al., 2005).

In contrast, men with erectile difficulties (and their partners) are often resistant to psychological or sex therapy interventions due to the potential implication that the problem is "all in his head," or that the male is purposely avoiding sexual intimacy. As noted by Zilbergeld (1992), men with ED usually experience both shame and guilt in association with their sexual dysfunction, and organic explanations of the disorder are obviously appealing. For this reason, it is frequently necessary to "bypass" the male's resistance by stressing the value of psychological or sex therapy interventions for the partner relationship. Also, as noted earlier, some men are more likely to accept psychological treatments when they are combined with medical treatments (Perelman, 2005; Rosen, Leiblum, & Spector, 1994).

Anxiety Reduction and Desensitization

Anxiety reduction techniques have historically been a central feature of psychological treatment approaches for ED. For example, the concept of forbidding intercourse and directing the male and his partner in techniques of nondemand body caressing (*in vivo* desensitization) can be traced back to the writings of an 18th century British physician, Dr. John Hunter (LoPiccolo, 1992). This technique was the forerunner of the "sensate focus" approach subsequently developed by Masters and Johnson (1970), which served as the foundation of their sex therapy program for ED. Early

behavior therapists, such as Wolpe (1958) and Lazarus (1965), similarly emphasized the importance of systematic desensitization in overcoming performance anxiety and inhibitions typically associated with erectile dysfunction. These authors also recommended the use of relaxation techniques and avoidance of intercourse during the early phases of treatment. Masters and Johnson (1970) coined the term "spectatoring" to refer to cognitive aspects of performance anxiety. They viewed performance anxiety as the major determinant of all forms of sexual dysfunction, including erectile dysfunction, and developed the "sensate focus" exercises as a form of *in vivo* desensitization and means to overcome or neutralize the effects of performance anxiety in the man with ED. Despite its widespread adoption, the effectiveness of this approach has not been adequately evaluated in controlled, prospective studies.

Based upon psychophysiological studies of males with ED compared to nondysfunctional controls, Barlow and associates have suggested that it is not anxiety per se that is responsible for the psychological component of erectile dysfunction, but the associated effects of cognitive distraction (Barlow, Sakheim, & Beck, 1983; Cranston-Cuebas & Barlow, 1990). In fact, laboratory manipulations of both anxiety and performance demand were found to increase sexual arousal in nondysfunctional males, whereas opposite effects were obtained for the dysfunctional subjects. Focusing on arousal, in particular, was found to facilitate performance in controls, but to be highly inhibitory in the dysfunctional subjects. Similarly, subjective arousal was rated as significantly lower in dysfunctional subjects, regardless of the actual physiological level of arousal. Finally, attention to nonsexual stimuli (i.e., cognitive distraction) was found to be more disruptive to nondysfunctional compared to dysfunctional men (Cranston-Cuebas & Barlow, 1990). Taken together, these findings suggest that physiological concomitants of anxiety may be less important than the effects of performance demand or cognitive distraction in males with ED. Clearly, it is important for sex therapy treatment approaches to focus on the cognitive aspects of performance anxiety (Rosen, Leiblum, & Spector, 1994).

Relaxation-based approaches that fail to address cognitive aspects may not achieve the desired effects. For example, LoPiccolo (1992) argued that sensate focus may represent a form of paradoxical intervention. While the therapist assigns sensate focus with the intention of relieving performance anxiety, many patients do not experience a reduction in such anxiety; rather they experience "metaperformance anxiety," or anxiety about not performing despite the injunction not to feel pressure to perform. This effect is illustrated in the self-report of a typical patient receiving sensate focus therapy: "I found myself lying there, thinking, 'I'm now free of pressure to perform. I'm not supposed to get an erection, and we're not allowed to have intercourse even if I do get one. So now that all the pressure

is off, why am I not getting an erection? I'm relaxed, I'm enjoying this, so where's the erection?' " (LoPiccolo, 1992, p. 189).

According to this perspective, it is insufficient to assign sensate focus or relaxation exercises in the face of highly internalized performance demands. Rather, the focus of therapy should be on confronting the source of these performance demands via cognitive or psychoeducational interventions (Apfelbaum, 1995; Rosen, Leiblum, & Spector, 1993).

Cognitive-Behavioral Interventions

Cognitive interventions are used increasingly in the psychological treatment of erectile dysfunction. In particular, bibliotherapy and cognitive restructuring techniques are used to overcome sexual ignorance and to challenge the unrealistic sexual expectations that typically accompany ED (Wincze & Carey, 2001). Men (and their partners) frequently harbor gross misconceptions regarding the basic mechanisms and processes of erectile function, and the causes of sexual dysfunction. The effects of illness and drugs, aging, and male–female differences in sexual response are additional common areas of ignorance. As noted by Zilbergeld (1992), men frequently subscribe to a "fantasy model of sex," in which male performance is viewed as the cornerstone of every sexual experience, and a firm erection is seen as the sine qua non of a satisfying sexual encounter. Sexual performance difficulties are often interpreted, according to this view, as a loss of masculinity or declining sexual interest in the partner.

Dysfunctional sexual beliefs and expectations are a potentially important focus for treatment. In an early study, elderly couples with a history of erectile dysfunction were randomly assigned to either an educational workshop program or a waiting-list control group (Goldman & Carroll, 1990). Posttreatment evaluations revealed a significant improvement in sexual knowledge and attitudes in the workshop participants, which was associated with increased sexual frequency and satisfaction. Educational interventions have recently been combined with medical therapies (Perelman, 2005), although the specific benefits of this combined approach need to be further evaluated.

Self-hypnosis and fantasy training procedures have been recommended in the past for overcoming psychogenic ED (Brown & Chaves, 1980; Araoz, 1983), although these approaches are less widely used currently. Other authors have recommended that positive imagery training, either with or without masturbation, can assist in the development of sexual confidence and control (Rosen, Leiblum, & Spector, 1993; Zilbergeld, 1993). Again, these fantasy and masturbation exercises can be combined with use of oral medications, and clinicians frequently recommend use of PDE5 inhibitors initially with masturbation or fantasy to develop familiarity and

comfort with the use of the drugs. On the other hand, Apfelbaum (2000) has cautioned that while sexual fantasies may be used by dysfunctional males to temporarily "bypass" a lack of arousal or interest in their partner, this solution is unlikely to remain effective, and may lead to a loss of sexual desire when used on a long-term basis.

Sexual Stimulation Techniques

It has often been noted that ED is most psychologically distressing for individuals or couples with limited sexual scripts and few alternatives to intercourse (Zilbergeld, 1993; LoPiccolo, 1992; Gagnon, Rosen, & Leiblum, 1982; Leiblum & Rosen, 1991). In particular, performance demands and fear of failure are increased markedly for individuals or couples who lack alternatives to penile–vaginal intercourse as a means of sexual satisfaction. For these individuals, the male's inability to achieve a firm and lasting erection typically results in a complete cessation of all sexual activity. This, in turn, may lead to diminished sexual desire in one or both partners, and increased distance or conflict in the relationship (Leiblum & Rosen, 1991). A "vicious cycle" phenomenon frequently ensues, as the loss of sexual or affectionate interaction is associated with increased performance demands and interpersonal distress. In one early study, sexual communication training was found to be superior to sensate focus alone in the treatment of secondary erectile dysfunction (Takefman & Brender, 1984).

LoPiccolo (1992) has emphasized the critical role of the female partner's attitude toward nonintercourse forms of sexual stimulation. According to this author, the partner's willingness to be satisfied by manual or oral stimulation may be a critical determinant of treatment outcome in most cases of erectile dysfunction: "Far more effective than sensate focus in reducing performance anxiety is the patient's knowledge that his partner's sexual gratification does not depend on his having an erection. If the patient can be reassured that his partner finds their lovemaking highly pleasurable and that she is sexually fulfilled by the orgasms he gives her through manual and oral stimulation, his performance anxiety will be greatly reduced." (LoPiccolo, 1992, p. 190). From this perspective, treatment is often focused on the sexual receptivity of the partner to nonintercourse forms of stimulation.

Elsewhere, I have advocated the use of a "sexual scripting" approach to a variety of sexual performance difficulties, including erectile dysfunction (Gagnon, Rosen, & Leiblum, 1982; Rosen & Leiblum, 1988; Rosen, Leiblum, & Spector, 1994). Essentially, this approach involves detailed assessment of both the performative, or overt, script between the partners and the ideal or imagined script of each individual partner. Performative scripts can be analyzed according to four major script dimensions: com-

plexity, rigidity, conventionality, and satisfaction. In couples with chronic sexual dysfunctions, including ED, performative scripts typically become increasingly restricted, repetitive, and inflexible, with diminishing sexual satisfaction for both partners. Script restrictions may either precede the onset of a specific sexual problem or may develop as a consequence of the disorder (Leiblum & Rosen, 1991).

Interpersonal and Systemic Interventions

Interpersonal and couple issues play a major role in many, if not most, cases of ED. As noted by Masters and Johnson (1970), "there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy" (p. 2). Relationship conflicts may be a primary source of the sexual difficulty or may serve to exacerbate or maintain the male's inability to achieve adequate erections. Although the role of relationship factors is widely acknowledged in the clinical literature on the topic (e.g., Masters & Johnson, 1970; Kaplan, 1974; Leiblum & Rosen, 1991), relatively few studies have assessed the relationship between interpersonal distress and treatment outcome for erectile dysfunction. In an early study, sensate focus and graduated sexual stimulation techniques were evaluated in 36 couples presenting for treatment of psychogenic erectile dysfunction (Hawton, Catalan, & Fagg, 1992). The major determinant of treatment outcome in this study was the couples' ratings of marital communication prior to treatment. Couples with higher ratings of marital communication responded more rapidly and with better outcomes to the sex therapy interventions provided.

In addition to the paucity of outcome data, there is a lack of consensus regarding the choice of conceptual framework or intervention strategies for overcoming relationship conflicts in couples with ED. Thus, some sex therapists have formulated couple issues from a psychodynamic perspective (e.g., Kaplan, 1974; Scharff, 1988; Levine, 1992); others have provided a cognitive-behavioral perspective (Hawton, Catalan, Martin, & Fagg, 1986; Wincze & Carey, 1991); and still others have argued for a family systems approach (Verhulst & Heiman, 1979; LoPiccolo, 1992). This lack of agreement concerning theory and practice of couple therapy has impeded efforts to develop more standardized approaches for dealing with couple issues in ED. Rather, this essential aspect of treatment is often based upon an eclectic array of techniques and interventions.

My colleagues and I have previously identified three major dimensions of couple conflict that are frequently encountered in cases of erectile dysfunction (Leiblum & Rosen, 1991; Rosen, Leiblum, & Spector, 1994). These are (1) status and dominance issues; (2) intimacy and trust; and (3) loss of sexual attraction. Status and dominance issues arise when

the balance of power in a relationship is shifted, either because of external factors such as the loss of a job and unemployment, or because of internal factors such as depression and loss of self-esteem. Similarly, loss of intimacy or trust may occur when either partner engages in an extramarital affair, a new career is undertaken, or a child is born. Additionally, loss of sexual attraction may be associated with weight gain, medical illness or surgery, and abuse of drugs or alcohol. Elsewhere, I have reviewed the multiple factors that may contribute to a loss of "sexual chemistry" between partners in specific cases of erectile dysfunction (Leiblum & Rosen, 1992).

Finally, a number of treatment interventions have been described for single males with chronic erectile difficulties (Reynolds, 1991, 1992; Stravynsky & Greenberg, 1990). Treatment strategies include sexual attitude change, assertiveness training, masturbation exercises, and social skills development. In the only controlled study to date of these interventions, a group treatment format for single men was compared to a waiting-list control (Price, Reynolds, Cohen, Anderson, & Schochet, 1981). Significant improvements in self-esteem and sexual satisfaction were associated with treatment, as well as a nonsignificant trend toward improved erectile function. Previously, sexual surrogate therapy had been used in several centers for treatment of single males (Apfelbaum, 1984; Dauw, 1988). Despite the value of this approach in some cases, the potential risks and uncertain legal status of surrogate therapy have greatly limited its use (Reynolds, 1991). Few therapist nowadays recommend the use of surrogates for these reasons.

Relapse Prevention Training

A major difficulty in both medical and psychological treatment approaches for ED is the high rate of dropout and relapse. In one early study, for example, a combined sex and marital therapy approach was evaluated in 16 couples with chronic secondary erectile dysfunction (Levine & Agle, 1978). After 3 months of treatment, 10 of 16 men had recovered erectile function. However, most of these men complained of other sexual difficulties (e.g., hypoactive desire, premature ejaculation), and significant relapse was observed in most patients at 1-year follow-up. A similarly high relapse rate was noted in a subsequent study of rational-emotive therapy for psychogenic erectile failure (Munjack et al., 1984). In this study, male patients and their partners were randomly assigned to either a 6-week treatment program or a waiting list control. Although significant improvements were noted in the treatment group, these were not maintained at 9-month follow-up.

To facilitate maintenance of treatment gains, McCarthy (1993) has advocated the use of a relapse prevention training (RPT) approach, similar

to that used in the treatment of addictive disorders (e.g., Marlatt & Gordon, 1985). Among the specific strategies recommended are scheduling of occasional nondemand or noncoital pleasuring sessions, rehearsal of coping responses for dealing with unsatisfactory or negative sexual experiences, increasing the range of affectional or intimate behaviors other than intercourse, and scheduling of periodic therapy follow-up visits. This encourages maintenance of treatment gains and provides opportunities for problem solving of ongoing sexual difficulties or conflicts. In addition to the areas emphasized by McCarthy (1993), I have noted that treatment outcome appears to be strongly linked to the level of confidence or sexual self-efficacy achieved by the end of treatment.

In summary, psychological and interpersonal approaches to treatment have been relatively neglected in the face of increasing "medicalization" of ED (Althof et al., 2005; Bancroft, 1990; Tiefer, 1994). This trend is attributed to the availability of medical therapies and involvement of a wide variety of physicians in the medical management of the disorder, as well as the reluctance of many males and their partners to consider the emotional or interpersonal antecedents of the problem. Disappointing outcomes associated with psychological intervention are another potential determinant of the shift toward biomedical conceptualization and treatment of the disorder. For many individuals, medical treatments such as sildenafil may represent a "quick fix" for the disorder that avoids the time-consuming and uncertain outcome of psychological treatment approaches.

ALTERNATIVE MEDICAL TREATMENTS

Prior to the advent of sildenafil and other PDE5 inhibitors, a broad range of medical and surgical options were available for treatment of ED. Since the introduction and widespread adoption of the PDE5s in the late 1990s, these other treatments are less widely used, and are viewed nowadays as alternative or "second-line" treatments for those cases in which PDE-5 inhibitors are not successful. Much less information is available concerning the safety and efficacy of these alternative therapies, although the treatments described below have all been approved by the FDA for routine clinical use. For a detailed presentation and discussion of each method, readers are referred to the relevant chapters in the recent 2nd International Consultation on Sexual Medicine (Lue et al., 2004).

Intracavernosal Injection Therapy

Prior to the approval of sildenafil, intracavernosal self-injection was the most widely used medical therapy for erectile dysfunction. Different forms of prostaglandin are primarily used for this purpose. Alprostadil sterile

powder and alprostadil alfadex are both synthetic formulations of prostaglandin E_1. Injection therapy is effective in most cases of erectile dysfunction, regardless of etiology. It is contraindicated in men with a history of hypersensitivity to the drug employed, in those at risk for priapism (e.g., due to sickle cell disease or hypercoagulable states), and in men receiving monoamine oxidase inhibitors. The effective therapeutic range is between 1 and 60 mcg with the majority of responders (85%) requiring less than 20 mcg. In general, intracavernosal injection therapy with alprostadil is effective in 70–80% of patients, although discontinuation rates are high in most studies. Side effects include prolonged erections or priapism, penile pain, and fibrosis with chronic use. In addition to single-agent injection therapy, various combinations of alprostadil, phentolamine, and/or papaverine are widely employed in urological practice. Intracavernosal injections have been shown to be effective in many men who fail first-line therapy with sildenafil.

Intraurethral Alprostadil (MUSE)

Alprostadil (prostaglandin E_1) may be administered intraurethrally in the form of a semisolid pellet inserted by means of a special applicator. To obtain an effective concentration of alprostadil in the corpora cavernosa, 125–1,000 micrograms of the drug are delivered by the device to the urethra. In a mixed group of patients with organic erectile dysfunction, 65% of men receiving intraurethral alprostadil responded with a firm erection when tested in the office, and 50% of administrations to that subset resulted in at least one episode of successful intercourse in the home setting. Side effects associated with the intraurethral administration of alprostadil include penile pain and hypotension. Prolonged erections and penile fibrosis are rare, but the clinical success rate is low.

Vacuum Constriction Device Therapy

The use of vacuum constriction device (VCD) therapy is a well-established, noninvasive treatment that has recently been approved by the FDA for over the counter distribution. It provides a useful treatment alternative for patients for whom pharmacological therapies are contraindicated or who do not desire other interventions. Vacuum constriction devices apply a negative pressure to the flaccid penis, thus drawing venous blood into the penis, which is then retained by the application of an elastic constriction band at the base of the penis. Efficacy rates of 60–80% have been reported in most studies. Like intracorporal injection therapy, VCD treatment is associated with a high rate of patient discontinuation. The adverse events occasionally associated with VCD therapy include penile pain, numbness, bruising, and delayed ejaculation.

Surgical Treatments

Surgical implantation of a penile prosthesis, which was at one time the mainstay of treatment for ED, is now performed only in rare or special cases. For select cases of severe, treatment-refractory erectile dysfunction, for patients who fail to be helped by pharmacologic therapy or who prefer a permanent solution for the problem, surgical implantation of a semirigid or inflatable penile prosthesis is available. Various types of surgical prostheses have been described in the literature. The inflatable penile prosthesis provides a more aesthetic erection and better concealment than semirigid prostheses, although there is an increased rate of mechanical failure and complications (5–20%) with the former. Despite the cost, invasiveness, and potential medical complications involved, penile implant surgery has been associated with high rates of patient satisfaction in previous studies. It should be noted, however, that these studies were conducted prior to the advent of oral medications.

COMBINED MEDICAL AND SEX THERAPY APPROACHES

Despite the widespread use of PDE5 inhibitors as first-line therapy for ED, interest in the combined or integrated use of medical and sex therapy approaches has been increasing in the past several years. There are several reasons for this, including growing awareness of the limitations of pharmacological therapy for individuals or couples with psychological barriers or conflicts. In some cases, prescription of a PDE5 inhibitor may underscore or exacerbate a couple's underlying conflicts or reveal a lack of desire in one or both partners. Sexual problems in the partner or other couple issues may be accentuated following successful (or unsuccessful) use of sildenafil. Although this concern applies equally in the use of any medical or surgical treatment for ED (Althof, 1998), in light of the sheer numbers of men taking PDE5 inhibitors (more than 20 million at the time of writing) and the widespread use of the drugs, the role of concomitant psychological or interpersonal problems has been highlighted dramatically. Rather than rendering sex therapy obsolete or unnecessary, the introduction of PDE5 inhibitors has led to a redefining of the role and importance of psychological interventions in ED. This is particularly relevant nowadays, in view of high rates of discontinuation and dropout from medical therapy (Rosen et al., 2004). Specific areas for special attention are as discussed below.

Problems of Initiation

In couples with long-standing erectile dysfunction, initiating or resuming sexual activity may be difficult following an extended period of sexual abstinence. Leiblum (2002) notes that chronic ED typically leads to sexual

apathy or avoidance in one or both partners, and that specific interventions may be required to assist the couple in resuming sexual activity. Sexual avoidance in these cases may be related to embarrassment or fear of failure on the part of the male, unrealistic beliefs or expectations, relationship conflicts, and low sexual desire in one or both partners. Many couples make long-term adjustments to the absence of sexual activity in their relationships or lifestyles, and the availability of the drug may not be a sufficient stimulus to overcome the sexual inertia that permeates their relationship. Few physicians assess the sexual relationship beyond the male's ability to achieve satisfactory erection or orgasm, and problems of initiation are unlikely to be addressed in this setting. Many of the men and their partners have difficulty in resuming or maintaining an active sexual relationship after months or years of sexual inactivity.

How should problems of initiation be managed clinically? As noted above, the "sexual script" is an important area for intervention in treating sexual abstinence or initiation problems in ED, and this approach can be readily combined with drug therapy in most cases. At the simplest level, physicians prescribing PDE5 inhibitors should be encouraged to inquire whether couples have maintained a degree of sexual activity or involvement despite the male's erectile difficulties, and whether any problems are anticipated in resuming sexual activity. Simple encouragement or advice about the importance of sexual stimulation and the need for foreplay may be adequate in some cases, whereas others may require referral for more in-depth couples or sex therapy. After long periods of abstinence, the sexual script is invariably limited to a narrow and restricted range of sexual activity, which the couple typically engages in without interest or enthusiasm. An important focus for therapy in these cases is to explore new options and approaches to lovemaking with the couple and to encourage a degree of experimentation in their sexual script. The use of oral medications can be viewed as an opportunity for the male to regain his sexual confidence, which should in turn facilitate a more open and experimental approach to sexual encounters. Partners should similarly be encouraged to adopt a more open-ended and, if possible, playful approach to lovemaking. Instructional videos, homework assignments, and open discussion with the couple have all been used as a means for broadening the sexual script.

Problems of Low Desire

Men with ED frequently have concomitant low desire, either as a cause or consequence of their erectile dysfunction. In some cases, the lack of desire may be sufficiently severe to warrant a secondary diagnosis of hypoactive sexual desire disorder (HSDD). In other instances, a generally low level of sexual interest or enthusiasm is evident, even though the full criteria for an HSDD diagnosis are not met. Although precise data are not available on

the proportion of erectile dysfunction cases that have concomitant HSDD or diminished desire, I would estimate that at least one-third of ED cases seen in our clinic in recent years involve low desire to a significant degree. Interestingly, this represents a marked discrepancy from the published clinical trial data on PDE5 inhibitors, in which relatively few patients are reported to have inadequate sexual desire. The discrepancy can be explained by the fact that patients need to be highly motivated to gain entry into the clinical trials, and are typically recruited on the basis of their being involved in an active sexual relationship. In this sense, conclusions about the effectiveness of PDE5 inhibitors based on results from clinical trials may significantly overestimate the efficacy of the drug in individuals or couples with desire disorders.

How should problems of low desire be approached in this context? First, a careful assessment of the couple's previous sexual history should be conducted, with special attention to each partner's past sexual feelings and desires. As noted by Leiblum (2002), male patients and their partners should be closely questioned about whether sexual activity was something highly valued and then lost, or something easily relinquished. For men, sexual intercourse may have long-standing associations with performance anxiety or an overall sense of inadequacy. Such individuals may feel threatened or insecure at the prospect of having to "perform" again sexually. Similarly, female partners frequently have sexual insecurities or dysfunctions of their own, and the loss of erectile ability in the male may be associated with feelings of relief in the female partner. These issues should be identified and openly addressed as early as possible in the therapy process. In some instances, the lack of interest or desire for sex becomes apparent as a form of "resistance" or noncompliance with the prescribed medical therapy (Pallas et al., 1999). If either partner is found to have primary HSDD that predates or is a major causal factor for the male's erectile dysfunction, couple or sex therapy should be specifically addressed to this problem.

Other Sexual Dysfunctions

Men with ED or their partners frequently have other sexual dysfunctions, such as premature or retarded ejaculation in the male and arousal or penetration difficulties in the female. Based on data from the MALES study of 30,000 men in 12 countries, approximately 30% of men with ED also report difficulties with control of ejaculation (Rosen et al., 2003; Fisher et al., 2005). Clinical experience would suggest that at least one in four cases involves concomitant sexual problems in one or both partners. Again, a careful assessment is essential in determining the history of these problems and their specific relationship to the male's erectile dysfunction. In some instances, ED may develop secondary to premature or retarded ejaculation in the male (Fisher et al., 2005), or in response to chronic penetration diffi-

culties (i.e., vaginismus, dyspareunia) in the female partner. Treatment of the male's erectile difficulties with a PDE5 inhibitor (or other medical therapy) may serve only to reinitiate or exacerbate these underlying problems. Whenever possible, other sexual dysfunctions should be clearly identified and addressed prior to the initiation of medical treatment. In many instances, however, the presence of other sexual problems only becomes apparent in the form of resistance to or failure of drug therapy (Pallas et al., 1999). At such times, the couple should be referred for more intensive couple or sex therapy.

Some observations are worth noting in regard to specific treatment issues with these problems. As noted above, premature ejaculation (PE) is the most common associated problem in men (Fisher et al., 2005), although little has been written about the treatment of men with both ED and PE. In some instances, we have found that effective restoration of erectile function with PDE5 inhibitors may sufficiently boost the male's (and his partner's) sexual confidence that control of ejaculation is similarly improved. Men with chronic or severe PE in addition to erectile difficulties are generally not good candidates for treatment with PDE5 inhibitors. Rather some form of pharmacologic or sex therapy treatment for the PE is recommended either prior to or in conjunction with the use of ED medications. Commonly used serotonergic drugs such as clomipramine or paroxetine are generally effective in restoring ejaculatory control in men, although these drugs may significantly worsen the patient's erectile difficulties and are generally contraindicated for patients with both PE and ED. Sex therapy procedures such as the "stop–start" technique may be preferable for this reason, although no data are available on the effectiveness of combining this approach with oral ED medications. Delayed ejaculation is a less common problem in men with ED, although additional sex therapy interventions may again be required for men with both ED and delayed ejaculation (Rosen & Leiblum, 1995; Rosen, 2000).

For women with penetration or lubrication difficulties, these problems should be addressed directly prior to initiation of treatment for the male's erectile dysfunction. In cases of dyspareunia or vaginismus, in particular, a complete medical and sex therapy evaluation for the female partner is recommended at the outset. Male partners of these women frequently develop concomitant erectile difficulties and both partners may experience pressure to resume intercourse, particularly if the couple is planning to conceive. Depending upon the severity of the problem and results of the physical and psychosexual evaluation, medical or sex therapy interventions should be initiated, and the couple should be counseled to avoid attempting intercourse initially. The male may wish to try a PDE5 inhibitor in conjunction with manual (either self- or partner) or oral stimulation but should be strongly discouraged from attempting intercourse until sufficient progress has made in treating the sexual dysfunction in the partner. Some women

report a recurrence of the penetration problem when the male begins to use a PDE5 inhibitor (or other medical therapy) and intercourse is resumed. Although less debilitating generally than dyspareunia or vaginismus, female arousal or lubrication difficulties might also make resumption of intercourse difficult or painful for the female partner. This is particularly common in postmenopausal women not taking hormonal replacement.

For women without specific sexual dysfunction, treatment of ED in the male partner typically results in an overall improvement in sexual function and satisfaction. In one recent study (Goldstein et al., 2005), female partners of men receiving vardenafil (Levitra) showed significant improvements in sexual arousal, orgasm, and overall sexual satisfaction. Again, these results should be cautiously interpreted in view of the potential artificiality of the clinical trial situation.

Couple or Relationship Problems

Couple or relationship problems are frequently implicated in the development of ED or may arise as a consequence of the problem (Rosen, 2000; Althof et al., 2005). In either event, couples with severe relationship conflicts or communication difficulties are unlikely to benefit from the use of PDE5 inhibitors or other medical treatments for ED. Again, these individuals were excluded from the clinical trials of PDE5 inhibitors, and information is lacking on the percentage of treatment failures that may be attributed to problems in the relationship. Althof et al. (2005) have recently emphasized the importance of addressing relationship issues in all sexual problems, including ED. Frequent problems that my colleagues and I have encountered include the possibility that one or the other partner is engaged in an extramarital affair, long-standing anger or resentment over unfulfilled sexual or nonsexual needs, power struggles in the relationship, and a loss of physical or emotional intimacy. Changes in physical appearance (e.g., significant weight gain) and loss of sexual attractiveness are additional factors to be considered.

Careful assessment should be made of the couple's relationship and concerns of the partner prior to initiating treatment with a PDE5 inhibitor. There are no clear guidelines or simple "rule of thumb" that can be applied across situations. In each case, a careful assessment should be performed of the type and degree of relationship distress, as well as the likely impact on the couple of beginning medical treatment for ED. In some instances, a resumption of sexual activity may lead to reduced tension in the relationship, thereby facilitating more effective communication and problem solving around couple issues. In other cases, however, attempts at sexual intercourse are likely to dramatically increase underlying conflicts or tensions and should be postponed until significant progress has been made in other areas. Particularly in cases involving extramarital affairs or sexual activity

outside of the primary relationship, the introduction of a PDE5 inhibitor should be handled with special care.

For couples with less severe relationship problems, physicians or therapists might provide simple guidelines for enhancing relationship satisfaction and for improving communication around sexual issues. For example, couples should be encouraged to communicate directly with one another about their sexual likes and dislikes, preferences, and priorities. Simple suggestions for increasing emotional and physical intimacy can be offered, such as taking more time to talk about personal issues and sharing personal feelings more frequently. Many couples experience a loss of romance along with sexual intimacy, and suggestions can be made for developing a more romantic sexual script (Rosen, Leiblum, & Spector, 1994). Some of these interventions may be offered by the primary care physician in conjunction with prescription of the drug. Recently, Perelman (2005) has recommended the use of "sexual coaching" by primary care physicians in conjunction with the prescription of PDE5 inhibitors. Referral for more specialized couple or sex therapy is recommended, however, for more complex or treatment-refractory cases.

CASE EXAMPLES

Case 1: John S

John S is a 54-year-old accountant, married to Marlene for 26 years, and with two children ages 21 and 19, neither of whom is living at home. He presents for treatment complaining of increasing erectile difficulties for the past 6 years. He states: "I can't remember when last I had a good erection. No matter how hard we try, it never gets more than half way. My wife is ready to quit on me!" The patient's medical history is significant for mild hypertension, which is controlled with a low dose of antihypertensive medication (enalapril, 5 mg/day). He has been a smoker since his early 20s, but is otherwise in good health. The physical exam and laboratory tests are unremarkable.

Sexual history taking reveals that John has experienced little interest in or desire for sex since the early days of his marriage. His early sexual history was unremarkable. He began masturbation late (age 15) and had few, albeit successful, sexual experiences before marriage. He recalls feeling more physically attracted to his wife prior to their marriage, and to the birth of their two children. "During that period [of childbirth and its aftermath], our sex went really downhill. I don't know if it was my problems with erection, or the other way around, but I starting wanting it less, and having it much less often also. It's hard to know which was the chicken, and which was the egg!"

Marlene generally concurs with her husband's appraisal of the ED problem. She blames the problem partly on the stresses of his family. His mother recently passed through a long bout with cancer and "leaned on him a lot," according to Mrs. S. She feels that the loss of his mother has affected him more than he recognizes. She denies difficulty with arousal or orgasm herself, and claims to have been approached sexually by other men, but not to have acted on any invitations thus far. She expresses frustration and angry at the loss of sexual activity, in addition to the loss of affectionate exchange that used to characterize their relationship.

During the final session of the evaluation, Mr. and Mrs. S were seen together and a discussion took place about their treatment options. They chose to continue couple therapy at the same time that John requested a trial of sildenafil. Mr. S was evaluated by his primary care physician, who prescribed sildenafil (50 mg) to be taken prior to intercourse in the usual manner. He has no history of cardiac disease or other medical complications. Sildenafil was introduced following the third session. Mr. S showed a slight response to the drug at 50 mg, and markedly improved erections at 100 mg. He reported occasional flushing at this dose.

Sex therapy focused initially on communication issues. John and Marlene needed to develop a clearer understanding of the problem and their treatment options. It is important for couples to discuss feelings and expectations openly at this phase, and to initiate more affection and physical exchange. The importance of combining sexual stimulation with the administration of the drug was discussed and emphasized. The couple began experimenting with new foreplay options, including oral and manual stimulation prior to intercourse. Marlene felt that her husband was being attentive to her sexual needs for the first time in many years. "I wish we could have started in this direction a long time ago," she reported.

The couple was seen intermittently during the following year. They continued to make steady progress, although other marital issues surfaced. She felt he had been emotionally unavailable for her at many times in the marriage. He resented her criticisms in this and other areas. Couple therapy focused on these issues, as well as follow-up of their sexual script and the inclusion of medication in their usual lovemaking experiences.

Comment

Although sildenafil played a major role in the recovery of Mr. S's erectile capacity, couple therapy served to open the door on a number of issues for the couple, to prepare them psychologically and practically for the use of the drug, and to continue to improve their relationship once sex was reintroduced. Mr. S's desire level increased over the 1-year period, most likely due to a combination of sildenafil's effects and the improvements in other

areas. He was strongly encouraged to act more confidently and assertively in the bedroom situation, and therapy sessions were focused on reinforcing this attitude. At the same time, the need for greater stimulation and attention to Marlene's sexual needs was reinforced throughout.

Case 2: Philip G

Philip and Barbara G are both in their early 30s, have been married for 6 years, and have no children. She complains that their sexual relationship "is a basket case!" Her husband had been a premature ejaculator since the earliest days of their courtship, and had begun to experience episodes of ED in the past year. The couple had previously had seven sessions of sex therapy focused on the stop–start technique. This had worked briefly, but results were not sustained after several months. They were reluctant to return for further sex therapy and felt a lack of emotional connection with their previous therapist.

Mr. G had recently seen a urologist for a consultation. The urologist had focused discussion on the patient's erectile difficulties and had prescribed a trial of vardenafil (Levitra). Both the patient and his wife felt reluctant to use the medication, partly due to his fear of becoming dependent on medication, and partly due to the lack of specific benefit he experienced for his premature ejaculation. A three-session consultation was arranged, focusing on his performance anxiety and on altering the couple's sexual script. In particular, the couple was encouraged to experiment with different approaches to foreplay, including nondemand touching and oral sex assignments. This proceeded well over the next 2 months.

In the interim, Mr. G had initiated sex on one occasion after taking half of his usual dose of vardenafil (10 mg). He felt unusually calm and aroused, and at this point requested a brief period of stop–start stimulation with his wife. She agreed, and the couple reported an unusually positive sexual exchange at this point. It culminated in intercourse, with Mr. G being able to last for approximately half an hour. He felt elated.

Comment

This case illustrates the unplanned or unpredicted course of events that one often encounters in therapy. The clinician can help to establish a more sexually conducive environment for positive sexual risk taking and experimentation. Mr. G had discovered, and the couple had fully optimized, his use of low-dose vardenafil in this context. The previous work on their sexual script and on broadening the couple's approach to lovemaking had maximized the "spillover" from drug treatment. The couple was also helped in interpreting these events, and in making plans to gradually decrease the need for any medication in the future.

Case 3: George X and Martha Y

George X and Martha Y are an unmarried couple in their early 40s. They were referred for treatment of his erectile difficulties of the past several months. Martha was previously married, but divorced after 2 years of marriage. George was single at the time of their meeting, 8 years ago. The couple describe themselves as intellectually compatible, but with an almost nonexistent sex life for the past several years. They live in separate apartments, but date each other exclusively. They both appear anxious and embarrassed when discussing their problem during the initial visit.

On inquiry, it emerges that Martha has had problems intermittently with both vaginismus and sexual aversion. Although neither problem is very severe, her sexual difficulties have dominated their sexual relationship. She describes a very abusive relationship with her first husband, and attributes some of her problems in this area to that marriage. Her partner, George, has felt increasingly frustrated and impatient, and angry that Martha has refused counseling in the past for this problem. It was only when he began losing his erection consistently that Martha finally agreed to seek help.

Treatment focused on communication issues and reducing the level of performance demand that both partners experienced. The couple was encouraged to refrain from intercourse and to focus on nondemand touching and Kegel exercises for a period of 6 weeks. Strong emphasis on the wife's having complete control in each of the sessions helped to maintain a low level of anxiety for her. Sensate focus exercises were also prescribed.

Four weeks into the treatment, the couple attempted intercourse for the first time since starting treatment. Although Martha felt some anxiety immediately after penetration, she reported telling herself to "relax" and being able to achieve climax soon after. She noted that this was the first time she had climaxed during intercourse for more than 6 months. George experienced no erectile difficulties during the experience.

Comment

Sexual problems and dysfunction in the partners of men with ED are a much-neglected topic in the literature. I have seen many cases in which women presented with low desire, lack of arousal or orgasm, and a variety of penetration problems, either in association with or as the primary cause of their partner's ED. This case illustrates one such pattern. In some instances, the preferred approach is to focus directly on the female partner's difficulties and to withhold or delay treatment for the male's problem until sufficient progress has been made. In other instances, it may be possible to work on both problems concurrently. In the present instance, the decision was made to focus initially on the female partner's vaginismus. Only a

small degree of success was needed in this area for Mr. X to recover his erectile function. If his problems had persisted, a PDE5 inhibitor would likely have been introduced.

SUMMARY AND CONCLUSION

Erectile dysfunction is a highly prevalent sexual disorder, with significant effects on mood, quality of life, and interpersonal relationships. Since the introduction of PDE5 inhibitors, approximately 20–25 million men worldwide have sought treatment for ED and the drugs are now widely used as first-line therapy for ED. Practice patterns in this area have also changed dramatically, as most men now seek treatment from primary care physicians for the disorder. In recognition of these developments, new treatment guidelines and recommendations for the evaluation and treatment of ED have been developed. This chapter describes an integrated or combined approach for the evaluation and treatment of all cases of ED, regardless of the specific etiology. Psychological and sex therapy approaches are strongly emphasized in this model, either in conjunction with or as an alternative to medical therapies. Despite the overall safety and effectiveness of PDE5 inhibitors, many couples discontinue treatment for psychological and interpersonal reasons. This combined approach is intended to address these issues and to improve overall satisfaction with treatment.

This chapter presents current sex therapy approaches for ED. Special emphasis is placed on the combined use of PDE5 inhibitors and traditional sex therapy approaches. Among the key areas to be addressed from this perspective are problems of initiation, low desire in one or both partners, the presence of other sexual dysfunctions, and couple or relationship problems. A series of case studies is presented to illustrate the use of combined medical and sex therapy approaches for erectile dysfunction. In each instance, a flexible, individualized treatment approach is recommended to produce optimal results. Finally, more research is needed on the costs and benefits of combined medical and sex therapy approaches to ED.

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PART IV

SPECIAL ISSUES

CHAPTER 11

Sexuality and Illness

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There is little doubt that medical illness impacts sexual function in myriad ways and that concerns about sexuality are widespread among individuals with acute or chronic illness. Diabetes, neurological disease, cardiac disease, and cancer are just a few of the most common chronic illnesses that can play havoc with sexual interest and sexual function. A host of psychiatric disorders, as well, are comorbid with sexual problems. Regrettably, many physicians treat the somatic manifestations of the disease state or the presenting symptoms of the psychiatric condition and ignore the psychological, interpersonal, and sexual sequelae.

In this chapter, Stevenson and Elliott highlight the types of sexual problems associated with a variety of chronic illnesses but, most important, provide a clinical framework for the assessment and management of sexual concerns and complaints. They stress the importance of evaluating both the direct and indirect effects of an illness as well as the iatrogenic and contextual concomitants and illustrate this with a variety of fascinating clinical examples.

Stevenson and Elliott also provide a comprehensive and extremely useful framework for understanding how physical, physiological, emotional, and cognitive signals are perceived and processed sexually and how, in turn, sexual responses are mentally evaluated, consciously and subconsciously. The mind–body circuit functions as a sexual feedback loop and has implications for diagnostic formulation and treatment. For instance, the biopsychosocial feedback loop may help normalize sexual dysfunction for individuals who are worried about changes in their sexual response. Explaining how both present expectations and experiences (an illness and its somatic conse-

quences) and those in the past (family history, religious, cultural) interrupt or interfere with the processing of sexual stimuli can be helpful to patients. They note that even though an individual may have significant trauma, he or she may be able to disregard that history and function well sexually if the sexual signals are not blocked. Finally, they note that during most sexual experiences, individuals are monitoring not only their own sexual response but also that of their partner, so that "there are really two overlapping feedback loops in play" that may be either reinforcing or inhibiting.

Despite even the most effective and enlightened therapies, total restoration of sexual functioning is not always possible. Consequently, therapists may need to help patients *adapt to* their present circumstances rather than *completely recover* their former sexual life. There are three principles associated with sexual rehabilitation: maximizing the existing physiological capacities, adapting to limitations with specialized interventions (e.g., using sexual aids), and persisting in therapy with an optimistic outlook.

Stevenson and Elliott are uniquely compassionate and informed physicians who are experts in sexual medicine. They both work in Vancouver, British Columbia, at the BC Centre for Sexual Medicine.

Ronald W. D. Stevenson, MD, is a psychiatrist with subspeciality training in sexual medicine and in child/adolescent forensic psychiatry. He is the former head of the University of British Columbia's Sexual Medicine Program, and the former clinical director of the BC Centre for Sexual Medicine at Vancouver General Hospital. In addition to his clinical practice, he is an associate clinical professor of psychiatry at the University of British Columbia, where he teaches at both undergraduate and postgraduate medical education levels. He is also adjunct professor in the Faculty of Health Sciences at Simon Fraser University, where he is developing a new undergraduate course on human sexuality.

Stacy L. Elliott, MD, is a family physician who took extra training in the sexual and fertility aspects of urology, gynecology, rehabilitation medicine, and neurology. She is the current medical director of the BC Centre for Sexual Medicine and codirector of the Vancouver Sperm Retrieval Clinic. She is a clinical professor in the departments of psychiatry and urology in the Faculty of Medicine, University of British Columbia. Her main interests and publications center around sexuality and fertility in medically and surgically rehabilitative patients.

Sexual function is a biopsychosocial phenomenon—the contributions of mind and body are as inseparable from each other as they are from the environmental and relationship contexts within which they operate. Though somatic or emotional factors can predominate, an individual with a sexual problem of "physical" origins will inevitably be affected psychologically, just as a "psychological" problem will always manifest with bodily signs or symptoms.

Sexual dysfunctions are highly comorbid with many physical and emotional illnesses and traumas, are a frequent and distressing side effect of medication or other medical treatments, and can even be a harbinger of serious medical disease.

This chapter provides information concerning the comorbidity between illness and sexual dysfunction, and the methods to conceptualize, assess, and treat the sexual concerns of patients.

THE RELEVANCE OF ILLNESS-RELATED SEXUAL PROBLEMS

The World Health Organization (2000), the U.S. Surgeon General (2001), and the World Association for Sexology (2005) have all endorsed the view that sex is a basic human right and a fundamental part of a full and healthy life. This remains true for the majority of people well into older age. The Global Study of Sexual Attitudes and Behaviours (Laumann et al., 2005) surveyed 29 countries and more than 27,000 persons between 40 and 80 years old. Over 80% of men and over 60% of women described sex as "extremely," "very," or "moderately" important.

In the general population, estimates of sexual problems vary from 10 to 52% of men and 25 to 63% of women (Heiman, 2002). For those ages 18–59, Laumann, Paik, and Rosen (1999) found prevalence rates of 43% for women and 31% for men. In a community sample of men between 40 and 70, 52% reported some degree of erectile dysfunction (O'Donnell, Araujo, & McKinlay, 2004).

The prevalence is even higher—over 90% in some surveys—when medical or psychiatric patients are surveyed (Aschka, Himmel, Ittner, & Kochen, 2001; Clayton, 2002). Even if only a portion of these patients fulfill formal diagnostic criteria for a sexual disorder, it is evident that sexual concerns, distress, and dysfunctions are extraordinarily widespread among persons with illness.

The impact of sexual problems, on patient or partner, can vary from embarrassment, unhappiness, and frustration to a more pervasive loss of self-esteem affecting relationship satisfaction and viability. Some patients can be so distressed and preoccupied that they avoid friends and social opportunities, and their concentration or performance at work can suffer.

Clinicians should be alert to sexual issues for several reasons (Stevenson, 2004):

- Many medications have sexual dysfunction side effects (Thomas, 2003). Direct effects include either increases or decreases in desire, arousal, and orgasm, effects on menstruation and fertility, and breast disorders (in both men and women), including galactorrhea, gynecomastia, and pain. Indirect effects include those due to changes in body image (e.g., weight gain), halitosis or altered taste, general physical comfort (e.g., nausea, bloating, dizziness), mood or mental state fluctuations, cognitive or perceptual distortions, and so on, all of which can affect one's emotional readiness for sexual activity (Crenshaw & Goldberg, 1996). Psychotropics

are particularly troublesome. Up to 85% of patients experience sexual difficulties with antipsychotics (Mullen, Brar, Vagnucci, & Ganguli, 2001). Angst (1998) compared controls, untreated depressed patients, and patients on antidepressants, to find that the prevalence of sexual problems was 26%, 45%, and 63%, respectively. Sexual side effects can lower a patient's compliance with treatment. Rosenberg, Bleiberg, Koscis, and Gross (2003) found that 41% of men and 15% of women admitted they stopped medications due to sexual side effects.

- Failure to explore the possible sexual etiology of an illness (e.g., anxiety, musculoskeletal pain, urinary tract infection, fatigue, infertility) could result in misdiagnosis, delaying appropriate treatment (Nusbaum & Hamilton, 2002). Conversely, identification of a sexual problem should prompt investigation for other treatable disease. For example, erectile dysfunction is found as an early symptom of endothelial disease associated with cardiovascular problems, stroke, and diabetes (Kirby, Jackson, & Simonsen, 2005) and can be the sentinel symptom of cardiovascular neuropathy in heavy drinkers (Ravaglia, Marchioni, Costa, Maurelli, & Moglia, 2004). There is a mutually reinforcing triad of comorbidity between ED, cardiovascular disease, and depression, so patients presenting with symptoms in any one of these areas should be evaluated for illness in both remaining areas (Goldstein, 2000).
- A sexual problem can affect the course of other illness. For example, it appears that the experience of ED can precipitate or exacerbate depression (Araujo, Durante, Feldman, Goldstein, & McKinlay, 1998). Conversely, men with depression and erectile dysfunction experience resolution of mood symptoms when their ED is successfully treated (Seidman, Roose, Menza, Shabsigh, & Rosen, 2001). In a parallel way, attention to sexual issues is now a routine part of cardiac rehabilitation programs (Muller, 1999) because sex has beneficial effects on mood and relationships, promotes compliance with treatment, and is even a good form of exercise, all of which speed recovery.
- Phosphodiesterase type 5 inhibitors (PDE5is) are simple, safe, and efficacious for the majority of men with ED. However, nitrates in any form are absolutely contraindicated with these oral erectogenics. A man who takes nitroglycerin intermittently for angina might want to try a PDE5i, but if reluctant to broach the subject of sex with his clinician, he might obtain the medication from friends or on the Internet, unintentionally placing himself at risk (Thurairaja, Barrass, & Persad, 2005). PDE5is are sometimes deliberately combined with recreational forms of nitrate (e.g., amyl, butyl, or isobutyl nitrite, or "poppers") to provide a "rush" during sex activity. Aldridge and Measham (1999) found that 3% of nightclub goers (men and women) used sildenafil, and almost all of them acknowledged concomitant use of amyl nitrite. In one San Francisco sexually transmitted disease (STD) clinic, 32% of gay respondents acknowledged use of

sildenafil along with club drugs, and these men also reported having more sexual partners and engaging in unsafe sex, increasing their risk for HIV transmission (Swanson & Cooper, 2002). Accordingly, it is imperative that clinicians be able to thoroughly discuss their patients' overall health, concurrent medications, recreational drug use, and general lifestyle in the context of sexuality.

- Sexual activity itself may be unsafe for a small number of patients, so attention to this issue is prudent even though the risk of death is very low. Parzeller, Raschka, and Bratzke (2001), in reviewing over 26,000 forensic autopsies, found that fewer than 0.2% of subjects had suffered a fatal heart attack during sex. But for the seriously compromised cardiac patient, sexual activities should be deferred until proper risk stratification and resolution of any unstable cardiac condition (DeBusk et al., 2000).
- Last, but not least, sexuality reflects and contributes to emotional and physical health. Sex is not a lifestyle issue; it is a quality of life issue. A health care professional's goal is to maintain, improve, or restore quality of life; accordingly, sexual function should be a routine part of the clinical service mandate.

SEX AND PHYSICAL HEALTH PROBLEMS

Satisfactory sexual function depends on a number of factors, including (1) the integrity/health of intact blood vessels and nerves that supply the genitalia or other erogenous area, (2) relatively intact anatomy, (3) an appropriate balance of hormones, and (4) a mind aware of sexual thoughts and feelings. Medical or surgical problems potentially affect all of these systems, and sexual dysfunctions are correspondingly frequent and usually multifactorial. A few examples of specific illnesses follow.

Diabetes

Approximately half of all men with diabetes mellitus (DM) experience erectile dysfunction, with less frequent effects noted on ejaculation, orgasm, and fertility (Tilton, 1997). The prevalence of ED in the diabetic population (20–85%) is three to five times higher than the general population, the risk increasing with age, and it is most strongly correlated with autonomic neuropathy, although both small and large vessel disease and smooth muscle dysfunction play a role. ED also correlates with poor glycemic control (Romeo, Seftel, Madhun, & Aron, 2000).

There are conflicting reports on the sexual function of diabetic women, but decreased lubrication is the most frequent complaint, affecting 27% of women with type I (Enzlin et al., 2002), and 51.3% of those with

type II diabetes (Erol et al., 2002). Women with more diabetic complications have more sexual dysfunctions, with both depression and lack of sexual drive assuming greater importance.

In both genders, neurovascular pathology can affect genital sensation, thus impairing orgasm (Erol et al., 2002). Also, sexual dissatisfaction is correlated with relationship and self-esteem problems, including reactions to catastrophic effects such as limb amputation (Tilton, 1997).

Neurological Disease

The neural perception and control of sexual function involves interconnecting brain, spinal cord, and genital pathways. Accordingly, there are many points of potential interruption (Saenz de Tejada et al., 2004).

Pelvic surgery (e.g., prostate, bladder, or bowel) can damage nerves affecting sexual function even if the genitalia are not part of the operative field.

The effects of *spinal cord injury* (SCI) depend on the level and completeness of the lesion. Mentally induced (i.e., "psychogenic") erections and vaginal lubrication are predictably lost if the injury is complete and above the T_{10} neurological level. If the sacral cord is damaged, there is loss of genital touch-induced ("reflexogenic") arousal potential (Elliott, 2005). Women's fertility is unaffected by SCI, although men do have changes to erection and ejaculation, and semen quality is poor (Elliott, 2003). However, approximately 45% of men and 50% of women report orgasmic ability after SCI, regardless of the level or nature of the injury (Sipski, Alexander, & Rosen, 2001; Elliott, 2002). Sex is not without risk for persons with SCI. Autonomic dysreflexia, a potentially life-threatening condition of acute hypertension from unopposed sympathetically mediated influences, can be triggered by sexual activity—especially ejaculation—in persons with SCI above the T_6 neurological level, and must be prevented or managed in private sexual or clinical sperm-retrieval situations (Elliott & Krassioukov, 2005).

Hibbard, Gordon, Flanagan, Haddad, and Labinsky (2000) found that, in contrast to uninjured controls, men and women with *brain injury* reported lower energy and interest in initiating sex (possibly due to low testosterone), difficulties with arousal (erection or lubrication), and difficulties reaching orgasm. Women also had difficulties with vaginal dryness causing pain during sex. Both genders reported physical difficulties with body position, movement, and sensation as well as body image changes influencing feelings of attractiveness and comfort.

Sexual dysfunction is common in *Parkinson's disease* (PD) in both sexes. At least 75% of women with PD report difficulties with arousal and orgasm and 50% experience low sexual desire. About 70% of men with PD experience erectile difficulties. In addition, 40% have premature ejacu-

lation and 40% have delayed orgasm (Bronner, Royter, Korczyn, & Giladi, 2004).

Demyelinating diseases of the central nervous system such as *multiple sclerosis* (MS) can affect cognitive, motor, and sensory dysfunction depending on the area of brain or spinal cord involved. It is estimated that more than 70% of men and women with MS experience some form of sexual dysfunction during their disease (DasGupta & Fowler, 2003). Sexual concerns in MS include libido problems (acute or chronic, especially linked to depression and cerebral plaques) and the inability to experience orgasm. Furthermore, spasticity, fatigue, and muscle weakness can affect the ability to engage in certain sexual acts, including intercourse.

The limited research on the sexual consequences of *neuromuscular diseases* (including myopathies) suggests that sexual dysfunctions are usually due to nongenital causes, such as physical limitations, privacy, and caregiver issues (Bach & Bardach, 1997).

Cardiac Disease

Taylor (1999) reports that 75% of patients either decrease or stop sexual activity following a heart attack, and 80% of patients with congestive heart failure report either marked problems with or an inability to engage in sex. This is despite the fact that sexual activity requires a fairly low energy output—about the same as climbing two flights of stairs or walking a mile in 20 minutes (Jackson, 2000). Up to 75% of men with chronic coronary artery disease do experience some degree of erectile dysfunction (Kloner et al., 2003), and this is not surprising given that atherosclerosis affects the genital blood supply as much as the heart and other vessels (Debusk et al., 2000). Cardiac medications also contribute to the problem (Sainz, Amaya, & Garcia, 2004). The reasons patients and partners give for the decline in intimacy are more complicated than mere loss of interest or an inability to respond, instead often reflecting the multiple preoccupations and stresses of a chronic disease, as well as unwarranted fears of experiencing a heart attack during sex. As noted earlier, this latter risk is extremely low, and the vast majority of heart patients can be encouraged to explore gradual resumption of noncoital sensual experiences, which eventually lead to a full range of sexual options.

Cancer

The prevalence of sexual dysfunction in cancer patients is high. The location of the tumor or metastases, as well as the intensity, duration, and form of treatment (surgery, radiation, chemotherapy) can have varying and profound effects on sexuality due to fatigue, depression, anxiety, pain, nausea, the effects of chemotherapy or radiation, and so forth. Sex-

ual consequences are not limited to the active treatment phase. At least 25% of persons with Hodgkin's disease and 25% of testicular cancer survivors have been noted to have long-term sexual problems (Schover, Montague, & Lakin, 1997; Arai, Kawakita, Okada, & Yoshida, 1997), including decreased libido, dyspareunia, erectile dysfunction, and body image changes. McKee and Schover (2001) found that, in women, about 50% of long-term breast or gynecological cancer survivors experienced global and profound sexual dysfunction. Fertility also can be affected by hormonal changes, or by direct toxicity of chemotherapy or radiation to the gonads.

Approximately 70% of men who undergo treatment for prostate cancer report impaired sexual function. Radical prostatectomy can damage one or both of the two neurovascular bundles critical for erection, although nerve sparing at the time of surgery, potency prior to surgery, and young age are all positive predictors of good postoperative erectile function (Smith & Christmas, 1999). Male orgasm may be altered, unchanged, or painful (Barnas et al., 2004), but there is no ejaculatory fluid after removal of the prostate and seminal vesicles. Chemical or surgical castration results in loss of sexual desire, ED, and difficulty reaching orgasm, and treatment with estrogens results in gynecomastia and other features of feminization (Kumar, Barqawi, & Crawford, 2005).

Other prostate diseases, such as benign prostatic hypertrophy causing lower urinary tract symptoms (LUTS), are common in middle-aged and elderly men. In men with bladder capacity problems, 90% report problems with sex function, and 45% indicate that their sexual lives have been spoiled (Peters, 2001).

Women whose chemotherapy or other cancer treatments lead to ovarian failure or loss have decreased levels of estrogen and testosterone resulting in vaginal atrophy, decreased vaginal lubrication, and loss of libido (Meyerowitz, Desmond, Rowland, Wyatt, & Ganz, 1999). Hormonal replacement may not always be possible due to the type of malignancy (e.g., women with estrogen-sensitive breast cancer). Surgery or radiation to the female genitalia or bladder can lead to vaginal shortening, stenosis, or dryness, making sexual intercourse painful or even impossible.

In both men and women, depression, anxiety, and relationship stress, as well as loss of independence and work identity, can all adversely effect sexuality.

SEX AND MENTAL HEALTH PROBLEMS

Given the mind–body nature of sexuality, it is unsurprising that sexual problems occur as symptoms of, or comorbidly with, most psychiatric disorders.

Depression

Kennedy, Dickens, Eisfeld, and Bagby (1999) determined that in untreated depression, sexual disinterest or arousal problems are present in 50% of women and 40% of men. The incidence of ED may approach 100% in older men with more severe degrees of depression (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994). Interestingly, despite the presence of disinterest or other sexual dysfunction, actual sexual behavior may not decrease in depressed patients. Nofzinger et al. (1993) noted that depressed men remained sexually active, though they reported a loss of sexual satisfaction. Depressed women may remain sexually active at a frequency that is not related to their own loss of interest, but rather matches the level of the partner's libido or the couple's established pattern of sexual interaction (Cyranowski, Frank, Cherry, Houck, & Kupfer, 2004). Accordingly, merely asking if a depressed patient is sexually active can miss the presence of a significant sexual dysfunction.

Anxiety

In anxiety syndromes, there may be heightened sexual performance fears or vulnerabilities to distraction, variously resulting in problems with interest, arousal, or orgasm. Premature ejaculation occurs in 47% of men with social phobia (Figueira, Possidente, Marques, & Hayes, 2001), compared to 21% in the general population (Laumann et al., 1999). Anxiety can lead to sexual avoidance even when libido is relatively intact. Figueira et al. (2001) found very high sexual aversion rates in panic disorder (35.7% of men; 50% of women), dramatically higher than the 2% rate estimated for the general population (Kaplan, 1987). Conversely, anxiety, obsessionality, or insecurity can be reflected in sexual acting out or compulsive sexual behaviors (Bancroft & Vukadinovic, 2004).

Personality Disorders

Patients with major personality disturbances can experience varying kinds of sexual difficulties, ranging from promiscuity (Gunderson & Kolb, 1978) to avoidance. In patients with borderline personality disorder, Zanarini et al. (2003) found that 65% of women and 43% of men avoided sexual intimacy due to fears of becoming symptomatic as a result of relationship volatility, indicating that this could be an important area for therapeutic exploration and treatment.

Bipolar Disorder

Sexual activity may escalate to inappropriate or harmful levels during hypomanic relapses, putting patients at higher risk for sexually transmitted

disease (Raja & Azzoni, 2003). Impulsive sexual behavior can contravene a patient's personal, cultural, or religious beliefs, later causing distress to the patient and significant others as they reflect on the impact of any sexual indiscretions (McCandless & Sladen, 2003). It is important to recognize that bipolar adolescents may not show all of the adult manifestations of this disorder, but hypersexuality and STD risks are important (Geller et al., 2002).

Psychotic Disorders

In schizophrenia or schizoaffective disorder sexual function is usually impaired. Teusch et al. (1995) found that patients with schizophrenia had significantly more dysfunctions of interest, arousal, performance, and orgasm than controls. Furthermore, sexual satisfaction was lower. Antipsychotic medications compound these problems because of their significant sexual side effects.

Illicit Substance Abuse

Use of street drugs can cause impulsivity or heightened libido, resulting in a greater number of sexual partners and a concomitant increase in the risk of acquiring an STD (Colfax et al., 2005; Maranda & Rainone, 2004). Subjective reports vary concerning sex function effects. Kall (1992) found that the majority of men using stimulants such as amphetamines reported increased sexual excitement, intensified orgasm, and longer duration of intercourse when using the drug. However, female polysubstance abusers report that crack cocaine inhibits their sexual performance and desire (El-Bassel, Gilbert, & Rajah, 2003). The majority of heroin addicts, as well as men treated with opioids for chronic pain, experience hypogonadism and erectile dysfunction or diminished libido (Daniell, 2002). Drug abuse can also represent attempts to self-medicate a sexual difficulty or trauma (Medrano, Hatch, Zule, & Desmond, 2003).

Alcohol

In women, alcohol tends to impair sexual response, at least with chronic use. Blume (1998) found that alcohol interfered with women's sex hormones and was associated with irregular menstruation, infertility, early menopause, lack of sexual interest, and painful intercourse. O'Farrell, Choquette, Cutter, and Birchler (1997) compared married couples with an alcoholic husband to nonalcoholic couples (both those with marital conflict and those without). They found that alcoholic men have problems with erectile dysfunction, delayed ejaculation, and less frequent intercourse as they age. However, the only measure on which these men differed from

men in maritally conflicted, nonalcoholic relationships was a greater prevalence of ED. There is evidence that erectile dysfunction secondary to the polyneuropathy from thiamine deficiency will resolve with vitamin B_1 treatment (Tjandra & Janknegt, 1997). Overall, however, alcohol-related sexual dysfunction may be due more to adverse effects on the liver and the gonads (Gumus et al., 1998).

Psychiatric Medication

Sexual side effects are common with many psychotropic medications. To some extent these effects can be predicted from the activity of four key neurotransmitters (see Figure 11.1):

1. Dopamine (DA) facilitates libido and has positive effects on genital arousal (Kruger, Hartmann, & Schedlowski, 2005). DA blockers (e.g., antipsychotics) will impair libido. DA agonists (e.g., levodopa) can elevate libido.
2. Noradrenaline (NA) has complicated effects depending on concentration and site of action. In the brain, NA is generally stimulating, so moderate doses can facilitate libido (though higher amounts provoke anxiety). In men, NA causes vasoconstriction, keeping the penis flaccid. But NA is necessary to trigger ejaculation. Accordingly, drugs that oppose it (e.g., alpha blockers) can promote erection but interfere with ejaculation.
3. Acetylcholine (Ach) is one of the preliminary neurotransmitters en route to nitric oxide release and thence to erection. It is also necessary for the pelvic muscle contractions of orgasm. Accordingly, drugs with anticholinergic activity can interfere with erection (or lubrication) or with orgasm (and ejaculation).
4. Serotonin seems to dampen all levels of sexual response. Accordingly, selective serotonin reuptake inhibitors (SSRIs), which boost synaptic serotonin, have a fairly high incidence of sexual side effects—

	Interest	Genital Arousal	Orgasm
Serotonin	X	X	X
Acetylcholine	~	✓	✓
Noradrenaline	✓	X	✓
Dopamine	✓	✓	~

X = inhibiting effect ✓ = facilitating effect ~ = neutral or unknown

FIGURE 11.1. "S.A.N.D.": an acronymn for four neurotransmitters that cause sexual side effects.

over 70% in some studies (Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001). In contrast, an SSRI may be useful in the treatment of premature ejaculation by raising the ejaculatory excitement threshold.

CLINICAL FRAMEWORKS

Effective management of medically related sexual problems depends on an accurate, comprehensive, multidimensional assessment and diagnosis, applied within some framework that makes sense to both patient and clinician. Three mutually compatible ways to organize such assessment–treatment concepts are *general*, *sexual*, and *rehabilitative*.

General Framework

At the broadest or most general level, various illness elements interface with treatment options along four dimensions:

1. *Direct* effects of vascular, neurological (including pain), hormonal, anatomical, or other damage to any area functionally connected to the sex response
2. *Indirect* effects of the medical/psychiatric condition, such as changes to perception or judgment, sensory or motor alterations, bladder and bowel incontinence, spasticity, tremor, fatigue, anxiety, and chronic pain.
3. *Iatrogenic* effects of treatment (e.g., radiation, surgery, medication, chemotherapy)
4. *Contextual* factors (the biopsychosocial complexity and the situational components)

Case Example 1

A woman who is wheelchair bound with multiple sclerosis (MS) may have three sexual concerns: disinterest, arousal disorder, and anorgasmia. The etiology of these problems could stem from *direct* neurological changes in brain or pelvis (altered neural signals; poor genital sensation), *indirect* influences of MS (adductor spasm making intercourse difficult; problems with positioning and weakness; concerns about incontinence with sexual activity; fatigue), effects of MS *treatments* (use of antispasmotics and antidepressants), and *contextual* factors (poor sexual self-image; reliance on caretakers for bladder/bowel and perineal hygiene; restricted physical independence and social accessibility; loss of income; a caretaking husband who is less

sexually interested). Each of these areas has a sexual consequence needing individualized attention.

Sometimes it must be accepted that sexual improvements will be limited. But all potentially reversible factors should be reviewed. For example, improvements in this patient's spasticity, continence, and fatigue might enhance her sexual drive and arousal, but such gains could be sabotaged by failing to address her husband's discomfort with the need to care for her bladder and bowel incontinence.

Many factors contribute to sexual problems in persons with medical conditions. The body parts responsive to sexual stimulation, as well as the ability to interpret sexual messages, can all be affected. After such a change, many try to recover what was lost physically and recapture the same mental sense of sexual pleasure.

Case Example 2

A man who recently suffered a heart attack presents with erectile dysfunction. It could be ineffective or counterproductive to prescribe a PDE5 inhibitor without first considering factors that are direct (his overall vascular status, including genital vasculopathy; the possibility of angina), indirect (the possibility of depression secondary to a chronic illness), iatrogenic (the effects of his medications on sex function), and contextual (fears he or his partner might have about a coital coronary; his true risk of such an event; modifiable risk factors; changes in roles at home, worries about financial security or social isolation, etc.; the attitude of his spouse to resumption of sexual activity).

Case Example 3

A 56-year-old man with onset of PD had severe erection problems and was unable to reach orgasm even with self-stimulation. The sexual relationship with his 48-year-old wife had dwindled after his Parkinson's diagnosis 5 years before when he became depressed and the ED began. As his motor impairments progressed, the rigidity and tremors interfered with the couple's sexual activity options (his ability to caress his wife; his ability to sustain certain positions). During sex, he was relatively immobile in bed, and his bradykinesia rendered him more passive than he was prior to PD. His wife found this change, as well as his flat expression, increased salivation, and excessive sweating, to be a sexual turnoff. With therapeutic replacement of his dopamine levels his sexual desire improved, although his requests for sexual release became quite persistent and sometimes socially inappropriate. Although his wife was clearly disinclined to resume their sexual life, the use of erectile enhancement therapy allowed him to pursue self-stimulation to orgasm, and she was content to occasionally assist him

with this in the same way she attended to his other needs. Issues of the difficulty of her caretaking role and his sexual expectations, assuming responsibility for one's own sexual life, and grief around the loss of their prior sexual relationship were all part of the sexual rehabilitation challenges for this couple.

Sexual Framework

Despite past depictions of the sexual response cycle as a simple, linear phenomenon that progresses from desire and arousal through to orgasm and resolution, it is really a complex, multilevel feedback loop. Physical, physiological, emotional, and cognitive signals are perceived and processed, either facilitating or inhibiting development of psychic and somatic excitement, including genital arousal. In turn, sexual responses are mentally evaluated, consciously and subconsciously, either maintaining or impeding further arousal. This "circuit" relies upon the mind–body connection—cognitions and emotions evoke physical reactions that depend upon anatomical and neurophysiological integrity (e.g., nerves, blood vessels, and hormones). In turn, the body's responses induce thoughts and feelings that prompt release of neurochemicals evoking further physical responses.

Diagrams that emphasize this idea of a sexual response feedback loop can inform diagnostic formulations and treatment plans (Barlow, 1986; Hyde & DeLamater, 1997; Motofei & Rowland, 2005). They can also be extremely useful in providing a framework for explaining sexual problems to patients (and partners), helping them to feel less stigmatized, better informed, and more inclined toward compliance with suggested treatment.

Using a Biopsychosocial Feedback Loop Diagram to "Normalize" Sexual Dysfunction

We suggest to patients that libido (sex drive) is not an irresistible force or instinct compelling us to sexual action. Instead, as the phrase sex *response* implies, we behave sexually *in answer* to a trigger or signal. If the ensuing reactions and experiences are positive, people want to repeat them, whereas negative experiences are merely endured or, preferably, avoided. The model is then explained to patients in detail as follows.

SIGNAL

There are two important aspects:

1. *Type of signal*: This can be something external (a certain touch, taste, sight, sound, smell) or internal (a memory, fantasy, emotion, physical sensation, etc.). A signal can be identified as sexual, but may or may not al-

ways be comfortable or acceptable. Conversely, something not identified as sexual at all by one person may be quite erotic to another. Individuals respond best to their own particular constellation of sexual triggers. Examples might be certain facial features, body shapes or parts, personality attributes, behaviors and temperaments, sensory and situational factors, and so forth. John Money (1984) proposed the term "Lovemap" to describe this set of sexual signals, which, in his view, is established very early in life for every person, and is therefore characteristically resistant to major change.

2. *Reception capacity*: An individual's awareness of a sexual signal is contingent on the psychological identification of something as being "sexual" in nature, but it is also dependent on biological factors such as hormones (testosterone), and the health of the brain, nerves, and sensory receptors, all of which diminish slowly with age.

If no signal is present, or if it cannot be perceived, or if it is unacceptable, then the lack of any sexual response is predictable and inevitable—in a way, *normal* (Figure 11.2). Conversely, an appropriate signal promotes the next step in the process.

EVALUATION

Genital sexual response is normally under constant inhibition from the brain. The process of activation can be quite involved, requiring the mind to evaluate all the elements of the situation and determine whether sexual response should be allowed or suppressed. Both immediate and past issues are considered.

Immediate issues are like "light switches"—they can be turned "on" or "off." And like the Lovemap, an individual's bank of light switches is specific to that person. Each light switch could be given a label. For example:

Person—Most people want to be with a partner with whom they feel safe and secure, and to whom they are attracted (including issues

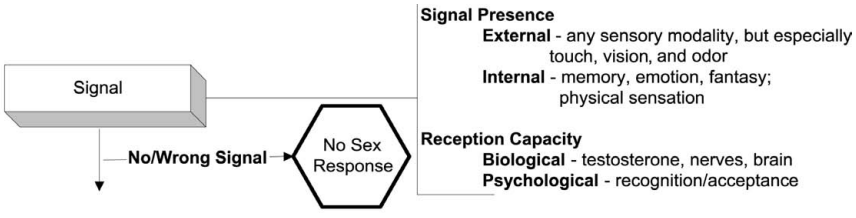

FIGURE 11.2. Sexual response depends on appropriate signals.

of appearance and hygiene). If those elements aren't there, that light switch stays off.

Place—Most people have a preference for the sexual setting, whether a private, quiet, semidarkened room with a comfortable bed, or a blanket in the woods, or experimenting with the possibilities of a subcompact car. Depending on how closely the setting fits the requirement, this light switch turns on or off.

Time—Is it late at night? Is company coming in half an hour? Are the kids expecting dinner? Various commitments or intrusions can make sex inconvenient or impossible, turning that light switch off.

Touch—Most of us have a preference for the site, intensity, rhythm, and pressure of touch; when it feels right, the lights go on; if not, they stay off.

Mood—For most people, joy and excitement promote sexual response; anger, sadness, or anxiety do not.

Preoccupation—Distractions about other situations (work, kids, family health), or about sex itself (*performance anxiety*) can by a very powerful lights-off signal.

In many people, if just one of their light switches stays off, the evaluation is negative, and the signal doesn't get through to generate a sexual response.

Past issues can be like a master circuit breaker—these are important lifelong personal beliefs (e.g., sexual information), values (e.g., family history, cultural and other influences; religiosity), previous sexual experiences (positive or negative), and attitudes and expectations (about sex and about relationships). Just as having any one light switch turned off can lead to a negative evaluation and inhibited sexual response, the "master switch" can potentially cause significant loss of power to the whole system (Figure 11.3).

However, the light switches and the master switch operate independently, and there are no predictable patterns of interaction between them. A person may have significant background trauma, but if all the light switches are on in the moment of a sexual experience, he or she may be able to disregard that history and function well sexually. Conversely, a person may find that all the lights are on and working, but the background factors (possibly unconscious) are too intrusive to overcome–the overall evaluation is still negative, so sexual response is blocked. Again, for that individual, this is predictable and "normal" in the full context of his or her circumstances.

Although most patients are relieved to hear their problem normalized in this way, they are sometimes surprised to learn that sexual response is such a fragile system. Another analogy can be helpful here: Imagine a caveman and a cavewoman making love in their cave bedroom; suddenly a saber-toothed tiger appears in the doorway. Com-

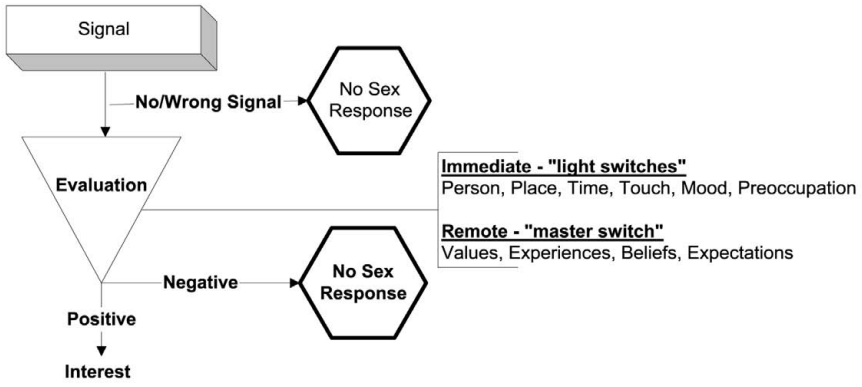

FIGURE 11.3. Evaluation of signals and context promotes or inhibits sexual response.

pleting the sex act is not a priority for this cave couple—they need to be able to turn off "Whoopee!" and turn on "Escape!" It makes sense that the brain would be designed to *turn off the sex response when there is danger.* The problem is that during sexual activity, for many people, the mind is not very good at distinguishing between real danger and perceived threat—the "tigers" of our worries or preoccupations. So our sexual responses can be vulnerable to a multitude of past and present distractions and other intrusions. In a sense, this is not abnormal—it is the way the brain is designed to operate.

So, if the evaluation is negative, a lack of sexual response is predictable and "normal." Conversely, if positive, the largely unconscious evaluation blends with conscious awareness of growing sexual interest, moving the process to the next step: response.

At this point in our explanation to patients we will sometimes add—in an elaboration adapted from work by Levine (1987)—that sexual interest has three components (Figure 11.4):

1. *Drive*—biological (testosterone-dependent) urgency, colloquially referred to as being "horny."
2. *Wish*—for closeness, for affection, for sensual or relaxing touch. A person may not feel especially "horny," but may nevertheless wish to be connected with a partner to show love, to deepen bonds, and to foster intimacy.
3. *Motivation*—a component of interest that involves deliberate choice. A person may feel neither drive nor wish for sexual contact, but he or she may nevertheless choose to be sexual, whether out of a sense of commitment, obligation, or routine, or for material gain, or to forestall some negative consequence.

So, what people recognize as sexual interest results from the combination of a positive evaluation of an acceptable signal, together with the appropriate mix of desire, wish, and motivation. With those elements in place, sexual response can be activated.

RESPONSE

In the presence of sustained interest, the body begins to respond. Nerves fire, blood vessels dilate, tissues expand—these phenomena are reflexes. Patients may be surprised to learn that reflexes can be suppressed. To explain this, we describe the familiar knee-jerk response—when triggered by a tap from a doctor's reflex hammer, the stretched kneecap (patellar) tendon triggers nerves that fire along their circuit up to the spinal cord and back to the thigh muscles, which contract, causing the knee to jerk—that is a reflex; it cannot be forced. But not infrequently, despite normal nerves and muscles, the reflex doesn't happen. The doctor knows to then ask the patient to clasp his or her hands tightly and pretend to try to pull them apart. While the patient is distracted by this task, there is no conscious attention on the knee or thigh muscles—the reflex is freed from the inhibition of the observing brain. The doctor's next hammer strike then triggers a normal reflex. Patients can extrapolate from this example to understand how the thinking brain suppresses sexual reflexes.

We explain that the body's *capacity* to respond is dependent on anatomical status, intact blood vessels and nerves, a healthy hormonal milieu, and the absence of pain or immobility. If these elements are damaged through illness or injury, impaired as a consequence of drugs or a side effect of medication, or merely dulled by age, then responses will be compromised. Again, this lack of sexual response is framed as an expected consequence of the physical or physiological impairments (Figure 11.4).

The model indicates that the body's reactions are fed back into the loop at the trigger and evaluation levels, where the brain assesses whether the response is satisfactory and desirable or, for example, incomplete, disappointing, or embarrassing. That critical secondary evaluation then maintains or inhibits the reflex somatic responses, thus creating a continuous feedback loop. A younger age tends to facilitate a rapid and direct throughput from signal to response with minimal distraction, whereas normal changes of older age cause a diminution in nerve sensitivity, and perhaps a greater vulnerability to distractions, such that stronger signal intensity, both physical and mental, may be required to trigger a response.

Issues relating to sexual self-confidence and to one's identity as a sexual person (body image, sexual self-esteem) can be especially impairing. Pain, disability, disfigurement, or deformities affect all three levels of the framework, for both patient and partner. Therefore, medically compromised patients may need additional interventions to resolve these issues.

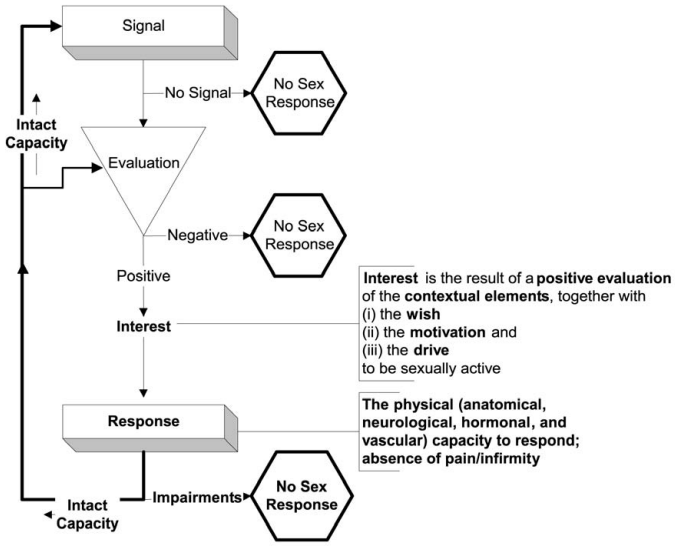

FIGURE 11.4. Psyche and soma: creation of the sexual response feedback loop.

It is in the nature of most sexual experiences that each person monitors not only his or her own sexual response, but also that of the partner, so there are really two overlapping feedback loops in play. Again, these can be mutually reinforcing or inhibiting. In a positive situation where both partners enjoy good physical and emotional health, these circuits continue to resonate and fortify themselves, reaching higher and higher levels of sexual excitement, potentially leading to orgasm. But even though the sexual response may begin satisfactorily, any element can change—suddenly a light switch goes off, or the memory of a previous bad encounter intrudes, or a position causes unexpected pain, or a diabetic man becomes so frustrated at the deteriorating quality of his erections that he loses all tumescence and interest, or a woman is suddenly self-conscious about a mastectomy scar or an ostomy apparatus, or one partner worries that the other is not really enjoying the experience or that pain is being exacerbated, and so forth. Some people can bridge the momentary fluctuations in arousal caused by these intrusions. But for many others, the transient "loss of power" to the system is sufficiently distracting or worrisome that it becomes a self-perpetuating negative loop, and all response fades.

An additional important concept can be added at this time (Figure 11.5). Both men and women can experience loss of spontaneous sexual thoughts or urges. But if they allow themselves to engage sexually with a partner, and allow the body's reflex arousal to begin in reaction to pleasing touch or to the emotional connection with the partner, the desire to

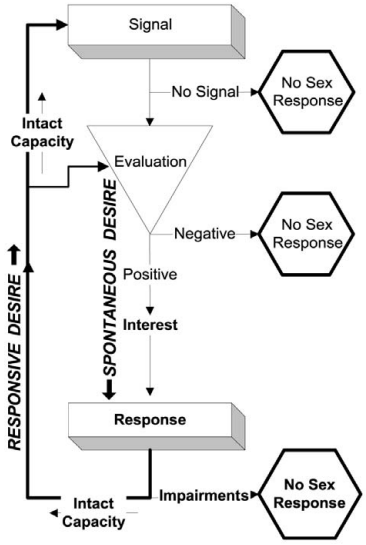

FIGURE 11.5. Normalizing dysfunction: points of entry and exit for the sexual response feedback loop.

continue the experience and perhaps seek orgasm can build as the responses unfold. Interest is still present, but primarily as a response to sexual activity, rather than as a prerequisite to it. Patients can be extremely relieved and reassured to hear that such responsive desire, with or without spontaneous sexual urges, is common and healthy (Basson, 2001).

The final concept explained to patients is the role that orgasm and satisfaction play in reinforcing the wish for future sexual experiences. These are depicted in a separate diagram as the *physical* and *emotional* aspects of outcome (Figure 11.6). It is possible for a person to have an orgasm but not find the experience satisfying, just as it is possible for a person to find an experience satisfying without achieving orgasm.

Rewarding experiences promote a wish to repeat them. Conversely, experiences perceived as failures can, if repetitive, compound disinterest and lack of response, leading eventually to avoidance of sexual intimacy.

To engage the patient in our explanation of the model, the whole framework is literally sketched out while it's described. The time it takes to do this will vary with the level of sophistication and comprehension of the patient, and with the clinician's facility and confidence with the model. In general 10–20 minutes is sufficient to present the diagram in reasonable detail and to solicit the patient's/partner's understanding and insights. The vast majority of patients find that the model reflects and explains their experience in specific ways. A separate appointment or series of visits can

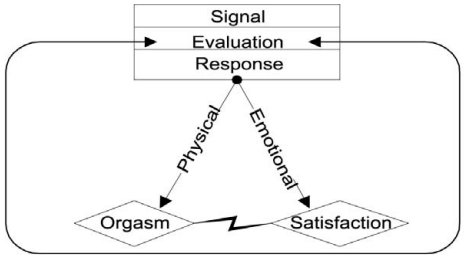

FIGURE 11.6. Outcome: reinforcing the feedback loop.

then be arranged to discuss the implications and possible interventions appropriate for the particular patient or couple.

This biopsychosocial model of sexual response may also be applicable (albeit less relevant) to healthy persons without a sexual dysfunction. But at any age, when sexual problems exist within the context of a medical or psychiatric illness (and even when dysfunctions exist in otherwise healthy persons), we have found the model to be of considerable value for individuals and couples from diverse cultures. There are three main aspects to its clinical utility:

1. It identifies four "zones" of assessment, corresponding to areas of potential intervention: (1) signal type and reception capacity, (2) evaluation, (3) response capacity, and (4) outcome. Depending on the predominance of biological or psychological factors, the patient(s) and the clinician can focus on one or more of these zones with various combinations of treatment, including counseling, psychotherapy, medication, sex aids, and surgery.
2. For patients with a sexual dysfunction due predominantly to biological/physical factors, it permits the clinician to emphasize and legitimize the importance of contextual and emotional elements. Conversely, for patients with psychologically based dysfunctions, it helps remove the stigma that it is "all in their head," since the role of the body is given equal importance to the role of the mind.
3. Use of the model contributes to a more comprehensive and humanistic assessment and diagnosis, engaging patients in understanding the complexities of, and the possibilities for improving, their sexual lives, hopefully leading to more enduring therapeutic success.

Case Example 4

Beth was a 34-year-old account married for 10 years to Brian, a 35-year-old dentist, currently not working. They had no children, by choice. Beth presented with sexual disinterest of several years dura-

tion, exacerbated by irritation at her husband's frequent and insistent sexual advances. The history was exceptionally complicated, however, due to Brian's recurrent major depressive disorder, present since his late teens. His latest episode had been severe, and he had only partially recovered after 2 years, despite intensive treatment including antidepressants and antipsychotics. Accordingly, he had been unable to work throughout that time. Although she accepted the reality of his illness, Beth found it puzzling and frustrating that Brian seemed to still have energy for various leisure pursuits around the home.

More importantly, despite erectile dysfunction (ED) attributed to his medication, Brian described a continuing high level of libido. Beth found Brian's overtures two to three times per week increasingly difficult to endure, describing them as "obsessive" and "harassing." She acknowledged that her libido had never been as high as Brian's, although during their early years of marriage she was sometimes spontaneously interested and was usually orgasmic. Over time, possibly coincident with their pursuit of separate leisure interests and her realization that her optimistic, extroverted personality was sometimes at odds with Brian's introverted pessimism, she began to find their sexual experiences devoid of emotional intimacy. Initially, she noticed loss of spontaneous sexual urges despite continuing responsive arousal and orgasm. Gradually, she found it harder to achieve arousal during sexual experiences, and reaching orgasm became elusive. Eventually, sex began to feel more like a chore than a pleasurable encounter. She was exhausted by the manifestations of Brian's enduring depression, especially his apparent self-absorption, lack of motivation, and inattention to hygiene. At the same time, she felt guilty for reacting to his illness in this way. In part for that reason, she routinely acquiesced to his sexual advances. At other times, she initiated sexual activity herself in order to forestall the mood deterioration that seemed to inevitably follow any deflection or rejection of his overtures.

When seen alone, Brian revealed that he routinely took "drug holidays" from his antidepressant because he had noticed that his erections were better within 2–3 days, worsening again when he restarted the medication. Since he had never discussed this with his physician, he was unaware that this degree of noncompliance could actually reduce the effectiveness of the medication in treating his depression. On more detailed inquiry, he disclosed that, unbeknownst to his wife, his allegedly high sex drive was actually not the result of any real sexual interest. Indeed, he had noticed a considerably reduced libido for 3–4 years. However, he said, "I remember that having sex is what people do when they are well." Accordingly, he was preoccupied with constructing an active sexual life in order to restore some semblance of emotional and relationship normalcy. Although he recognized that, with respect to his erection, "the harder I try, the worse it seems to be," he had no insight into his wife's sexual dissatisfaction.

This case presented an interesting mixture of biopsychosocial factors—depression, medication side effects, performance anxiety, relationship deterioration, and alienation—any one of which might be

sufficient to impair sexual function in either partner. In combination, these elements had resulted in a very dysfunctional sexual and marital relationship. The couple responded very well to the presentation of the sexual response model described above, and they were able to discuss their own respective sets of triggers and the immediate and past issues that impacted on their interest. They gained new insights into the dynamics of their own and each other's sexual responses, and into how Brian's illness played a role. It became evident quite quickly that it wasn't just Brian who was angry; Beth had also developed, but suppressed, a great deal of anger at him, which was interfering with her sexual interest and therefore her willingness and ability to become sexually aroused. As the focus shifted to ways they could constructively resolve or reframe their mutual disappointments and past hurts, they rediscovered ways in which they could be "romantic" rather than explicitly sexual. In turn, they realized that it was romance, rather than contrived sexual intimacy, that truly kindled sexual desire in them both. Brian was subsequently able to use a PDE5 inhibitor to good effect, without requiring changes in his other medications. Overall, this couple recovered a more satisfying sexual relationship and a greater degree of comfort in their marriage.

Rehabilitative Framework

The sexual problems of persons with medical conditions are multifactorial. Men and women who have previously experienced healthy, enjoyable sex functioning have a positive mental and physical template on which to base recovery of sexual function after an acute injury or illness. However, if their condition becomes chronic or gradually debilitating, expectations of *recovery* must give way to pursuit of *adaptation*. For these reasons, the term *sexual rehabilitation* is sometimes a more accurate term than *treatment* when managing medically related sexual dysfunctions.

The framework categories below, adapted from Szasz (1992), are especially helpful in patients with a neurological disability, but are applicable to any medical or (with obvious modifications) psychiatric condition. Although the material covered by these categories may seem daunting to the inexperienced professional, we have found that the framework is relatively intuitive, following a logical order for assessment and management, and quickly becomes second nature with repeated use. We have also found that the framework improves patient motivation and is less clinically pessimistic than other approaches because the person's sexuality is supported in a holistic and practical real-life way.

Sexual Interest

Compare current and premorbid libido. If changed, are there reversible etiologies (e.g., medication side effects, thyroid disease, low testosterone,

depression)? Assess whether the emotional, relationship, and physical outcomes of sexual activity ("sexual payoff") are positive or negative. Some factors will be amenable to individual or couple psychotherapy, and others to medical therapies (e.g., relief of pain, muscle strengthening, hormone replacement).

Sexual Response

Elicit a description of the couple's approach to a typical sexual encounter. Are there manifestations of arousal (erection; vaginal lubrication and accommodation; awareness of neuromuscular tension in the pelvis; feelings of emotional excitement)? Does any activity reliably lead the man or woman to orgasm? Are there changes in the timing, intensity, or volume of the man's ejaculation?

Sensation

The touch to which people learn to respond sexually requires awareness of pleasant sensory input, so it is important to assess loss of sensation in the genital area (e.g., multiple sclerosis; surgery) or other erogenous areas (e.g., loss of breast sensitivity after mastectomy). Unpleasant hypersensitivity may also occur (neurological changes; scarring; drugs/chemotherapy). There may be genital discomfort (e.g., vaginismus or vulvodynia; ejaculatory pain), or more generalized symptoms (e.g., arthritis; fibromyalgia; cancer). Not only can pain be a serious sexual deterrent for the affected patient, but their partner may also be inhibited by the concern that sexual activity could aggravate the pain.

Movement and Motor Function

Assess the ability to undress independently, to get into a bed, to reposition oneself or one's partner, and to caress and hold a partner. Spasm, tremor, and other motor problems limit the options for sexual activity and, for men, can exclude the use of erection enhancement methods that require good visual acuity or hand function. Motor loss and dependency on wheelchairs or caretakers can also limit access to certain social venues and opportunities.

Continence

Concerns with bladder and/or bowel accidents during sex can completely dampen an otherwise intact sexual response (even if the partner is supportive). Some patients become social/sexual recluses due to fears around this issue of incontinence.

Factors Associated with the Condition

Ask about medications, treatments, and overall medical status and sense of wellness. Medication or other treatments can directly affect sexual function, or the medical symptoms of the condition can impair sexual response and the willingness to be sexual (e.g., feeling unwell, nausea, fatigue, depression, excess nighttime sweating, halitosis). Sexual self-image (and the sexual response of others) can be affected by the ability to independently manage oral, genital, and menstrual hygiene. Comorbid conditions can exacerbate any sexual problem. For example, a man with diabetes may already have several elements contributing to his erection difficulties (vasculopathy, neuropathy, endothelial dysfunction), but if he then has a radical prostatectomy for prostate cancer, his sexual functioning is further disadvantaged due to direct nerve damage.

Fertility and Contraception

Fertility is dependent not only on the ability to engage in sexual intercourse, but also on age, and gonadal and hormonal status. Assess the effects of the illness or treatments on fertility. Is there an interest in sperm banking? (Ovarian strip preservation for women is not as accessible or reliable as sperm cryopreservation.) Assess the ability to safely use or effectively administer birth control methods (e.g., a woman with SCI and impaired motor function may be unable to place a barrier method of contraception, or her immobility might put her at higher risk for blood clots with hormonal birth control).

Parenting

Illness can affect the mobility, accessibility, and both the physical and emotional energy necessary to fulfill parenting roles and responsibilities. At times, the needs of the children may be perceived differently by caretakers or by society, such that conflicts arise between those perspectives and the needs and wishes of the patient. It is important to preserve patients' parenting rights without endangering their care or that of their offspring.

Partnership Issues

The context in which sexual activity occurs (or is not occurring) should be explored. Being the caretaker of a partner with a medical condition presents special challenges. It can be awkward and anxiety provoking for both partners to navigate the transition from caring for basic physical needs to being sexual. If the person with the medical condition is single, accessing social and sexual opportunities may be problematic, particularly when the medi-

cal condition is apparent to others (e.g., motor impairments or wheelchair dependence, or having a disfigurement). However, hidden disability (e.g., brain injury) can be just as devastating to one's sense of confidence in attaining and maintaining an intimate partnership.

Sexual Self-Esteem

Illness and the related issues (e.g., continence, hygiene, independence) can adversely affect one's sense of sex appeal, masculinity, or femininity. Previous social roles may be upset or reversed, further undermining sexual confidence. Other important variables include the living conditions and number of family members in the house or in the community, the availability and loyalty of friends and other supports, the ability to work, financial status and prospects, and the level of independence in daily living.

With the above categories in mind, treatment of sexual disorders in persons with medical conditions is most successful when patients and clinicians follow three principles of sexual rehabilitation (Elliott, 2002):

1. *Maximize* the remaining physiological capacities of the total body before relying on medications or aids.
2. *Adapt* to residual limitations by utilizing specialized therapies (positioning options or specialized support cushioning, vibrators, erection enhancement medications, or devices, etc.).
3. *Persist* in rehab efforts with a positive outlook. In contrast to tissue, motor, and sensory recovery, sexuality has the potential to keep on improving long after the physical body has reached its maximum recovery.

Special Clinical Considerations

TECHNIQUE OF THERAPY

The special knowledge, attitudes, and skills needed to elicit personal and sensitive sex functioning information are just as critical when the complaints are associated with illness. That is, the approach needs to be professional, nonjudgmental, respectful, and compassionate. The association of a sexual problem with a medical complaint can convey a "legitimization" that may make attention to this important quality of life issue easier for some patients. For others, it may be necessary first to help refute the view that sex is secondary (or even irrelevant) to other health concerns. Our preference is to assess patients with partners, although separate sessions for each partner are also critical to access certain especially sensitive topics (e.g., previous relationships and experiences; personal reactions to, or fears

about, the illness). Overall, our approach to assessment and treatment is to utilize the comprehensive biopsychosocial approach emphasized in the various frameworks above.

DURATION OF THERAPY

Interventions for sexual problems related to medical or psychiatric illness depend on the nature of the dysfunction and the expectations of the patient/couple. On occasion, a single intervention can be sufficient to provide information, reassurance, some basic suggestions, and a specific treatment. For example, a 42-year-old single diabetic man with combined situational and neurovascular erectile dysfunction, and with recent onset of retrograde ejaculation, was advised about the complicated etiology of his symptoms (i.e., performance anxiety, vascular and neurological pathology from the diabetes). With this explanation he was able to use a PDE5 inhibitor with excellent results. Patients with physical illnesses or disabilities may need to be encouraged to take the time to "relearn" their sexual capacities, or discover new potentials, through both genital and nongenital self-stimulation. Therapeutic efforts may then (1) end with a resolution of the sexual problem coincident with recovery from the illness; (2) continue intermittently and indefinitely if the condition is chronic or deteriorating; (3) terminate when the remaining sexual difficulties have been accommodated into the relationship or adapted to, as noted above. Therapy may also end if the patient/couple decide to relegate sex to "a past part of one's life." All these outcomes are legitimate options.

USE OF SEXUAL AIDS

What types of "sexual aids" might be helpful to someone with a medical condition (e.g., loss of vaginal patency following cancer surgery; loss of genital sensation from multiple sclerosis or an injury)? Ensuring that the options are presented in a professional, nonjudgmental, and respectful manner is more important than the nature of the devices themselves. An open, rehabilitative approach is necessary (i.e., practical, solution-oriented). Vacuum devices for erection enhancement are very practical for men with serious illnesses, or those on multiple medications, and are often better received by couples who have been together for a long time (versus a young, single male). Vibrators, usually placed near a woman's clitoral area, or the glans frenulum area of men, may enhance the chance of orgasm or ejaculation. Phallic or other devices for insertion (anal or vaginal) may allow an avenue of pleasure for some, but not be acceptable for others. Thus, the neutral presentation of any sexual aid is critical to helping patients make a fully informed decision about the use of a device, whether as a temporary ("rehab") or as a permanent solution. Finally, it is always important to

help a couple explore their capacity to "recruit" nongenital sensual/erotic areas into their sexual experience, to maximize their intimacy skills, and to nurture and strengthen their overall (nonsexual) relationship.

Case Example 5

Colin, age 57, had been married for 30 years to Cathy, age 53, and they continued to enjoy an active sex life 2–3 times per week. Two years ago, after a routine digital exam and a prostate-specific antigen (PSA) indicated possible cancer, Colin underwent a prostate biopsy that proved positive for a low-grade carcinoma. Due to the size of the prostate, a radical prostatectomy (surgical removal of the prostate and reattachment of the urethra) was suggested by his urologist, even though this would affect Colin's erectile function. Colin explained that sex was important to him and Cathy, and the prospect of having erectile difficulties was very unwelcome. The surgeon hoped he could spare the neurovascular bundles on either side of the prostate (to preserve erectile capacity), but he was concerned that a wider operation might be necessary. He offered Colin hormone therapy to potentially reduce the tumor size prior to surgery. After one medication injection, Colin's serum testosterone levels were drastically reduced, he lost his libido, and he was having difficulty reaching orgasm. He began to use a PDE5i to assist with his erections. However, in the midst of the couple's various stresses, opportunities for sex seemed to diminish, and the loss of sexual intimacy along with the anxiety surrounding the impending surgery began affecting their relationship adversely. Subsequently, the surgery went well, but the urologist advised Colin that he had to remove the nerves on one side of the prostate to ensure complete removal of the cancer. After surgery, Colin was incontinent for three months, requiring a catheter. When the catheter was eventually removed he was not able to hold his urine and had a few accidents. He found this very socially embarrassing and basically stopped his social interactions outside his home, although he continued to work. There, however, he would make hourly trips to the washroom to be sure his bladder was barely full. After 6 months, despite some improvement, he was still not able to totally control urinary dribbling after voiding, and he began wearing thin feminine pads in social situations.

His urologist had recommended that he take a PDE5i three times per week to encourage return of erectile function. Despite feeling sexual arousal at times, and despite using the oral medication, Colin achieved only partial erections that were inadequate for penetration. He tried self-stimulation and after 6 months was finally able to reach orgasm despite having only a semi-erection; however, there was no ejaculatory fluid (as expected with the removal of the seminal vesicles). He also found his orgasm to be brief and less intense than he remembered. He and Cathy tried to resume a sexual life, but Colin found several things disheartening. Without an adequate erection he

felt less manly, and despite Cathy's denials, he felt the resumption of intercourse was necessary for them to have a normal sexual life again. He did not like the fact that he leaked a small amount of urine at orgasm. The months of incontinence and his previous experience with hormonal suppression left him feel sexually "turned off." After 2 years, Colin and Cathy saw a sexual rehabilitation therapist. Loss and grief for the sexual life they once had were acknowledged. Discussions then focused on maximizing the sexual signals for Colin and diminishing the preoccupations, including his embarrassment around urinary issues. These were not issues for Cathy, who felt they were manageable. Having a consistent, reliable erection was one of Colin's main goals, and while this was not achievable with PDE5i use, it was possible with intracavernosal injections. A special mixture of papaverine and phentolamine was used since Colin had penile pain with the use of prostaglandin E_1. With some experimentation he found that this medication was consistently and fully effective. With the resolution of some of the "light switch" distractions related to his illness, and with his trust in Cathy's love and acceptance, they were able to resume a satisfying sexual life.

Case Example 6

A 25-year-old woman was injured in a tourist bus accident 18 months ago on her honeymoon. It was a serious accident that resulted in several deaths. Her lower spinal cord was damaged and she acquired an area of numbness over her perineal area, including vulva, vagina, and lower buttocks, some lower limb motor dysfunction (she was walking with a cane), and bladder and bowel disturbance. Prior to her injury she was fit, attractive, and a "very sexual person." Her most distressing sexual symptoms at this point in her rehabilitation were her lack of feeling with sexual intercourse and her inability to reach orgasm. She felt a great loss at this ability that had previously been so easy and gratifying. She also felt controlled by her bladder and bowel: she was not able to spontaneously void and had to catheterize several times daily. While her bowels were relatively "trained," she was careful about what she ate as she was unable to hold back gas or stool in some sexual and social situations and had to deal with bowel incontinence. This was mortifying for her. Her sexual self image had also declined due to some muscle wasting and loss of pelvic floor control. She mourned the loss of sexual options and was concerned that she would only be a "passive vessel" for her partner. She was also concerned that her fertility might be affected and that, if she were to become pregnant, she would not be able to "hold the baby inside." Despite these concerns about her sexuality and function, her sexual drive had been slowly returning over the last 6 months and she was keen, albeit apprehensive, to explore her potential in this area.

She and her husband were able to use their previous sexually

gratifying experiences as a benchmark for possibilities, and both set out to learn new options. It was important that the sexual losses they had both experienced were acknowledged. It was also necessary to address her sense that, having survived a horrible trauma, she was no longer entitled to the "luxury" of sex. She was reassured about her remaining fertility and her capacity to maintain a pregnancy. The couple gradually accepted that sex was an important and legitimate quality of life issue for them, and they became more confident and enthusiastic in exploring their considerable remaining potential. Basics were dealt with: she saw a pelvic floor specialist, accommodated to regular catheterizations to protect her kidney and avoid overflow incontinence, had dietary advice to assist with bowel control, and experimented with sexual positions on her own to see what was manageable. With those issues mastered, she was then able to focus on learning nongenital methods of sensual recruitment. By 24 months she had regained a small amount of pelvic floor control and incomplete sensation secondary to some nerve regeneration. Over time she learned to recruit breast stimulation to achieve high arousal levels and eventually experienced an altered but satisfying orgasmic release. Both partners felt their experience with nongenital arousal was a new and exciting area of intimacy they might never have known if the injury had not forced them to expand their previous horizons.

OBSTACLES TO IDENTIFYING SEXUAL PROBLEMS

Despite their prevalence and importance, sexual concerns are possibly the most difficult area of health for patients and professionals to address. Sexual function is a subject that is uniquely private and sensitive, something that many individuals have never openly discussed with anyone, even a sexual partner. Conversely, North American media inundate us with images of people who are young, vibrant, extroverted, and sometimes overtly erotic. Directly and indirectly these images propagate a mythical sexual standard suggesting that youth, beauty, fitness, and robust health are all prerequisites to an active sexual life. Perhaps many young people are themselves intimidated by this illusive and unrealistic stereotype. But certainly people who are ill, injured, or elderly have little validation to see themselves as sexual beings whose concerns are legitimate and deserving of medical attention. Instead, the implication is that a disabled, infirm, or merely older person is unattractive, uninterested, and incapable or even unworthy of sexual thoughts, feelings, and needs. The combination of these insidious cultural myths and the intrinsically private nature of sexuality inhibits patients from disclosing questions, concerns, or problems. Patients apparently expect little help from physicians in any event. Marwick (1999) reported on a public opinion poll in which 71% of respondents said they thought their doctor would dismiss any concerns about sexual prob-

lems, although 85% said they would broach the topic with their physician even if they might not get treatment for it. Still, embarrassment, misinformation, fear of stigma, or concerns about insurance coverage can all be factors that exacerbate nondisclosure.

Notwithstanding many patient, professional, and systemic obstacles to conducting a careful assessment and offering treatment for the sexual problems of medical patients, it is clear that patients need and value clinicians who will take the time to discuss these issues.

COMPREHENSIVE ASSESSMENT: INTEGRATING THE MIND AND THE BODY

Combining medical and psychological approaches results in the most comprehensive understanding of sexual response and dysfunction and provides the opportunity for the most comprehensive intervention.

It is not necessary to be a subspecialty expert to provide meaningful care for patients with sexual problems. The sexual response model and other frameworks used above can be combined easily with the PLISSIT scheme outlined by Jack Annon (1976) and modified to suit the skill level of any clinician.

For example, PLISSIT for a postcoronary patient could look like this:

Permission: legitimize topic of sex, validate patient's problem, empower to make choices (to change or not change the status quo).

Limited Information: prevalence of sexual concerns in the community or with specific illnesses; typical variations of sexual behavior; need for physical health and comfort and for emotional safety/trust to be able to be sexually responsive; effort of coitus and risk of death; value of exercise; medication side effects.

Specific Suggestion: optimize medications; address modifiable risks (e.g., smoking, obesity, diabetes, hypertension); noncoital sex options and alternative coital positions; avoid sex with fatigue, food, or alcohol; use and safety of erection enhancement (e.g., PDE5is; prostaglandin injections; vacuum erection devices); use of feedback loop diagram to identify the role of modifiable "light switches" or past issues.

Intensive Therapy: individual or marital/couples counseling; sex therapy.

SUMMARY

Contrary to the notion that sexual problems are either "organic" or "psychogenic," sexual dysfunctions are biopsychosocial phenomena with an

extraordinarily high rate of comorbidity across the spectrum of physical and mental illness. Fortunately, some degree of resolution is achievable for many patients with sexual concerns. For that reason, and because medically related losses in sexual function have a significant effect on quality of life, health care professionals should assess sexual issues as a routine part of their clinical work with most patients.

Health care professionals who undertake a respectful, empathic, sincere, nonjudgmental, and compassionate exploration of these issues will find the majority of their patients receptive and grateful.

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CHAPTER 12

Sexual Dysfunction and Childhood Sexual Abuse

Gender Differences and Treatment Implications

KATHRYN HALL

The prevalence of unwanted sexual contact with children and young adolescents by adults is staggering, and it often goes underreported and undisclosed. In almost all cases, it involves the abuse of power, and the perpetrator is often someone known and familiar. There appears to be little variation across ethnic or cultural groups, although girls are more likely to experience sexual abuse than boys, to endure it for longer periods of time, and to be abused by a family member.

In this chapter, Hall reviews the effects of child sexual abuse on the adult sexual functioning of men and women. Women with a past history of abuse are vulnerable to many sexual inhibitions and relationship problems as adults, including flashbacks, dissociative episodes, feelings of shame and guilt, compulsive sexual behavior, and sexual aversion. These effects can persist long after the abuse has been terminated. While not as widely studied as abuse of women, the sexual abuse of boys may lead to sexually aggressive behavior, multiple sexual partners, fears of intimacy, compulsive sexual behavior, and confusion regarding sexual orientation.

After considering the various theories accounting for the association between child sexual abuse and later sexual functioning, Hall highlights the unique aspects of conducting sex therapy with adults sexually abused as children. She emphasizes the importance of pacing treatment to match the client's needs and current level of func-

tioning and indicates that there is a shortage of data supporting the view that past sexual trauma must be resolved prior to initiating sex therapy treatment. As with all sex therapy treatments, attention must be paid to both the individual who has been abused and the partner.

Hall summarizes the most important general principles to observe when working with abused clients, highlighting the significance of pacing assignments slowly, reframing the sexual problem as a couple issue, establishing clear and realistic goals, teaching anxiety reduction techniques such as focused breathing or the use of signals to request a break during a sexual activity, and above all, the necessity of remaining positive, patient, and compassionate. She presents two complex cases illustrating the issues that emerge and the therapeutic skill required in providing sex therapy to men and women with a past abuse history.

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The behaviors that constitute sexual abuse are numerous. In essence, child sexual abuse (CSA) is any behavior that exploits a child for the sexual gratification of another. The exploitation may involve physical force, threat of force, intimidation, bribery, drugs, or other abuse of power, such as taking advantage of one's greater status or authority either by virtue of age, knowledge, or position. Sexual abuse has come to the cyber age, and technological advances such as computers, "nanny cams," and other devices are being used to watch, record, and transmit child pornography with an ease never before available.

Although one must be aware of the fact that CSA is often unreported (Summit, 1983), commonly cited prevalence rates in community samples are approximately 33% of girls under the age of 18 and 5–10% of boys the same age (Finkelhor, 1994). While these estimates are for contact abuse and exclude behaviors such as exhibitionism, voyeurism, and exposure to pornography, the contact can vary from frottage to fondling to forced vaginal, oral, or anal penetration. The perpetrator could be a stranger, a relative, or one's father and the abuse may have occurred once or repeatedly for years. What we call sexual abuse is not a discrete phenomenon, but rather a broad category of experiences and behaviors.

There does not appear to be significant variation across ethnic and cultural groups in terms of rates of sexual abuse (Loeb et al., 2002) but this has not been well studied. There is some indication that African American girls are more likely to be sexually assaulted than their white counterparts (Cecil & Matson, 2005) and the circumstances and types of abuse may vary along ethnic lines with European American women reporting a higher incidence of childhood rape (Wyatt, Loeb, Romero, Solis, & Carmona,

1999). Prevalence rates in clinical populations are generally higher than in community samples (Leonard & Follette, 2002).

The sexual abuse experienced by boys and girls often differs quite significantly. While girls are more likely to be abused by a family member and to suffer abuse for a longer period of time, boys are more often abused by a perpetrator of the same gender and one who is closer to them in age (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Gordon, 1990). Although boys are more often abused by a nonrelative, it is important to remember that boys do experience sexual abuse from important family members, including mothers (Kelly, Wood, Gonzalez, MacDonald, & Waterman, 2002).

The dichotomous classification of CSA and adult sexual assault leaves open the murky middle ground of adolescence. Researchers and clinicians reference different ages to define CSA. Cutoff ages of 12, 14, 16, or 18 are often cited in treatment and research reports. Regardless of age, CSA is distinguished from adult sexual assault by virtue of the fact that the sexual abuse occurs prior to the formation of an adult sexual identity or the experience of mature consensual sexual activity. Clinically speaking this will encompass some adolescents, but not others.

This chapter deals with adults who have a history of CSA, commonly referred to as "survivors." This moniker does not presume any particular level of functioning but assumes that the individual has lived through a traumatic ordeal. This terminology reflects the strong roots that the study of CSA has in the field of posttraumatic stress. Because not all individuals who have been abused in childhood are traumatized in the clinical sense (McMillen, Zuravin, & Rideout, 1995; Rind, & Tromovitch, 1997; Rind, Tromovitch, & Bauserman, 1998) the term "survivor" is not used in this chapter.

EFFECTS OF CSA ON SEXUAL FUNCTIONING

Effects of CSA on Functioning in Women

Women with a history of CSA report sexual dissatisfaction more often than do their nonabused counterparts (Bartoi & Kinder, 1998; Gold, 1986; Jackson, Calhoun, Amick, Maddever, & Habif, 1990; Tsai, Feldman-Summers, & Edgar, 1979). Classifying the sexual dysfunctions according to DSM-IV-TR (American Psychiatric Association, 2000), one notes that the most prevalent problems reported are disorders of desire, arousal, and orgasm, while dyspareunia and vaginismus are also reported but less frequently (Leonard & Follette, 2002). However, many women sexually abused in childhood report feeling sexually dissatisfied without meeting the DSM criteria for sexual dysfunction (Jehu, 1988; Westerlund, 1992). Indeed the sexual difficulties reported by sexually abused women do not

easily fit into the DSM classification scheme. In a sample of such women seeking sex therapy, frequent complaints included flashbacks of abuse during sexual activity, dissociative experiences during sex, distress, shame and guilt about sexual responding, sexually compulsive behavior, panic, aversion to specific sexual activities, and sexual avoidance (Hall, 2005).

Women with a history of sexual abuse have been found to engage in sexually risky behaviors that could expose them to numerous dangers, including risk of HIV infection (Walser & Kern, 1996) and sexual assaults in adulthood (Wyatt, 1992). Adult sexual assault victims with a history of CSA have been found to have significantly more sexual problems and greater levels of sexual dissatisfaction than women with a history of only adult or only childhood sexual abuse (Mackey et al., 1991). Indeed, the number of times a woman has been victimized is correlated with a greater frequency of unwanted, unprotected, and risky sexual activity (Wyatt, Guthrie, & Notgrass, 1992). However the victimization need not be limited to sexual abuse. In a sample of Native American women, physical and emotional abuse was more predictive of engaging in risky sexual behavior than was a history of CSA (Hobfoll et al., 2002). While this study may reflect cultural differences it is also possible that the physical and emotional abuse occurred more often than sexual abuse, thus accounting for the greater impact of these forms of abuse on subsequent sexual behavior.

Victims of childhood physical abuse and neglect have also been found to have relationship problems, infidelity, and sexual dissatisfaction (Colman & Widom, 2004). Perhaps women who suffered multiple forms of abuse in childhood and later years experience the most profound effects on their sexuality. Multiple forms of abuse are frequently coincident. It is often the case that incestuous sexual abuse is accompanied by at least emotional abuse, but also by physical abuse and neglect as well.

In a large-scale survey of Australian men and women ages 18–59 years, a significant relationship was found between the reported occurrence of sexual problems and a history of CSA for women, but not for men (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). Women who experienced any form of abuse, but especially those whose abuse involved oral, anal, or vaginal penetration, were more likely to report experiencing three or more sexual problems in the previous 6 months. Nevertheless, for both women and men, a history of CSA was not associated with diminished physical or emotional satisfaction with their sexual relationship. While reaffirming that sexual problems do not necessarily indicate the presence of a diagnosable sexual dysfunction, this survey also shows that sexual abuse in girlhood can have an impact on adult sexuality many years later.

In one of the few studies looking at women in midlife, Dennerstein, Guthrie, and Alford (2004) found that there was still an impact of CSA on women between the ages of 51 and 62 years. Women who recalled sexual abuse in their childhood had significantly shorter relationships and tended

to rate their partner more negatively than did women who were not so abused. Women who were both physically and sexually abused suffered the greatest negative impact on their sexuality in their middle years and reported a lower frequency of sexual activity when compared to women who had not been physically abused, whether they had been sexually abused or not. Clearly, sexual abuse may affect women differently depending upon how frequently the abuse occurred, if it was accompanied by physical violence, or involved penetration and also when the effects of the abuse are measured.

Meston and Heiman (2000) examined the cognitive processes that might mediate CSA and adult sexual functioning in women. They found that sexually abused women were more likely than nonabused women to describe themselves in negative terms and less likely to attribute positive meaning to sexual behavior. The authors surmise that a history of CSA may create a negative frame of reference when it comes to sexuality and a woman's sense of self. Indeed, Wenninger and Heiman (1998) found that women who had a history of sexual abuse viewed their bodies as less sexually attractive than did nonabused women.

Mullen, Martin, Anderson, Romans, and Herbison (1994) hypothesized that a history of sexual abuse disrupts the formation of trust in intimate relationships. They found that not only did women with a history of CSA report more sexual problems but also they were more inclined to view their partners as uncaring and overcontrolling than were nonabused women. Schloredt and Heiman (2003) found that women with a history of sexual abuse or with a history of both physical and sexual abuse experienced more negative affect (fear, anger, disgust) during sexual arousal than did nonabused women in a community sample. These authors argue that this pattern of negative affect during arousal may be a precursor to sexual dissatisfaction and sexual dysfunctions as outlined in DSM-IV-TR.

Not all women abused as children will suffer from sexual difficulties in adulthood (Alexander & Lupfer, 1987; Fromuth, 1986, Rind et al., 1998). Schloredt and Heiman (2003) noted that studies using college samples typically find few associations between childhood abuse and adult sexual problems, while those studies using clinical or community samples generally find a relationship. College samples may represent the most resilient women.

Effects of CSA on Sexual Functioning in Men

Although the sexual abuse of males has received far less clinical and empirical attention than has the sexual abuse of females, there is a growing interest in this long-neglected area. Men who were sexually abused in childhood have been found to suffer negative emotional, behavioral, and sexual consequences when compared with men who were not abused (Dhaliwal et

al., 1996). Several reviews of the literature have noted some or all of the following sexual problems in men with histories of CSA: compulsive sexual behavior, sexually aggressive behavior, multiple sexual partners, fear and sexual avoidance, erectile problems, premature ejaculation, retarded ejaculation, fetishism and sadomasochism (Dhaliwal et al., 1996; Dimock, 1988; Loeb et al., 2002). Compulsive sexual behaviors include frequent masturbation (up to four or five times per day) and sexual activity with men in pornographic bookstores and restrooms, as well as frequent and multiple sexual partners. These activities are distressing to the men experiencing them and viewed as beyond their control. Frequent urogenital complaints and surgeries have also been noted in men with histories of childhood sexual abuse (McCarty, Roberts, & Hendrikson, 1996). However the nascent literature in this area suffers from small sample sizes, lacks control or comparison groups, or is based largely on clinical populations (men in treatment).

In their review of the literature, Loeb et al. (2002) concluded that adolescent males with histories of CSA experience a higher rate of sexual acting out and sexual identity confusion and higher rates of HIV infection and other STDs than their nonabused peers. However, the majority of the studies they reviewed dealt with HIV-infected men, as well as gay and bisexual men. The generalizability of these results is open to question.

Examining the results of their qualitative study of men with a history of CSA, Gill and Tutty (1999) argued that men's sexual problems arise from their difficulty forming stable relationships and integrating sex and emotional intimacy in adulthood. A recurring belief that one would ultimately be used, manipulated, or abused in an intimate relationship was common among the men in their sample. Difficulties establishing trust and stability in a relationship have been noted elsewhere (Dimock, 1988). Dhaliwal et al. (1996) commented on the tendency of men with histories of CSA to partner with someone who is abusive and to experience difficulties in their intimate relationships. Poor boundaries and sexually provocative behavior with others, including health care professionals, has been noted (Courtois, 1993; McCarty et al., 1996).

While there does not appear to be a causal relationship between sexual orientation and sexual abuse history for men, gender identity confusion, internalized homophobia, and ambiguity regarding sexual orientation have been noted in sexually abused boys (Dimock, 1988; Loeb et al., 2002). Many men have also reported feeling confused about their masculinity, as being a victim is not considered part of a stereotypical masculine identity (Dimock, 1988; Gill & Tutty, 1999).

In studies that have examined the impact of other forms of childhood abuse on men, emotional abuse, neglect, and family environment have been found to be more predictive of sexual and social dysfunction than sexual abuse alone (Colman & Widom, 2004; Kinzl, Mangweth, Traweger,

& Biebl, 1996; Rind, Tromovitch, & Bauserman, 1998). In their study of 1,032 undergraduates Meston, Heiman, and Trapnell (1999) found significant gender differences in the impact of sexual abuse on the sexual functioning of college students. Specifically, women who were sexually abused reported lower sex drive yet engaged more frequently in intercourse and other sexual behaviors including masturbation when compared to their nonabused counterparts. The story was quite different for the male students. A history of sexual abuse was not related to sexual functioning while a history of emotional abuse was. Frequency of emotional abuse was negatively related to sexual satisfaction and body image, independent of the effects of physical or sexual abuse or neglect. This study is not alone in finding a stronger relationship between adjustment problems and sexual abuse for women as opposed to men (c.f. Najman et al., 2005). However, many of these studies may inadvertently be comparing men sexually abused by a stranger or acquaintance with women who were abused by a family member. Most scales or questionnaires designed to detect abuse consider emotional or physical abuse only if it is perpetrated by a parent or parental figure, whereas sexual abuse may have been perpetrated by anyone (Hobfoll et al., 2002). The violation of trust is therefore inherent in the sexual abuse of girls in a way that it may not be with boys. Evidence suggests that incest experiences are as damaging to the formation of trust in intimate and sexual relationships for boys as they are for girls (Kelly et al., 2002). Nevertheless, the cautionary tale here is to take into consideration the family environment in which the abuse occurred and not to attend solely to discrete sexual events (Melchert, 2000).

Still other studies have led to the conclusion that sexual abuse of males does not always lead to a negative outcome. Dhaliwal et al. (1996) found that men rate their childhood sexual abuse experience more positively than do women. The authors note that while boys may be truly less distressed than girls by sexual abuse, another interpretation of these findings is that men may be complying with society's notion that males enjoy early sexual experiences. Indeed, men are less likely than women to self-identify as a victim of sexual abuse, especially if the perpetrator is female (Stander, Olson, & Merrill, 2002). However, initial positive perceptions of abuse experiences may predispose some men to have a greater number of adjustment problems, including sexual problems, when the abuse involves incest (Kelly et al., 2002).

In a study of gay and bisexual men, Stanley, Bartholomew, and Oram (2004) found that only half of the 50 men who reported sexual experiences in childhood with someone 5 or more years their senior regarded these experiences as negative, coercive, and/or abusive. Males who did not view the experiences negatively were similar in adult adjustment to those men who had never had such experiences. Only those men who viewed their childhood experiences as negative had a poor adjustment in adulthood.

These findings echo those of Rind et al. (1998), who also found that only those men who viewed their childhood sexual experiences negatively were adversely affected by them.

When looking at studies employing clinical samples, it seems that some men are profoundly affected by the experience of CSA. Community samples and university samples do not always find a negative effect of sexual abuse. It is possible that there is a bimodal distribution effect for men with histories of CSA. Some are seriously and negatively affected by the experience and others are more resilient. Although this issue is controversial, the way sexual abuse is defined for boys may require revision, as relying solely on an age differences between sexual participants does not adequately reflect the damaging and coercive nature of a truly abusive experience.

Summary

Men and women are impacted differently by sexual abuse. It is clear from studies looking at clinical samples that sexual abuse can have devastating effects on the sexuality of individuals of both genders. This seems to be especially true for incestuous abuse. However, standard definitions of abuse based on age and status differences may not always reflect a boy's experience of a sexual interaction. Emotional abuse and especially the experience of powerlessness seem to be key elements in determining negative outcomes of sexual experiences (Kallstrom-Fuqua, Weston, & Marshall, 2004). For boys and girls, a higher incidence of abusive events and more types of abuse experienced predict a greater negative impact on sexual functioning.

THEORIES

Theories regarding the impact of CSA on adult sexual functioning can be divided into two groups: those that posit a direct effect of sexual abuse on later functioning and those that assume mediating or intervening effects. Trauma based theories assume a direct link between the sexual abuse and the development of later sexual problems: the greater the trauma, the greater the disruption in adult sexuality. Developmental theories assume that there are mediating events and variables that explain the long-term sexual effects.

Of all the trauma-based models the one put forth by Finkelhor and Browne (1985) is perhaps the best known and researched. It has come to be known as the traumagenic model. According to this model different aspects of sexual abuse will produce different traumatic reactions, namely betrayal, traumatic sexualization, stigmatization, and powerlessness. For

example, incest has elements of betrayal that are not evident in stranger molestation. Hence, according to this model, trust and intimacy will be more impaired in those who experienced incest than in victims of stranger rape. In terms of sexual functioning, Finkelhor and Browne posit a relatively straightforward path from traumatic sexualization in childhood to sexual problems in adulthood. This would account for the strong association between sexual abuse and later sexual functioning that is often found in clinical samples and that is more obvious in samples of women. However, this model does not predict what the problems will be—either avoidance of sexual activity because of its aversiveness or heightened sexual interest and greater sexual activity due to an early introduction to sexual stimulation. This model also fails to adequately account for the resiliency of some men and women, except to note that social support and reactions following the discovery of abuse can have ameliorating effects. But the greatest drawback, according to Browning and Laumann (1997), is that the model fails to locate sexual abuse within an "unfolding life course" (p. 542). In other words, by focusing on the characteristics of the sexual abuse to explain long-term effects, the model fails to take into account subsequent events including consensual sexual activities and relationships in adolescence and young adulthood. While there is some empirical support for this model (Kallstrom-Fuqua et al., 2004), many of its predictions have not been substantiated. Using the data from the National Health and Social Life Survey (Michael, Gagnon, Laumann, & Kolata, 1995), Browning and Laumann (1997) did not find a relationship between severity of abuse and subsequent long-term effects. Furthermore, they found no evidence of sexual avoidance, only an increase in sexual activity in adolescence for girls who were sexually abused.

Browning and Laumann (1997) argue that sexual trajectories account for the association between CSA and adult sexuality. In other words the link between CSA and adult sexual functioning is an indirect one determined by the patterns of sexual activity that are established in the aftermath of the abuse. They call this the life course perspective.

Others have also argued that the long-term effects of sexual abuse are determined by behaviors and patterns of coping in the interim (Tsai et al., 1978; Wyatt, 1993). There is some empirical support for the life course perspective and other developmental theories. Merrill, Guimond, Thomsen, and Milner (2003), in their study of 547 female navy recruits, found that women who used self-destructive coping strategies in response to the abuse (such as drug and alcohol abuse, suicidal ideation, and running away from home) engaged in indiscriminate, risky sexual behavior and had more sex partners as adults. Women who used avoidant coping strategies (suppressing thoughts and feelings, being reclusive) had a higher level of sexual distress and dissatisfaction as well as sexual dysfunction. In one of the few prospective studies on the impact of CSA, Noll, Trickett, and

Putnam (2003) looked at the sexual adjustment of women 10 years after disclosure. Sexual aversion was predicted by the presence of sexual behavior problems that were noted subsequent to the sexual abuse. Sexual ambivalence, which was defined as the presence of both sexual preoccupation and sexual aversion, was predicted by pathological dissociation used to cope with the sexual abuse. In both of the aforementioned studies, however, a significant portion of the variance in sexual functioning and attitudes remained unaccounted for by use of coping strategies or adjustment factors.

Most of the theories regarding the impact of CSA are based on studies done primarily on women and tend to explain outcomes found primarily in women. The traumagenic model accounts for gender differences only insofar as the sexual abuse experienced by boys and girls differs. Meston et al. (1999) suggest that a sex role perspective may be helpful in understanding the relationship between sexual abuse and sexual adjustment. They note that sexual norms differ for men and women such that women are supposed to be more sexually constrained than men. Therefore, the authors argue, sexually abused women may come to see themselves as sexually atypical (i.e., unconstrained, damaged, seductive, provocative) and that once they see themselves in this light, further sexual behavior and adjustment problems will result. Men, on the other hand, are supposed to be sexually unconstrained and that fits in with the definition of successful men (e.g., powerful, competent). This may help explain why the sexual acting out behavior of adolescent males following sexual abuse does not necessarily augur a negative outcome in adulthood whereas the sexual acting out of adolescent girls does.

No one theory has garnered overwhelming empirical support. It appears that for some men and (more) women there is a direct and traumatic effect of sexual abuse on sexual functioning. Powerlessness appears to be an important dynamic in defining abuse (Kallstrom-Fuqua et al., 2004), whereas age disparity, especially for boys, does not. The reactions that one experiences and receives are important in determining outcomes for sexually abused children. Some negative trajectories make the normal tasks of adolescence difficult if not impossible. Developing trust and intimacy in romantic relationships is usually affected. Sex may become instrumental rather than intimate and may be used as barter (for affection, stability, for someone else's happiness).

Treatment Options

Treatment for adults sexually abused in childhood is unsystematic and usually long-term (Meston & Heiman, 2000). This is often problematic for those clients who seek therapy with a specific problem, as is the case for those seeking help with sexual problems. Some have argued that dealing with the past abuse in therapy will result in an alleviation of sexual symp-

toms (Dimock, 1988). There is only limited clinical and anecdotal evidence to support this supposition. Controlled outcome research in this area is sorely lacking.

Group therapy for women sexually abused as children has been found to result in increased trust and self-esteem and decreased sexual problems and sexual avoidance (Kessler, White, & Nelson, 2003). Groups lasting a year or more generally report better therapeutic gains (Hazzard, Rogers, & Angert, 1993) even though they do not focus specifically on the resolution of sexual problems. There are no published outcome studies regarding the efficacy of group treatment for men abused as children.

Individual treatment and couple therapy for the sexual problems of men and women abused in childhood are still relatively new and many of these treatment protocols are designed for and used with female clients. The remainder of this chapter deals with treatment of the sexual problems of men and women who were sexually abused in childhood, highlighting gender differences where appropriate.

SEX THERAPY FOR ADULTS SEXUALLY ABUSED IN CHILDHOOD

Sex therapy is ideally suited to deal with the sexual problems of adults molested as children, given its focus on alleviating sexual anxiety and the emphasis on good communication and relearning ways of being sexual. Unfortunately there is little or no data on the effectiveness of sex therapy for men and women with a history of sexual abuse. Sarwer and Durlak (1997) found that prior childhood sexual abuse did not affect treatment outcome for couples in sex therapy. Althof and Leiblum (2005) note that motivation for success, relationship satisfaction, and compliance with homework assignments are the factors most associated with positive treatment outcome in sex therapy. To the extent that sexual abuse contributes to these factors, it may impact on treatment outcome.

For clients with past abuse histories, developing a trusting therapeutic alliance may be difficult (Leahy, Pretty, & Tenenbaum, 2003). Since sexual abuse is de facto an abuse of power and a violation of trust, more time and effort needs to be spent on developing a trusting therapeutic relationship than is usually the case. With sexually abused clients, and perhaps men in particular, therapists must be aware of the possibility of poor boundaries and sexually provocative or even aggressive behavior. While many male clients may seek affirmation of their masculinity from their therapist, it is helpful to make the connection between past experiences and present inappropriate behavior in order to deal with boundary transgressions in a therapeutic context. The therapist must maintain appropriate boundaries at all times.

It is especially important to be aware of biases about the sexual abuse

of boys and men. Many therapists tend to blame males more than females for their victimization (Gill & Tutty, 1999). Furthermore, therapists are less likely to believe abuse stories involving female perpetrators and are less likely to use abuse-focused treatments when they do not believe that abuse occurred (Gore-Felton et al., 2000). Just as it is a mistake to assume a history of sexual abuse based on a client's presenting complaint, it is a mistake to assume there is no history of abuse, based solely on one's disbelief. As Alpert, Brown, and Courtois (1998) note: "Ultimately the client, and not the therapist, is responsible for achieving a personal understanding of his or her history." It is important to respect the client's perspective on his own history even if it means that incestuous abuse or distress about an abusive childhood is not overtly acknowledged.

Given that anxiety and conflict about sex are high in most, if not all, couples seeking sex therapy, one can assume that the situation will be even more charged for clients who were sexually abused. It is often recommended that "safe touch" exercises precede sensual touching and genital exploration (Douglas, Matson, & Hunter, 1989; Glanz & Himber, 1992; Maltz, 1988, 2002; McGuire & Wagner, 1978). As with traditional sex therapy, it is important to pace the therapy to suit the client's needs and current level of functioning.

Many therapists believe that before sexual concerns can be addressed, abuse trauma must be resolved. While it makes good clinical sense to prioritize treatment of serious emotional problems, there are no data to support the contention that sexual abuse issues must be resolved prior to sex therapy. Neither is there any agreement regarding what resolution would look like. In fact, just as dissociative experiences and flashbacks can occur during sexual activity, they can also occur during sex therapy (even if they have never occurred before) and one must be aware of this possibility.

One of the basic tenets of sex therapy is that sexual problems are couple problems. Too often partners have been treated as supports for spouses who have been abused rather than as clients in their own right (Balcom, 1996). An exception to this has been the tendency to view partners as secondary victims of their spouse's abuse (Maltz, 1988; Barcus, 1997). It is not unusual for male partners to complain that they are suffering for the wrongs of others, as their relationships have been disrupted by their partner's distress (Hall, 2005). Partners may also experience vicarious trauma when they hear details of their partner's abuse. Nevertheless, it is important to include the partner in sex therapy and to acknowledge the partner's past experiences and present reactions as a focus of therapy. Buttenheim and Levendosky (1994) express the opinion that sexual dysfunction in a relationship is "an elaborate mutual reenactment of the survivor's incestuous relationships" (p. 407). They caution that individual treatment for abuse-related issues might contribute to and exacerbate incest reenactment in the marriage. In other words, individual treatment or even treatment

that focuses on sexual abuse issues may result in a worsening of the intimate relationship if the partner is not also in treatment. This is an important caveat for therapists.

Thorough assessment of the sexual abuse and its aftermath is an important aspect of the initial evaluation. Assessment is an ongoing process as disclosure about shameful details of abuse often occurs slowly and only after a trusting therapeutic relationship has been established. Men often have difficulty accepting their victimization. Making sense of the connection between past and present behavior is helpful. Far more important than all the support and understanding provided by a therapist is giving clients a way of *thinking* about childhood sexual experiences that makes sense of their feelings and their current sexual relationship.

It is possible that sex therapy will be experienced as a reenactment of abuse, where one person directs another's sexual activities (Glanz & Himber, 1992; Maltz, 1988, 2000). A collaborative approach to designing and suggesting homework exercises is necessary. When the client is motivated to work on the sexual relationship because of a threat (divorce or separation, for example) or out of a desire to please their partner (but not themselves), the therapy may again reenact elements of the CSA. It is helpful for the client to define and acknowledge personal goals for therapy (to relax more during sex, to experience sexual feelings without anxiety). Goals may change as the therapy progresses.

CASE ILLUSTRATIONS

The following two cases illustrate the process of sex therapy in couples where at least one partner presents with a history of overt CSA. In the first case it is the wife who is identified as having a history of sexual abuse; in the second it is the husband.

Jocelyn and Paul

Jocelyn and Paul came to therapy after almost 20 years of marriage, which was marked by infrequent and unsatisfying sex. Paul said that he was drawn to Jocelyn because of her "strong values." Jocelyn stated that when she met Paul she was struck by his gentleness, his intellect, and his respect for her, which she recalled was manifested by his "hands off" approach to their courtship. They did not have sex until they were married, and during their courtship they primarily held hands, kissed occasionally, and talked a lot.

Sex was a problem for the married couple almost immediately, although they did not acknowledge it to each other for many years. The first crisis came when Paul disclosed that he was having an affair, 5 years into

the marriage. This pattern would be repeated several times over the next 10 years; Paul would confess to an affair, amid much heartbreak and soul searching he would end the affair, Jocelyn would forgive him, and the couple would renew their efforts to have a better sex life. Finally, the couple went to marriage therapy and then each to individual therapy. In her therapy, Jocelyn revealed that she had been sexually abused by both her biological parents, a fact she then reluctantly revealed to her husband almost 17 years after they had first met. Paul was saddened by Jocelyn's disclosure and said that for the first time he did not take Jocelyn's sexual disinterest personally.

After several years of individual therapy, Jocelyn asked Paul to go to sex therapy with her. She said that she now felt ready to have a fulfilling sex life and she felt sad and disappointed that she had missed out for so long. It was meaningful to her that Paul had not had any extramarital sex since her disclosure of abuse and she now felt more trusting of him.

Jocelyn and Paul were in their late 40s and had one son who was in college. They both agreed that their sex life had been the major problem in their relationship and both excused Paul's affairs as due to his sexual unhappiness. Sex had been sporadic throughout the relationship and mainly occurred when Jocelyn initiated. Jocelyn stated that if she felt like having sex, she would initiate; if she did not feel like having sex, nothing Paul could do would persuade her. Often during sex, however, Jocelyn would "disappear." As she reported it, she would begin to feel as though she were in a fog and when she became aware of herself and her surroundings again, it was obvious that time and sexual activity had passed. Paul said that he could tell when Jocelyn "disappeared," but he did not know what to do about it. Most often, he would continue on with sex, knowing that eventually she would be present again. When Jocelyn disappeared, however, her sexual pleasure and interest also disappeared and did not return. She would continue with sex, however, because she felt it was unfair to her husband to stop.

In an individual session Jocelyn disclosed details of her abuse. She recalled that her parents were heavy drinkers and partiers. For as long as she could remember, Jocelyn was part of her parents' sexual activity. Jocelyn recalled being forced to perform fellatio and to submit to oral sex and simulated intercourse. She recalled feeling disgusted and humiliated by the activity. Jocelyn is not sure why the abuse stopped, but she was sent to boarding school when she was 13 years old and she has no memory of abuse when she came home for visits or holidays. Jocelyn continues to have a relationship with her parents, primarily because they are paying for her son's college tuition. The details of the abuse are very vague for Jocelyn, as she has spent 30 years actively trying to forget or block the memories. She does not dissociate at any other times apart from sex, although she is extremely uncomfortable when people drink too much.

In an individual session with Paul, he presented as extremely embarrassed about his past infidelity and was very concerned for Jocelyn. He said that he was ready to help her in any way that he could. However, when discussing his sexual history, it became apparent that Paul had his own sexual issues to deal with as well. Paul was raised by a single mother and lived with her and his maternal grandparents until he joined the military at age 18. He never knew his biological father, and his mother's unwed status was an embarrassment to him and his grandparents. From the time he could remember, he went on dates with his mother. He said that he knew he was his mother's "cover" so that her parents would not be suspicious of her activities, as they did not approve of her going out or neglecting her parenting duties. Paul recalled numerous occasions when his mother instructed him to go to sleep in the back of the car while she and a boyfriend had sex. He recalled feeling emasculated, embarrassed, and humiliated. He also recalled being curious and sometimes sexually aroused. In the army he had a few sexual experiences with men, which left him feeling confused and uncertain about his masculinity. When he left the army and enrolled in college he was, by his own definition, sexually promiscuous with women. When he met Jocelyn he recalled not wanting to ruin their perfect relationship with sex.

As with many couples entering therapy, there is a tendency to identify one partner as the patient. Most often this happens to the partner with an acknowledged history of abuse while the other partner takes on the role of co-therapist. As Jocelyn and Paul's story clearly illustrates, this is a disservice not only to the person identified as the patient, but to the other partner as well. In their initial conjoint sessions, Paul took on the role of the helpful and patient husband. This role helped Paul avoid his own sexual history and resultant sense of embarrassment. After a few individual sessions, Paul was more aware of his own issues and prepared to be a participant in the therapy. The effect of this on Jocelyn was dramatic. She was visibly relieved and more motivated. Articulating the fact that both Paul and Jocelyn needed to learn how to be sexually intimate with each other reframed the problems from being Jocelyn's to being a couple issue. This is an important step in removing the stigma of abuse.

In establishing their individual and joint goals for therapy, Paul said he wanted to initiate sex and feel more connected to Jocelyn during sex. Jocelyn also wanted sex to be a more intimate experience and her goal was to stay present and enjoy sex. Jocelyn and Paul were eager to start on sexual exercises. They were curious about the exercises and the ways in which sex therapy would be different from marital therapy. However, when they heard the description of a typical sensate focus exercise, in which the couple would take turns sensually pleasuring each other without touching genitals or breasts, Jocelyn became upset and stated that she could not do this. Thus the first exercise that was given to this couple was to think

about doing the exercise described, to visualize it happening, and to pay attention not just to potential pitfalls but also to ways in which it could occur. They were to do this on their own and discuss it in the therapy together.

Paul remarked that surprisingly he found himself feeling very happy about the prospect of doing the exercise. He thought of it as starting out anew, and he found that the very defined boundaries were comforting to him. He thought that a pitfall would be that Jocelyn would not be interested, which would make the exercises impossible. He said that he could not envision doing something that Jocelyn did not want to do. Jocelyn was surprised by Paul's comments. Her concern was that Paul would be angry and upset with her if she did not want to do the exercises. She worried that he would withdraw from her and perhaps have an affair. Interestingly, the way Jocelyn envisioned the exercise was as if Paul were blasé about it, and she had to cajole him into it. To Jocelyn, Paul's interest and motivation was both comforting and disconcerting.

The couple decided that they would like to do the sensate focus exercise. It was structured such that Jocelyn would approach Paul first and begin to pleasure him. Then Paul would pleasure Jocelyn. On the next occasion, however, Paul was to gently approach Jocelyn to do the exercise. A session was scheduled for the next week so that any issues that arose could be addressed quickly.

The couple returned feeling very disheartened. They had not done the assignment at all, given that Jocelyn had not approached Paul. Both were feeling very discouraged. Jocelyn came to realize that she felt pressured to approach Paul and that this pressure, whether real or imagined, made it impossible for her to initiate the sensate focus. At certain times in therapy, the therapist must be the one who holds on to the hope or the optimism for the couple. What they considered setbacks were reframed as opportunities to learn. Indeed, the insights gathered from these and other difficulties would help in creating more positive sexual and sensual experiences in the future. It is vitally important not to let couples become overwhelmed by a sense of failure. Jocelyn herself suggested the very easy remedy for this problem. She said that if they had at least 3 weeks to do two sensate focus assignments, she would feel less pressured. So the next appointment was scheduled for 3 weeks later.

The couple stayed with this level of sensate focus for about 12 weeks with appointments scheduled 2 to 3 weeks apart. During this time they discovered several things of importance: Jocelyn discovered that she felt panic and "froze" emotionally and sexually when she was unable to breathe (this happened several times when Paul would kiss her repeatedly and amorously), when Paul's head disappeared below the sheets and she could not see him, and when she felt that she must lie still while Paul "worked on her." Each of these concerns were dealt with easily—Paul made sure to

limit the number of passionate kisses that were directed to Jocelyn's mouth and he began to kiss her neck and ears, which Jocelyn discovered she liked very much. Jocelyn and Paul made sure to keep within eyesight of each other during the exercises and the sensate focus was restructured so that Paul and Jocelyn pleasured each other simultaneously. Paul experienced difficulty and displeasure when Jocelyn moved outside of the defined boundaries for touching. On several occasions, Jocelyn ventured to touch Paul's genitals, which left him feeling angry and confused. Paul recognized that he needed and wanted very clear boundaries, but it also left him feeling somewhat emasculated to have to set them. In talking about this during therapy, Paul felt he had more permission to set boundaries for himself, and Jocelyn began to realize that far from needing to satisfy Paul's sexual needs, she needed to be more considerate of his needs in general. Insofar as men and women who are sexually abused tend to recreate the dynamics of their abuse in their most intimate relationships, sex therapy can help couples talk honestly and recognize their own and their partner's sexual needs and wants for what they are, not what they assume or fear they may be.

After 12 weeks, Jocelyn and Paul were regularly doing sensate focus exercises once or twice a week, they were comfortable with the exercises, and they expressed an interest in doing something more explicitly sexual. Although Jocelyn's panic had been avoided by changing some of the sexual logistics, dissociation during assignments that were more sexual was a distinct possibility. The basic pattern of the sensate focus with mutual touch was continued, with increasing amounts of genital and sexual touch being incorporated. However, the instruction was that if Jocelyn felt that she was going to "disappear," she would signal to Paul and they would stop the sexual interaction, perhaps kiss and cuddle or talk and then resume the sexual touching when Jocelyn felt present again. Paul was instructed to signal a stop to the sexual interaction if he felt disconnected from Jocelyn, either by virtue of her "disappearing" or because of his own discomfort. Because "stop" usually has negative associations from its overuse in many couples with abuse histories, or because "stop" was meaningless during the abuse, or finally because it is more a pause than a stop that is desired at this point, the word "stop" should not be used as a signal. Jocelyn and Paul were opera fans and so chose the word "intermezzo" (intermission in Italian) as their signal.

Jocelyn and Paul had no trouble determining when Jocelyn had disappeared during sensate focus, but they did not use the signal. Jocelyn had a great deal of difficulty with the goal of enjoying sexual interactions as opposed to simply being able to "do sex" ostensibly to make Paul happy. Paul had a great deal of difficulty stopping or taking a break. Not only did he think that it was not masculine, he also worried that they would not resume sex. These concerns had roots in the early sexual experiences both Jocelyn and Paul had, but had also been reinforced during their 20-year marriage. Jocelyn "knew" that the repercussions of unsatisfying sex were

that Paul would seek sex elsewhere. Therefore, it was important to accomplish sex. Paul "knew" that his sexual connection with Jocelyn was tenuous. "Get sex while you can and hope it is good" was his mantra. The new assignment was therefore to take breaks—at least one each time they did a sensate focus exercise. At first the break was early in the interaction and then scheduled later when both were feeling some level of sexual arousal. Initially Paul was put in charge of taking the break since he would not feel rejected if he were the one calling for the "intermezzo." Once the couple felt comfortable breaking and resuming sensate focus, Jocelyn was encouraged to call for several breaks before increasing the sexual nature of the assignments. This was done relatively easily, with Jocelyn and Paul talking, joking, caressing backs and arms, and kissing during their intermission. Slowing down and taking scheduled breaks actually precluded Jocelyn's dissociation. Only once over the course of therapy did Jocelyn call for a break when she felt imminent dissociation.

As therapy progressed and the assigned activities became more sexual and began to include genital touching and oral sex to orgasm, Jocelyn would periodically ask for a session between scheduled appointments to talk about her lack of desire. It soon became apparent that there was a pattern; Jocelyn needed to know it was safe not to want to have sex before she felt it was safe to have sexual desire. Several sessions were devoted to having the couple talk about how not to have sex, how to say no without being rejecting, and how Paul could handle his sense of rejection without going outside the marriage for sex. It was agreed that they would practice saying no to sex but staying emotionally connected to each other. Initially it helped both to know that not having sex was an assignment although eventually saying, "I'm not in the mood" became possible for both to say and to hear.

Soon Jocelyn and Paul were coming to therapy every 2 months. They seemed reluctant to stop for fear of reverting to old patterns. They continued to come to therapy every 2 to 3 months for the next 18 months until they felt more confident in the stability of the changes they had made.

Jocelyn and Paul had a successful outcome for several reasons. Both had had positive experiences with therapy in the past and were ready to trust both the therapist and the process of therapy. They were able to tolerate the slow pace of therapy and to overcome and learn from early obstacles. Jocelyn came to therapy with a clear goal to have positive sexual experiences for herself, not just to please Paul or maintain a marriage. In addition, the marriage was strong despite the infidelity and there was a clear commitment to stay in the relationship for both parties.

Jay and Gayle

Men who come to therapy with an acknowledged history of sexual abuse often represent the more clinically distressed end of the spectrum. When

such men also have no prior history of treatment, the clinical challenges are even greater. However, it is often a sexual concern that will prompt a man with an abuse history into treatment. Jay was one such client. A 32-year-old man, he presented for treatment with his 26-year-old wife, Gayle, due to his anxiety regarding sex. His concern was that his sex drive was "abnormally" high and that his wife would ultimately leave him because of his unrealistic sexual demands. Jay wanted to have sex at least once a day, and he masturbated as often as three to four times each day, often at times and in places that were risky in terms of discovery (e.g., public bathrooms at work). However, sex between Gayle and Jay was limited to once a week because Gayle had little or no sexual desire. Their primary sexual activity was fellatio, and Gayle got little sexual pleasure from it. Still, she said that she liked having sex once a week because it made her feel close to Jay and it was what married couples do.

It was apparent that the relationship was one in which Jay relied on Gayle's lack of desire to control his sexual urges. After taking sexual histories, it was also apparent that what Jay labeled as his "abnormally high sex drive" was a reaction to his history of childhood sexual abuse. Jay reported in an individual session that he and his father used to shower together and perform fellatio on one another. This occurred over a 2-year period when Jay was about 7 or 8 years old. His recollection was that the activity was pleasurable and that it was "fun" to have a secret with his father. Once the abuse progressed to sodomy Jay told his mother because he had rectal pain. He received a beating from his mother following his disclosure. He is not sure if his mother believed him, as the abuse was never discussed again, but he also never showered with his father after that time.

Jay believed that the abuse made him overly sexual. He said that in the third grade he began asking (and getting) girls to suck his penis. When this activity was discovered, Jay was again beaten by his mother and was labeled as a "weird kid" by his classmates. Jay was ostracized and found solace in masturbation. Instead of feeling or acknowledging vulnerability, Jay identified with his father: "Given what I did to those little girls, I am no better than him." He used masturbation to decrease anxiety, to assuage feelings of loneliness, or to bolster his confidence. Jay's social isolation continued until college. He had a serious relationship with a woman in his senior year and became suicidal when that relationship ended. He met Gayle several years later.

Gayle was the only other person Jay had told about the abuse. In an individual session she said that she felt sad for Jay and wanted to help him control his sex drive. She did not feel any interest in sex for herself. Reluctantly Gayle talked about her own sexual and personal history. Prior to Jay she had had a brief sexual relationship with a classmate in college motivated by her desire not to be a virgin any longer. Gayle's parents divorced when Gayle was 12 years old. The divorce was precipitated by the discovery of her mother's affair. Gayle continues to be angry with her mother and

blames her for the divorce and for the fact that Gayle rarely saw her father growing up.

Gayle and Jay were very resistant to reframing their difficulties as a shared problem. There was a strong investment in Gayle being sexually normal, ostensibly so that she could stay in the position of controlling Jay's sexuality (as he felt out of control sexually) and also so that Jay could feel that he had a "normal" marital relationship. It was also with great difficulty that goals were established for therapy. Ultimately Jay stated that he wanted to enjoy the sex he had with his wife instead of feeling sexually deprived most of the time. He also wanted to reduce the frequency of masturbation. Gayle initially stated that her only goal was to help Jay and to feel less pressured sexually. Ultimately Gayle's goal was restated as: "I want to feel less pressured sexually. I want to relax and be able to feel close to Jay during sex."

Collaboratively designing sensate exercises presented challenges with this couple. Jay was very anxious about any clause to abstain from sex, although he was assured that he could continue to masturbate. Gayle was clearly happy with the prospect of nonsexual caresses but was willing to do more sexual touching to please Jay. In general, the therapist should refrain from directing the sexual activity of a couple. The exception to this rule is when the therapist needs to slow the couple down and encourage (or direct) them to engage in nonsexual activities. Ultimately, the first few assignments that Gayle and Jay did were not collaboratively designed. They needed permission to be nonsexual, and they needed external boundaries since neither had the ability at this stage to set limits. This inability to set and maintain boundaries would continue to be a problem for this couple as Jay would often have difficulty staying with nongenital or nonsexual touching and Gayle would invariably acquiesce. These boundary transgressions were explained to Jay as a way he had developed of dealing with anxiety. Subsequent to the abuse Jay had found solace primarily through masturbation. It made sense that he would want to use sex to relieve anxiety. This gave Jay a way of understanding his rather compulsive sexuality apart from feeling either like a "sexual pervert" or an "oversexed male." It also helped Gayle have an understanding that made setting boundaries more palatable for her.

Given Jay's high level of anxiety and inability to relax and stay within the boundaries of the assignments, time was taken to teach Jay relaxation and focused breathing. Whenever he felt anxious or wanted to stray outside of the boundaries of sensual caressing, Jay was to do relaxation and focused breathing. Ultimately, Jay was able to maintain boundaries during nonsexual touching and caressing. Jay's newfound ability to maintain his own boundaries freed Gayle to begin to experience and enjoy sensual pleasure with Jay for almost the first time in their relationship. These beginning stages of sex therapy took over 3 months of weekly sessions to accomplish.

Jay and Gayle began with a typical sensate focus program. They took

turns caressing each other in sensual ways, excluding breasts and genitals. Once the boundary issue was successfully resolved, touching progressed to include genitals and breasts, but without the intent to sexually excite and without neglecting other body parts. As Gayle became aware of her own capacity for pleasure, she and Jay did mirroring exercises in which she showed Jay what she liked by doing it to him and he mirrored the touch on her body. Over the course of time, Gayle and Jay began focusing on what they knew each other liked and desired.

At this point in the therapy Jay requested individual time to deal with new anxiety. He stated that he felt nauseous and disgusted by Gayle's expressions of sexual pleasure. Jay again worried that he was an abuser or pervert who could only be excited by forcing someone to have sex. Encouraged to look for alternate sources of his reaction to Gayle, Jay began to talk about a sexual relationship he had not disclosed in the evaluation. When Jay was 15 years old his 37-year-old cousin had initiated a sexual relationship with him, ostensibly to help him with his social isolation and anxiety. Jay had not found his cousin sexually attractive and in retrospect realized that the relationship was more for her sexual pleasure than to help him. Although he had been able to perform sexually, his cousin's arousal and display of sexual pleasure made him feel sick and he had sometimes vomited after having sex with her. In the session, Jay worried aloud that he would vomit as he was recollecting the experience. Jay rejected the notion that he had been forced or manipulated into the sexual activity: "I was not a victim, not an innocent kid. I wanted to have a sexual experience with a woman, and she was willing to give me that opportunity and I took it." Jay could agree that he had developed a negative association to displays of arousal. This old association now needed to be replaced with positive feelings about his wife's sexual pleasure.

At the next couple's session, Jay told Gayle what he had discussed during his individual appointments. As incest and sexual abuse can only occur in secret, secrets are especially damaging to clients who have experienced past abuse. The discussion was very helpful to Gayle, who had discerned Jay's uneasiness. Her awareness of his discomfort had reinforced Gayle's feeling that her sexual arousal was not desirable.

Jay was encouraged to use internal talk to focus on the fact that he was with Gayle, the woman he loved, and he *wanted* her to experience sexual pleasure. Jay was counseled to have his eyes open during these sensual and sexual encounters with Gayle in order to stay fully present. It was helpful that Jay was able to adjust to Gayle's arousal while her expression of pleasure was still relatively muted. Gayle was continuing to feel sexual arousal and entertaining the idea that she could be orgasmic. She was aware of feeling sexual desire and looked forward to the sensual touching.

As the sensate focus exercises became increasingly sexual, the couple eventually decided they would like to include oral sex, possibly to orgasm. However, Jay had had a disturbing flashback during one of their exercises.

In the process of performing fellatio, Gayle told Jay: "You are really enjoying this!" Almost immediately, Jay felt himself in a cold sweat. He lost both his erection and desire to continue the exercise. Jay said that he felt tremendous fear and thought he heard footsteps outside the bedroom door. He had difficulty calming down and had trouble sleeping that evening. He alternated between feeling frightened and ashamed. That night he had a disturbing dream about being raped by the CEO of his company.

In deconstructing the event, Jay explained that he had heard his father's voice instead of Gayle's telling him how much he liked fellatio. Instead of the "fun" activity Jay had always portrayed it as, Jay now reported the guilt, anxiety, and fear he felt during the incest. What Jay had experienced was a flashback. Just as a drug flashback is the experiencing of a drug's hallucinogenic effects long after the drug has been discontinued, a flashback in the clinical sense is the reexperiencing of some aspect of sexual abuse, long after the abuse has ended. It is often triggered by something that is reminiscent of the abuse, in this case Gayle's comment on Jay's pleasure. However, this was probably not the sole trigger for Jay's flashback. If it were, it would be easy enough to deal with by having Gayle refrain from making statements about Jay's arousal. If a flashback is triggered by a certain event or stimulus (a particular scent, the color of a bedspread, or the music playing in the background), the best solution is to avoid these things. However, Jay's anxiety was also triggered by his experience of sexual pleasure, something that should not be eliminated or avoided. It was therefore decided that if Jay should start to feel anxious or guilty or nauseous he should tell Gayle and temporarily interrupt their exercise. The flashback should not signal the end of sex, but since it did signal an interruption in Jay's ability to experience sexual pleasure, they should not continue until Jay's anxiety abated. Jay was told to practice relaxation with breathing exercises. Most importantly, Jay was reassured that he was not crazy. Previously, Gayle and Jay had rushed through sex. Slowing the pace in therapy allowed them to experience sexual pleasure and enjoyment but it also resulted in Jay experiencing distressing feelings that were associated with past (abusive) sexual activity. This explanation helped Jay to feel sane and more self-confident, an attitude that was reflected in the manner in which he now approached the sexual exercises with Gayle.

With encouragement to keep a slow pace, Gayle and Jay continued with the sensate focus exercises but when Jay felt anxious, had a flashback, or dissociated, he was to tell Gayle. Sharing this information with his wife reinforced their sense of connectedness and increased their level of intimacy. Gayle spontaneously began to reassure her husband that his pleasure was okay, that she loved him, and that she loved to make him happy. In fact, by reassuring Jay, Gayle found that her own anxiety diminished and her sexual pleasure increased. She reported feeling like a sexual person for the first time in her life. When resuming touch, it was easier for Jay to begin to caress Gayle and she was comfortable having him doing so.

As their sexual relationship improved, Jay was able to distinguish between sexual desire and sexual urges designed to alleviate other feelings, (e.g., stress, need for sleep or escape). Jay used the breathing exercises and relaxation techniques he had learned in therapy to alleviate anxiety and he made a list of things he could do instead of masturbating when he felt anxious at work. Jay set himself a personal goal of masturbating only when he felt sexual desire and Gayle was unavailable, unwilling, or uninterested. Jay never quite achieved this goal but felt satisfied that the frequency of masturbation had declined to once or twice a day.

Gayle and Jay were able to incorporate intercourse into their sexual repertoire with little difficulty. By the end of treatment, Gayle was orgasmic by manual stimulation of her clitoris. The frequency of their sexual contact was about six times a month. Their treatment had taken almost 2 years. Gayle and Jay's success was due, in part, to their strong relationship. While trusting a therapist was a new experience for both Jay and Gayle, they were able to build a trusting therapeutic alliance over time. Jay was able to tolerate high levels of anxiety during therapy because he was always offered a way of thinking about his reactions that helped him make sense of them rather than being overwhelmed by them. As Jay was able to cope with his own anxiety, Gayle was free to experience sexual pleasure.

GENERAL PRINCIPLES OF SEX THERAPY WHEN THERE IS A HISTORY OF ABUSE

Pacing

Sex therapy proceeds much more slowly when at least one client presents with a history of abuse. Some therapists begin with pre–sensate focus exercises (Maltz, 1988) that help clients learn touch, communication, and boundaries by caressing hands. While these types of exercises are appropriate for clients who are currently experiencing high anxiety relating to physical touch, choosing a starting point that is too far removed from sexual activity is often discouraging for other clients. Exercises that involve physical touch should start at a level that is currently comfortable for the client. In general, the therapist must often slow the progression through the exercises. The therapist should never push clients to do more or go faster in treatment than what is comfortable. Sex therapy should build positive associations to sex and sexual feelings. A slow pace ensures that there is room for the client to experience sexual desire, sexual curiosity, and sexual pleasure. It also increases the likelihood that clients will feel comfortable and confident in the treatment process.

Three general rules apply in deciding when to progress in the sensate focus or other sexual exercises:

1. There is compliance with the present assignment.
2. The clients experience comfort with the present assignment.
3. The clients experience a desire to move forward.

Reframing the Problem

When a couple presents for treatment, it is important to make sure the presenting complaint is defined as a couple issue. As can be seen in the above two cases, it is common for the person with the history of sexual abuse to take the blame for the sexual problems and for the partner to want to take the role of co-therapist. Reframing the problem as one the couple is experiencing reduces the stigma of sexual abuse and does not allow the nonabused partner to minimize significant sexual issues of his or her own.

It is increasingly common to encounter couples where both partners have a history of abuse. Often, as was the case for Jocelyn and Paul, the person with the more blatant abuse history takes on the role of identified patient. However, where both partners have significant abuse histories, both are often feeling the stigma or the sense of being "damaged goods" from the abuse. Given the high prevalence of sexual abuse in girls, it will be much more common to see sexual abuse in both partners in lesbian couples versus heterosexual and homosexual pairs. It is important to know that a history of abuse does not determine sexual orientation. Whether both partners have a history of abuse or a client with an abuse history presents for treatment on his or her own, the problem can be reframed from "I've been damaged by sexual abuse" to "I have learned ways of being sexual or have coped with sexual abuse in ways that are no longer adaptive and that I want to change."

Setting Goals

The goals for sex therapy should be different from the goals that clients had for dealing with their abuse. Being able to get through sex is a goal that is more relevant to abuse than to consensual sex. All too often, clients come to sex therapy under pressure from their partner and feel threatened with emotional or physical abandonment if they cannot please their partner sexually. Setting healthy and realistic goals is an important initial step in the treatment process. Sometimes a client's initial goal is simply to determine what role sex should play in his or her life or relationship.

Dealing with Anxiety

Even in clients without a history of posttraumatic stress reactions to their sexual abuse, it is possible that sex therapy and the sensual or sexual exercises may precipitate anxiety, panic, dissociation, or flashbacks. A collabo-

rative approach to treatment can reduce the chances that the client will be traumatized by the experience of therapy. However, when acute anxiety manifests itself there are a number of treatment options:

1. Teach the client relaxation or focused breathing to help him or her stay present, to reduce anxiety, and to increase awareness of sensual or sexual pleasure.
2. Inner self-talk can help the client stay focused on the present activity (which is adult, consensual, and desired) in order to minimize the occurrence of dissociative episodes and to reduce the risk of traumatic responses to sex.
3. Have the couple devise a word or signal to be used by either member to indicate a need for a break during sexual activity. The signal or word should be used when there is a flashback, dissociation, or discomfort during sex.
4. Clients should be discouraged from using sexual fantasies that are disturbing to them in order to accomplish sex. This is another form of dissociation and disconnection and should be treated as such.

Wherever possible, an anxiety reaction should not signal an end to sexual interaction. Anxiety should be reduced, a degree of calm and relaxation restored, and the sexual or sensual activity continued. Not only does this take the power out of a dissociative experience or a flashback, but it also helps the couple accept and deal with such reactions more compassionately.

Gender Differences

While the treatment of men and women with abuse histories shares many of the commonalities listed above, there are some important differences that often exist. As can be seen in Jay's case there is often a greater resistance in men to acknowledging their vulnerability as a result of the abuse. The experience of powerlessness is tremendously difficult for men as it confronts their gender role expectations in ways that it does not for women. Fortunately, it is not always necessary for men to acknowledge or work through their experience as a victim in order to have a successful treatment outcome. As the case of Jay and Gayle illustrates, Jay required cognitive interventions to help him make sense of his reactions to the abuse, to his partner, and to sex therapy. Once he had an intellectual understanding of his reactions, Jay was able to accept the slow pace of treatment and establish and maintain boundaries.

Sexual abuse is not a discrete phenomenon. Unfortunately sexually abusive, coercive, and shameful experiences are an all too familiar part of

many clients' histories. Sex therapy is well suited to address and redress the sexual repercussions of sexual abuse. The most important ingredients for success are a strong therapeutic alliance and a creative and collaborative approach to designing, implementing, and completing sex therapy assignments.

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CHAPTER 13

Therapy with Sexual Minorities

Queering Practice

MARGARET NICHOLS
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> The universe is not only queerer than we suppose, it is queerer than we *can* suppose.
>
> —EVOLUTIONARY BIOLOGIST J. B. S. HALDANE
> (quoted in Bagemihl, 1999, p. 9)

For many therapists, the description of the dazzling variety of sexual options and behaviors practiced and enjoyed by nontypical clients may be both provocative and challenging. In this chapter on therapy with sexual minorities, Nichols and Shernoff reject both the pathology model and the medical model of sexual nonconformity. They maintain that sexual impulses can be "hostile, dangerous . . . and anxiety evoking" as well as "joyful and intimate, and sweet"; there is no preferred or "natural" way of expressing one's sexuality. Rather, sexual diversity is to be appreciated and affirmed and clinicians can treat sexual minorities effectively only if they abandon their preconceptions about what is "normal" and what is "pathological."

Nichols and Shernoff provide a thoughtful review of the recent history of the "Gay Pride" movement and its implications for the sexual behavior and practices of both gays and straights. It is not unusual for clients to present with questions and issues concerning a variety of sexual lifestyles about which the traditional sex therapist may be unfamiliar—everything from how to deal with jealousy in polyamorous relationships to how to persuade one's partner to explore BDSM.

Nichols challenges the notion of lesbian bed death, presenting data suggesting

that lesbians may enjoy more varied sexual relations and may experience orgasms from a greater variety of sexual acts than heterosexual women. Shernoff reminds the reader that while homosexual men present with many of the same issues as heterosexual or bisexual men, there are some differences. For example, gay men may seek assistance in dealing with pain during receptive anal intercourse or raise concerns about HIV and safe sexual practices.

An intriguing variety of clinical case vignettes is presented, suggesting the range and diversity of issues experienced by sexually atypical clients. As the authors remind us, working within the "queer" community challenges clinicians to expand their sexual knowledge and learn things not commonly taught in graduate school. Suspending preconceived notions about gender, relationships, and sexual lifestyles may enable the "traditional" therapist to grow in unexpected and satisfying ways.

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Since the 1960s, one of the most interesting changes in the sexual culture of the United States and Western European countries has been the emergence of "sexual minorities"—groups of people who affiliate, self-label, and seek human rights and acceptance for sexual lifestyles that are often considered psychologically and/or morally deficient by mainstream citizens. As Bettinger (2002) states, "We live in a sexually multi-cultural society. Different ways of expressing sexuality have resulted in the creation of distinct subcultures within the dominant American culture" (p. 94). Members of these different subcultures have gradually affiliated so that in the 21st century, the "queer community"—the subculture of sexual and gender minorities that began as the gay and lesbian community—includes within its boundaries bisexuals, transgendered individuals, people who practice the many varieties of dominant–submissive sex ("kink," BDSM [bondage, discipline, sadomasochism], "leathersex," "S&M"), and those who are pioneering alternative forms of nonmonogamous relationships.

The goal of this chapter is to help prepare therapists of all sexual persuasions and orientations to be better prepared to work with sexually nontypical clients. While we focus primarily on gays and lesbians, we include all the other sexual minorities listed above. We hope to challenge the "pathology" paradigms most of us have been taught, and to provoke readers into examining some of their own biases and positions about what constitutes normal, healthy, and adaptive sexual expression. Although this chapter primarily describes sexual minorities near or in a large urban/suburban setting, it is still relevant to more rural or mid-American areas. When refer-

ring to this group we use the term "LGBTQ"—lesbian, gay, bisexual, transgendered, queer—where "queer" refers to other sexual minorities, most prominently "kinky" and "polyamorous" people, and to people who embrace multiple identities (e.g., a butch bisexual dominant woman).

This chapter is written from what Morin (1995) calls the "paradoxical perspective" of sex. This paradigm considers the pathology model of sex to be simplistic moralism, and the "new sex therapy" approach mechanistic and medical. In the paradoxical model, sexuality is powerful, complex, multidetermined, and multifunctional; it is part hard-wiring and part early environmental imprinting, with perhaps a few modifications along the way. "Environmental influences" may be chance—an exposure to something or someone at a moment of arousal—or they may be an expression of universal experiences that have to do with the terror and powerlessness inherent in childhood, for example. Thus sex is by design hostile, dangerous, shame and anxiety evoking, objectifying, and frightening as well as joyful and intimate and sweet. The paradoxical view takes little for granted, including the two-gender system, the assumption of heteronormativity, and romantic views like the belief that monogamy and high sex drive are compatible.

From the paradoxical point of view the queer community is particularly interesting because of its sheer diversity and inventiveness. Extremes of sex and gender behavior can be observed in intelligent and psychologically healthy individuals. The community, particularly in urban centers, validates and seems to encourage pushing the envelope of tradition. Thus the paradoxical paradigm of sexuality allows clinicians to work with sexual minorities in a way that is free of preconceptions about what is "normal," and allows genuine appreciation of diverse sexual expression rather than a pathologizing of the unusual.

The reader should be aware that there are problems inherent even in arriving at common definitions of sexual minorities, because the phenomena we are attempting to define are so variable and complex. Let us take sexual preference as an example. Sexual orientation is often conceived as (1) dichotomous (you're either gay or straight) or at most tripartite (gay, "bi," "het"); (2) a single phenomenon in which identity, behavior, and attractions are all consistent; (3) unrelated to gender identity; and (3) stable throughout one's lifetime. In fact, it seems none of these things are true. As Kinsey et al. (1948) pointed out over 50 years ago, same-sex attractions exist along a continuum, and we superimpose discrete categories upon this continuum. Desire, behavior, and self-identification are not consistent within an individual; for example, many people experience at least occasional same-sex desire, while fewer indulge in behavior with same-sex individuals, and fewer still consider themselves to be gay (Laumann, Gagnon, Michael, & Michaels, 1994).

The categories themselves are arbitrary and artificial, and vary with

factors such as historical time period or who is applying the label. For example, many individuals with primary same-sex attraction and secondary heterosexual desire self-label as "gay" if they are over 35 and "bisexual" if they are under 25, simply because the "older generation" of gay people tends not to believe in a tripartite or continuous view of sexual orientation. Moreover, sexual identity and gender identity seem to be related to one another, at least for some. For example, we have records of women who "passed" as men back into the early part of the 20th century. And Joan Nestle explains the persistence of "butch/femme" labels where "butch" denotes, "I'm both male and female, more man than woman" (Nestle, 1992).

And while sexual identity is indeed stable and fixed for many, some individuals seem to have more fluid and changing orientation (Diamond, 2003b; McWhirter, Sanders, & Reinisch, 1990). The switch from lesbian to bisexual is so common that some women call themselves "wasbians" or "hasbians."

In fact one of the most fascinating attributes of the queer community is the "mixing and matching" of stereotypes and beliefs about sex and gender (sometimes colloquially called "gender fuck" or "gender bending"). The male tendency to split lust and love and pursue the former relentlessly is evidenced at its extreme, but gay men also write and speak openly about sex, including group sex and anonymous sex, as a spiritual experience. There are male-to-female transgendered lesbians and support groups for gay male semen donors used by some lesbians desiring children. While many lesbians value relationships above all, there are gay women CEOs and others who produce lesbian-oriented pornography or run lesbian topless bars.

Finally, it must be remembered that social class, education, and geog raphy have a great influence on the lifestyles of queer people. The suburban gay male couple may have more in common with their hetero neighbors than they share with urban, "gay ghettoized" gay men.

PSYCHOTHERAPY MEETS SOCIOLOGY: THE IMPORTANCE OF HISTORY

In order to understand the issues that LGBTQ clients bring to therapy, one must understand the subculture of sexual minorities that has developed just since the 1960s. As recently as 1950, few people self-labeled as gay, those who did so were ashamed of themselves, and only a few, mostly urban, homosexuals got to affiliate with others. Throughout most of history, same-sex behavior was just that—acts, not "essential" nature. By contrast, in most Western industrialized nations today, homosexuality connotes not just a preferred sexual partner; it also represents an identity, a lifestyle, and a subculture (Boswell, 1980). The very newness of the community suggests

its fluid, evolving nature; so far, it has expanded from gay men and women to embrace pretty much all adult consensual sexuality

In some ways, sexual minorities resemble racial or ethnic minorities, but while the discrimination may be similar, there is at least one major distinction. Gays can hide as racial minorities rarely can; this has been both a curse (when people don't "see" you they can demonize you more) and a blessing (generally speaking, if you pass you can make more money). Because gayness can be hidden, individual gay people have the option of "passing" for straight with all the psychological issues attendant to that choice, but also with the economic advantages of passing. In this regard, many gays could be compared to, for example, Jews who change their names and try to assimilate or light-skinned blacks who "pass" for whites.

But one thing that makes LGBTQs distinctive is that members of racial or ethnic subcultures can generally count on family support to help with the stresses of life. Because sexual preferences are frequently not passed from one generation to the next, LGBTQ people cannot count on family-of-origin networks to help buttress them against prejudice or hostility from the mainstream culture. To compensate for this loss, the LGBTQ community has done an outstanding job of creating traditions for forming extended families.

Identity, Shame, and Pride

Arguably, the most common problems LGBTQs bring to treatment involve the development of a personal identity that includes sexuality, and the resolution of shame and fear around having a socially stigmatized self. The latter problem—transforming self-hatred—was first tackled by gay men and lesbians with the help of gay activists. Before the late 1960s, gays were still regarded as sick, pathetic, depraved creatures who were at best to be pitied and at worst a danger to society. Then, in the wake of the civil rights, peace, and women's rights movements, along came the Gay Liberation movement, largely considered to have begun with the Stonewall Riots of 1969 (Carter, 2004). From the beginning, mental health practitioners, especially psychiatrists, played a role in influencing public opinion. In 1973, the American Psychiatric Association ceased to consider homosexual adjustment as psychopathological (Bayer, 1981). It is hard to overestimate the impact of that decision. First, declaring homosexuals "normal," or at least as normal as heterosexuals, undermined laws, civil commitment procedures, and the practice of therapy itself. Before the American Psychiatric Association decision, involuntary hospitalization, aversive conditioning techniques, and extended attempts at cure by "talk therapy" were routine in the "treatment" of homosexuality, and legal rights were denied to gays on the grounds of moral turpitude and mental illness. Today the situation is vastly different and most mental health professionals accept at least les-

bian and gay orientations as inherently "equal" to heterosexual orientation, though most have problems with other sexual minorities.

More importantly, the decision reinforced the basic ethos of the Gay Pride movement. Like the civil rights and women's movements before them, the Gay Liberation movement helped people get ride of the shame they all carried and replace it with pride. The DSM decision helped pump up gay pride—"we're just as good as heterosexuals." This, in turn helped encourage gay people to do perhaps the single most politically valuable thing possible—come out to others. As more people discovered gays in their families, among their friends, and as their neighbors, the demonizing of them decreased. Indeed, lesbians and gay men have succeeded in many of their activist efforts, and therefore achieved a remarkable gain in "social acceptability"—acceptance by the heterosexual majority—in about three decades.

When the authors of this chapter began private practice early in the 1980s, a good number of our clients tried to deny their gayness, were riddled with shame and self-loathing, and experienced rejection and punishment from family, friends, and employers. But social acceptance does a lot to help self-esteem. Today when we see young people in our urban and suburban practices, they more rarely reject their sexual orientation and experience substantially less shame, and if they have identity issues, they are more likely to be struggling with whether they are poly or just into BDSM with "playmates" on the side than they are to be wondering whether they are gay or heterosexual. The number of gays entering treatment with identity or shame issues has dramatically decreased. Nevertheless, outside of urban areas these may be still be the most common issues one sees in treatment.

Gay Male Communities

There is no better testimony to the fact that male homosexuality does *not* result from the absence of testosterone than the development of the gay male community from the 1970s on. Not surprisingly, when gay men began to build community in the 1970s a good deal of it revolved around sex and sexual availability. Bathhouses, bars, and discos with "back rooms" or "sex floors" proliferated wildly. Unburdened of shame for the first time, many men celebrated by being as sexual as possible. In urban areas men enumerated their sexual partners in the hundreds, at least, and the "norm" for many gay male relationships was nonmonogamy (Kippax, Crawford, Davis, Rodden, & Dowset, 1993; Bryant & Demian, 1994). Moreover, gay men experimented in large numbers with sexual practices previously considered the domain of fetishists (Jay & Young, 1979).

The golden age of gay male sexual adventuresomeness was short lived—a decade long—because AIDS struck in the early 1980s. As the era

of unrestrained sexual expression was replaced by the time of funerals and memorial services, sex became anxious and frightening. AIDS elicited homophobia in the general public and "erotophobia" among gay men, thus having a profoundly negative impact on how they viewed their sexuality. Many gay men came to view penises and ejaculate as "toxic" or dangerous. Inhibited sexual desire (ISD) and sexual aversion, problems once rarely encountered among gay men, became more widespread. A few men found themselves unable to stop unsafe sex practices, and the concept of "sex addiction" was discussed for the first time in the gay male community. Religious fundamentalists placed the blame for AIDS upon gay men ("You deserve this disease because you caused it by your sinful promiscuous behavior") and, not surprisingly, some gay men blamed themselves as well.

Faced with a disease that had few treatments and no cure, the health care and AIDS activist communities developed campaigns to try to prevent HIV and other sexually transmitted diseases (STDs). Programs were developed to help gay men eroticize safer sex (Palacios-Jimenez & Shernoff, 1986; Shernoff & Palacios-Jimenez, 1988; Shernoff & Bloom, 1991) and to use condoms more reliably during anal intercourse. Widespread AIDS prevention programs and effective antiretroviral drugs for those who could afford them resulted in the "normalization of HIV." At least in the United States among gay men with health insurance, HIV became primarily a long-term chronic illness, rather than a death sentence.

Without a heightened sense of HIV as "deadly," and without visual reminders of obviously ill men, large numbers of gay men have grown more complacent about the disease. Experts agree that the riskiest form of sex for transmitting HIV is unprotected anal intercourse (Vittinghoff, Douglas, & Judson, 1999). This form of sexual behavior has increased in recent years, as have new infections among men who have sex with men (Centers for Disease Control, 2002). This type of sex has a name in the gay male community: barebacking. Barebacking may be increasing in frequency both in its unprotected/unsafe form and its unprotected/safe form. Unsafe sex refers to condomless anal sex between an HIV-negative man and either a partner of unknown HIV status or one known to be HIV positive, thus opening the possibility of HIV transmission and new infection. Unprotected safe sex is anal intercourse without a condom between two HIV negative men. Men in monogamous male–male relationships where both partners know that they are HIV negative are not at risk for transmission of HIV even if they do not use condoms, provided that they have sex only with each other or only have safer sex with any outside sexual partners.

In recent years one particular drug has played a large role in the upsurge of unsafe sex among gay men. That drug is crystal methamphetamine, referred to as crystal, Tina, meth, crank, or ice. Use of this drug is associated with enhanced hypersexuality, feelings of euphoria, eased self-esteem, and

confidence (Murray, 1998; Guss, 2000; Halkitis, Parsons, & Stirratt, 2001). It often leads to unprotected and unsafe sex.

Lesbian Community, Lesbian Sex

At the same time that gay men were building a community emphasizing sexual experimentation, novelty, and diversity, lesbians were building communities based on feminist principles. For many gay women, feminism became the foundation of their orientation, and they were more likely to join feminist or lesbian-only organizations than gay rights organizations. Not only was sex not the focus of lesbianism, it was actually quite a problematic issue. The women's movement of the 1970s focused its interest in sexuality upon the sexual exploitation of women: rape, incest, and pornography occupied center stage; women's sexual pleasure was less discussed or explored.

Within the lesbian community this perspective resulted in the promulgation of sometimes absurd standards of "politically correct" sex. Anything associated with stereotypical heterosexual sex was viewed automatically as "patriarchal," even when practiced by two women. This attitude toward sex proved stifling for many gay women, and eventually this minority made their voices heard.

Lesbians in the 1980s, in contrast to gay men, became *more* interested in sex. The community fostered a sex radical movement that continues to grow and that has no parallel among heterosexual women. The sex radicals included both lesbian and "bi" women, and they went far beyond enthusiastically promoting the joy of sex for its own sake. The radicals also engaged in sexual activities that were outside the boundaries of "normal" female sexuality, especially BDSM sex, sex with multiple partners, and role-polarized sex (Nichols, 1987). By the mid-1980s, women were producing pornographic magazines and videos for lesbians, creating support groups for women who liked kinky sex, holding "play parties" where women could be sexually active more or less anonymously, and running sexual paraphernalia stores.

Within the lesbian community, the current ethos of diversity and respect for individual difference stands in sharp contrast to earlier years. Thus the explosion of lesbians choosing motherhood has been matched by an explosion of lesbians interested in reexamining sex. Lesbian mental health professionals have questioned heterosexual norms of sexual expression (Rothblum & Brehony, 1993), just as their heterosexual female counterparts question phallocentric sexual definitions (Basson, 2000; Kaschak & Tiefer, 2001). In the lesbian community, manifestations of lusty sexuality continue to abound for lesbians, especially "kinky" ones. At the same time, the romantic side of sexuality is being expanded: lesbians are quite prominent in the polyamory movement.

Bisexuality as Identity and Community

Although a "bisexual pride" movement was just becoming visible in the 1980s and 1990s, even within the gay community, bisexuality was viewed with suspicion, and bisexuals were seen as "gays in transition" or gays who were too afraid to come out to themselves. There continues to be some truth to that, at least among men (Carey, 2005). But beginning in the 1990s, the scientific discourse about bisexuality had increased (Klein & Wolf, 1985; Weinberg, Williams, & Pryor, 1994), as had the publication of personal testimonials (Hutchins & Kaahumanu, 1991). The number of self-identified bisexuals appears to be increasing, and some of this increase comes from the ranks of those who previously identified as gay. In fact, during this decade a new phenomenon emerged in the gay and lesbian subculture: a bisexual movement led by women, often by women who had formerly identified as lesbian (Clauson, 1990; Nichols, 1994; Weise, 1992). Many bisexuals prefer to affiliate with the gay community.

The 21st Century: Emergence of the "Queer Nation"

Among the newest sex or gender groups to join or be considered part of the community of sexual minorities are transsexuals and anyone on the transgender continuum. Among many, the old categories of "transsexual" versus "transvestite" were abandoned in favor of an array of gender/orientation variations ranging from postoperative transsexuals who self-define as homosexual to "he/she"s—men who retain their penises but dress as females and take hormones to increase breast size and change secondary sex characteristics to "bois," (lesbians who identify as male and dress and comport themselves as males without taking hormones or contemplating gender reassignment surgery). A general relaxation of the strictures of the two-gender system has resulted from the acceptance of transgendered folk.

Additionally, alliances were formed in the "kink" community between lesbian, bisexual, gay, and heterosexually oriented kink organizations, so much so that sometimes these groups now overlap or call themselves "pansexual." The polyamory movement, people espousing a lifestyle of multiple loving/sexual relationships are now also considered to be part of the sexual minority community. As we discuss later in this chapter, gay men have always experimented with "open relationships" as did heterosexuals in the "open marriage" movement of the 1970s, but now, polyamory is becoming more common in the lesbian community (Anapol, 1997; Munson & Stelboum, 1999). In fact, there is considerable overlap among all these communities, and it is not uncommon to find people who consider themselves members of multiple groups—a kinky lesbian living a polyamorous lifestyle, especially within urban areas and especially among younger people.

If there is a current political division in the LGBTQ community it is between the majority who espouse assimilationist politics—witness the huge gay marriage movement—and those who tend toward separatism and are proud of and want to foster differences (Warner, 1999). It is an issue that has probably been part of the growth of every minority group in America and the queer version of this scenario has been triggered in part by the gay marriage movement.

ISSUES AND CASES IN SEX THERAPY

Overall Similarities and Differences

For the most part gay men, lesbians, and members of other sexual minorities utilize psychotherapy for the exact same reasons as do their more mainstream counterparts. In these situations, the sexual orientation of the client may be largely irrelevant. However, it is important that the therapist be perceived as "queer friendly," by doing things like using gender-neutral language, not making the "heterosexual assumption," especially when asking about sexuality, and making statements that indicate an accepting attitude toward diversity. An alarming number of queer people don't come out to their doctors, even their psychotherapists, because they don't feel certain that the professional would be accepting of their sexual orientation. Most psychotherapists would agree that this kind of withholding mistrust on the part of a client would necessarily interfere with therapy. Yet many clients naively imagine they can "deal with their depression" without mentioning their sexual orientation.

Some issues may have a different spin for members of sexual minorities. For example, while many people experience trauma in childhood, people on the sexual fringe have additional stresses. Gay men who were "sissy" boys often have been deeply damaged by the reactions of others in childhood; gay, lesbian, bisexual, transgendered, and kinky clients who were aware of their predilections in puberty have almost never had "normal" adolescent experiences, as their experience was complicated by an unusual degree of secrecy, shame, and self-hatred.

And there are problems that just don't seem to exist, or to exist in the same way, for queer clients. For example, vaginismus and dyspareunia are rare complaints for lesbians; women who experience these difficulties tend to avoid penetrative sex. Delayed ejaculation often does not particularly trouble gay men: many gay men accept masturbation as a way of culminating a sexual encounter. In addition, there is an absence of gender-specific roles among gay and lesbian couples. Even in couples where partners seem role stereotyped in physical appearance, these apparent roles rarely hold up in actual behavior. The partner who looks masculine may be the one who likes keeping house, whereas the woman in the lipstick and high heels

may repair the plumbing. It is rare to find one member of a gay or lesbian couple totally financially dependent on the other, and it is less common for a gay or lesbian household to contain children. Thus, gay couples obviously are less likely to stay together because one person is financially dependent on the other or "for the sake of the kids." These differences make the power dynamics in gay couples somewhat different and, interestingly, make the quality of their sexual/intimate relationship assume a higher priority than in many more traditional heterosexual marriages.

The absence of rigid gender roles influences sex therapy with couples in other ways. Same-sex partners do not have opposing sexual role expectations (e.g., male must initiate, female must be submissive), so therapists do not have to work to eradicate these sex role stereotypes. Gay men and lesbians tend to have a more varied sexual repertoire than heterosexuals; penetration is not the main focus of sexual activity for either men or women. Moreover, some sexual beliefs held by heterosexuals are less frequently held by gay people. Many gay man and lesbians feel that their orgasm is truly their responsibility; there is more tolerance for each person masturbating themselves to orgasm at the end of a sexual encounter, less false romanticism attached to the idea that your partner has to bring you to orgasm. Lesbians, and especially gay men, often are very knowledgeable about sexual technique, and because there is nothing in gay sex comparable to the heterosexual emphasis on vaginal intercourse, they may be more willing to be sexually experimental.

Special Issues of LGBTQ Clients

Table 13.1 charts the problems most commonly encountered with queer clients by sex therapists, along with indications of which subgroups of the LGBTQ community are most likely to experience them. We will touch on all of these problems in the discussion and case examples below.

Identity Problems

Because our culture still demonizes members of sexual minorities, it is difficult for anyone who has a statistically nonnormative sexual orientation to come to terms with his or her identity. The natural internal resistance to accepting that one is a member of a despised minority, coupled with lack of information and role models, makes identity formation a complex problem.

Gay men and lesbians probably have the easiest time with this process, because of the increased acceptance of homosexuality over the last several decades. In the past, an individual with same-sex attractions could be expected to experience a sometimes prolonged period of internal struggle and conflict before embracing a gay or lesbian identity (Nichols, 1990, 1995).

TABLE 13.1. Most Common Sexual Issues in LGBTQ Community

Issue	Found among these groups[a]
Identity/coming-out/shame issues	
1. Determining orientation	All; **bi, trans, kink**
2. Changing orientation	**Bi (women)**
3. Overcoming shame	Gay/lesbian/bi/**trans/kink**
Sexal dysfunction issues	
1. Aversion to oral or anal sex	**Gay**
2. Low/discrepant desire	All; **lesbian**
4. Discrepant scripts—dominant/submissive discrepancy	**Gay, kink**
Other	
1. Open versus closed relationships	**Gay/lesbian/bi**
2. HIV positive/negative issues	**Gay/bi men**
3. Risk reduction/harm reduction	**Gay/bi men**
4. Counseling multiple partners	Gay/lesbian/bi/kink/**poly**

[a] **Boldface** type = most common.

Now, many self-identified lesbians, gays, and bisexuals come out to themselves and others with a minimum of fear, shame, or self-hatred. The degree to which gays and bisexuals experience internalized homophobia has also diminished pathology dramatically. Nevertheless, these cases do still exist, particularly among individuals with strong ties to an ethnic or religious community very disapproving of sexual diversity. When internal shame is extreme, some people may deny their orientation. An example of this is men on the "down low," a phenomenon observed first among African American males (Trebay, 2000; Denizet-Lewis, 2003; King, 2004) but prevalent among men of all racial and ethnic groups. The expression "down low," or "DL," refers to sexual relationships between men that are never discussed or openly acknowledged. The refusal of men on the "down low" to acknowledge their gayness may have disastrous consequences: "These men's unwillingness to address the fact that they may be gay or bisexual leads many to engage in unprotected sex when on the DL. To use a condom would be to acknowledge in some way what one is actually doing" (Williams, 2004, p. 6).

Alternatively, some clients who come to therapy now with identity concerns are grappling with more complex issues of personal orientation. They may be bisexual and still feel pressured to "choose up sides," and may be unsure about both sexual and gender orientation. An example is women who are not sure if they are butch lesbians or female-to-male trans-

sexuals. Some individuals may be going through an unexpected (and possibly unwanted) change in what they thought their sexual orientation was, such as bisexuals who self-identify as heterosexual and later experience same-sex attractions—or those who self-identify as gay or lesbian and later experience opposite-sex attractions! Finally, many transgendered or kinky clients present with the same degree of shame and self-hatred as did gays in the 1960s and 1970s. A nonjudgmental, accepting therapist can literally transform the lives of these clients.

Case Example: Internalized Homophobia and More. Daniel, 26, entered therapy complaining about the conflict between his self-acknowledged identity as a gay man and his hatred of gay people, especially gay men. His revulsion for gay men was so complete that he could only masturbate to heterosexual pornography or heterosexual fantasies.

Daniel grew up in a suburban town with cold, unsupportive, disapproving parents, and he was routinely ridiculed and scapegoated for his effeminacy by peers. As a freshman in college, he became active in the student gay and lesbian group, apparently transforming rapidly from someone who exhibited immense shame about his homosexuality to a proud, angry young activist. However, he managed to alienate nearly everyone in the student group with his judgmental attitudes and hypersensitivity. Shortly after leaving the campus gay community, Daniel suffered a severe manic episode and was hospitalized. His return to school was marked by poor performance, isolation, and suspicion and hostility toward almost everyone with whom he had contact, especially his gay and lesbian peers. He barely managed to graduate.

When Daniel came to therapy he was underemployed by the university from which he had graduated, living in a rooming house, drinking too much, and isolated from all but one or two heterosexual female friends.

Daniel's therapist (Nichols) was able in a few months to use cognitive methods to help Daniel transition back from homophobic to accepting feelings about his sexuality. Because Daniel prided himself on his intellect, she assigned him to read complex, highly researched academic books that demonstrated the widespread existence of homosexuality as a normative variation in animals and humans throughout history. She specifically challenged some of Daniel's negative beliefs about gay relationships and behavior, again documenting her assertions with research. In all probability, Daniel's respect for Dr. Nichols's intellect facilitated the cognitive work; in addition, he was genuinely impressed by the books he read, most of which had been written by gay men. Unconsciously, Daniel, who himself harbors ideas of being a writer, started to identify with the authors of the books. As a result, Daniel was forced to acknowledge that his feelings about gay men were in fact an expression of his feelings about himself, and his sexual function changed: he became comfortable masturbating with pleasure to

gay male images and fantasies. He came out to coworkers with success and assumed the queer label with a defiant pride characteristic of his personality.

But after two years of treatment, Daniel is still isolated, still drinks too much, and has avoided contact with other gay men. Daniel warrants several diagnoses: bipolar disorder, posttraumatic stress disorder (PTSD), and alcohol abuse on Axis I (PTSD from childhood peer victimization as well as from 9/11) as well as avoidant personality disorder and some features of paranoid personality disorder on Axis II. Current treatment, which includes EMDR and hypnosis, is aimed at the PTSD. At Daniel's request, EMDR sessions targeted his experience on 9/11, but, not surprisingly, the memories that surfaced during EMDR were all memories of his early stigmatization and abuse for being a "sissy boy." This process has helped Daniel understand how much of his self-hatred stems from childhood incidents of being victimized by peers and being unprotected and unsupported by his parents. Daniel's self-esteem is growing and he is beginning to recognize the victimized outsider role he consistently plays out in his daily life. Daniel's alcohol abuse undoubtedly helps keep him isolated—alcohol substitutes for human relationships—but he is resistant to giving up drinking and manages to control it enough so that it has not seriously interfered with his life in other ways. Nichols works from Prochaska, DiClemente, and Norcross's stage model of addiction (1992), which conceptualizes recovery in phases that begin with precontemplation (being in denial of the problem) and proceed to contemplation (knowing one has a problem but not ready to take action), and then to planning, action, and maintenance. She is trying to gently move Daniel from precontemplation to contemplation by offering him information (e.g., that his mood shifts may have to do with alcohol consumption, that his inability to save money to move from a rooming house to an apartment may have to do with the amount he spends at bars).

Currently, another trauma has emerged. During the manic episode that preceded his hospitalization, Daniel stalked a man with whom he was infatuated. He is now deeply ashamed of himself for this behavior and has acknowledged he is afraid to have contact with other gay men for fear of repeating the stalking. This trauma is being targeted for EMDR and hypnotherapy work, and Daniel feels if he can overcome this fear he might be ready to venture out socially. Clearly, for Daniel, internalized homophobia and concomitant sexual problems were intricately tied in with other disorders, and turned out to be the least troublesome of his problems.

Lesbian Issues

THE NATURE OF LESBIAN SEX

In 1983, Blumstein and Schwartz compared heterosexual married, heterosexual cohabitating, gay male, and lesbian relationships and found lesbian

couples to have the least frequent sexual contact. Shortly after this, other work written from a clinical perspective also noted the existence of lesbian couples who had little or no genital contact (Hall, 1984; Loulan, 1984; Nichols, 1987). By the end of the 1980s the term "lesbian bed death" was in common usage in the gay community and eventually became part of a stereotype: the lesbian as a sensual-but-not-sexual woman. Lesbian relationships were viewed by professionals and lesbians alike as unions in which both partners had relatively low sex drive, low sexual assertiveness, and a high degree of intimacy (Nichols, 1988, 1990).

In recent years, some sexologists have criticized mainstream sexual theory as being phallocentric and heterosexist (Kaschak & Tiefer, 2001; Kleinplatz, 2001; Rothblum & Brehony, 1993). Lesbian psychotherapists have been vocal in questioning the traditional definition of sex as genital contact directed toward orgasm, and have questioned using sexual frequency as an indicator of sexual health. For example, some studies have shown that lesbians spend more time on the average sexual encounter than do heterosexuals; using the measure of time spent on sex rather than sexual frequency, lesbians might be healthier than their straight counterparts (Iasenza, 2002). Still others (Cole, 1993) contend that sex is not necessary for healthy relationship function. In particular, lesbian relationships, which some view as more egalitarian and intimate than the average heterosexual marriage (Schwartz, 1994), may not need genital sex for connection—sex may be in effect, redundant. Some lesbian psychotherapists argue that lesbian bed death is a myth based on insufficient data. Matthews, Tartaro, and Hughes (2003) found no differences in sexual frequency rates of heterosexual versus lesbian women. And Iazenza (1991) found lesbians to be more sexually arousable and more sexually assertive than heterosexual women.

Nichols and her colleagues at IPG Counseling/Institute for Personal Growth collected hundreds of Internet surveys from women of all sexual identities and backgrounds and analyzed the data with regard to how self-identified lesbians and women currently in relationships with other women compared with bisexual and heterosexual women and women in relationships with men (Nichols, 2005, 2004).

Some of the findings to date from the IPG Internet study indicate that:

- Including both single and coupled women, lesbians had less sex in the year preceding the survey ($p < .02$) but did not differ from heterosexual women in their frequency of masturbation or how often they thought about sex.
- Overall, women with men had slightly more frequent sex than women with other women ($p < .02$) and this difference was independent of length of time in relationship. There was no difference between the groups in the percentage of women who never had sex, however, thus casting suspicion on the concept that lesbians are more likely to have totally nonsexual relationships.

- As for other aspects of sexuality, the women involved with other women spent more time on sex ($p < .000$), had more non-penis oriented sexual acts as part of their typical repertoire ($p < .001$), and were less likely to have sex because their partner wanted it ($p < .001$). Most significantly, they were more likely to have orgasms during sex with their partner than were women involved with men regardless of marital status or length of relationship ($p < .001$). And the tendency to orgasm during partner sex was not at all related to the length of time the partners had been together, but was strongly related to the amount of time spent on sex for both women with women and women with men ($p < .000$).
- The typical sex acts associated with orgasm for women (regardless of gender of partner) were kissing ($p < .000$), nongenital touching ($p < .006$), receiving oral sex ($p < .000$), digital–vaginal stimulation ($p < .001$), and the use of sex toys ($p < .004$). And of these acts, kissing ($p < .000$), nongenital touching ($p < .01$), digital–vaginal stimulation ($p < .000$), and use of toys ($p < .000$) were more likely to be practiced by women with other women than by women with men.

If we incorporate new information about the lesbian community with the results of more recent research and theory about female sexuality, the picture of lesbian sex is more complex than the old stereotype portrays. While it may be true that women in lesbian relationships have somewhat less sex than their heterosexual counterparts, it is by no means true that the typical lesbian relationship becomes asexual. Women in relationships with other women are less likely to have sex simply because their partner wants it, which may account for part of the difference in sexual frequency.

Furthermore, there is evidence to suggest that lesbian sexuality is "better" for women: it lasts longer, is more varied, includes more sex acts likely to lead to orgasm for women, and is in fact more correlated with orgasm. Indeed, if one measures sex not by frequency but, say, by Kinsey's original standard—sexual contact to the point of orgasm—women with other women have more sex than women with men, and are more likely to have that sex of their own volition. In addition, lesbian sex is healthier: several studies including the IPG Internet study showed lesbians to have lower rates of sexually transmitted infections than bisexual or heterosexual women (Nichols, 2004; Roberts, Sorenson, Patsdaughter, & Grindel, 2000).

SEXUAL DYSFUNCTION IN LESBIANS

What about lesbian sexual dysfunction? Clinical data suggest that sexual desire discrepancy between partners and/or low sexual desire is the most common problem lesbians face, as it is with heterosexual women (Loulan, 1987; Nichols, 1995). There is little nonclinical information on the nature

of lesbian sexual dysfunction as compared to that of heterosexual women. Therefore, the IPG Internet study compared the self-reported sexual problems of lesbians with other women. In the IPG research, lesbians reported significantly fewer sexual problems than heterosexual women ($p < .002$). Not surprisingly, lack of interest in sex and/or having less desire than one's partner were the most frequently reported problems for all women, followed by problems with orgasm, problems experiencing more desire than one's partner, trouble lubricating, and anxiety about sex. Lesbians checked significantly fewer problems than heterosexual women in 6 of 11 categories. The greatest difference ($p < .000$) was in the number of lesbians versus hetero women who reported trouble lubricating during sex, followed by the number who reported orgasm as a problem ($p < .02$) and those who said they experienced pain upon penetration ($p < .02$). The orgasm data is consistent with data sharing that women sexually involved with women orgasm more reliably than those with men. There is no way of knowing whether lesbians indeed lubricate more and have less painful penetration than heterosexual women, or whether lesbians simply avoid these problems by downplaying the role of vaginally penetrative sex.

The cases that follow illustrate therapy with lesbian couples who have low or discrepant desire. It must be mentioned, however, that when lesbian couples present with complaints of low sexual frequency, it is important to determine the nature of the complaint. There are many lesbian couples who rarely have genital sex together but are otherwise happy, affectionate, and well-functioning couples. Some of these women have been influenced by the cultural belief that frequent sex is necessary for the success of a relationship, and so seek sex therapy because they believe they should be having more sex, not because they actually miss it.

Case Example: Genuine "Lesbian Bed Death." Liz and Scottie requested sex therapy for lesbian bed death, describing a sexual frequency of only once or twice a year. The pair had been together for 12 years and sex had dwindled down to this minimal level 2 or 3 years before they came to therapy. The therapist (Nichols) first questioned whether the couple genuinely wanted to be more sexual or whether they felt they were supposed to have more sex because sex was an indication of a healthy relationship.

In this case, Scottie had lost desire first and after many rejections Liz first gave up trying to initiate sex behaviorally and then "gave up" experientially: she, too, lost desire. But a recent experience in which Liz found herself attracted to another woman frightened her and motivated her to insist that Scottie and she seek sex therapy.

The couple reported good intimacy in nonsexual aspects of their relationship. However, their age undoubtedly contributed to their sexual problems—both women were in their mid- to late 40s, prime time for perimenopausal drops in both hormones and sexual desire in women.

Moreover, both women had gained some weight and become less attentive to their appearance. Cognitive-behavioral approaches were used in the treatment of this couple.

First, Scottie and Liz were taught about the "Basson model." Basson (2000) has proposed an alternative model of the female sexual response cycle in which many women in long-term relationships are presumed to have changed from experiencing an active, lusty desire to what Basson calls "receptive desire." In this model, the decision to have sex is driven by the desire for intimacy, not lust. Receptiveness to sex leads to sexual activity, which in turn leads to arousal and *then* desire. Lesbian relationships sometimes suffer from what might be termed the "Basson squared" effect. That is, if both women lose active desire, then, without consciousness of what is happening, no one initiates sex at all. In the case of this couple, Scottie had experienced what Basson describes while Liz had not. Nevertheless, both women benefited from being educated about this model, Scottie because it validated her experience and Liz because it helped depersonalize Scottie's rejection of her sexual advances. Scottie became aware that she had rejected Liz in the past because of her belief that if she felt no active desire, sex would not be enjoyable.

Once Scottie was aligned with the concept of "sexual willingness" rather than "lust," the couple was disabused of their belief that sex should be spontaneous, and convinced to make "dates." They were also encouraged to behave as though they were on a date—choose clothing carefully, look their best, act seductive and flirtatious.

Both women were trained to foster "simmering" (Barbach, 2001). They were taught that once they had made a date, during the time leading up to that date, they could make themselves ready for sex by consciously thinking and fantasizing about sex, facilitating arousal over time. "Simmering" is particularly helpful to women who have a relatively long arousal period.

Liz and Scottie were encouraged to be pragmatically honest about their sexual differences. They were helped to see that certain overromanticized myths about sex impeded their working out a good compromise. For example, they believed all sexual encounters had to end in orgasm on the part of both partners, orgasms that were "given" by one partner to the other. But equality doesn't always work in bed. The truth was Liz had a higher sex drive than Scottie, and was easier to arouse and bring to orgasm. Scottie's lower sex drive meant that there were lots of times she would have liked to engage in sexual contact with Liz, and would have been happy to facilitate an orgasm for Liz, but the pressure of her having to have an orgasm, too, made her refrain from such contact. Scottie and Liz were helped to redefine a sexual encounter: it loosened up to include "sensual/genital contact between them that may or may not result in orgasm for one or both partners, and if orgasm ensues, it may or may not be

facilitated by one's partner." This freed the couple to have sexual encounters where Liz orgasmed and Scottie didn't; the overall frequency of their sex life increased in a way that gave pleasure to them both.

This couple had a rather narrow sexual repertoire, limited to oral and manual genital sex, lots of touching, a little digital penetration. When prodded, they acknowledged having role-played once or twice, and it seemed they were open to the idea of expanding their repertoire. Scottie and Liz spent a session with the IPG Toy Box—a therapeutic aid that includes a large collection of sex toys ranging from vibrators, dildos, and butt plugs to feathers and bondage straps and lube samples. Nichols demonstrated the use of these toys in an enthusiastic and matter-of-fact way to reduce negative fears and attitudes about the use of "toys." The women were given the homework assignment to go to a local women's sex store and make a purchase together. Finally, they were given copies of sexual negotiation questionnaires that have been developed by BDSM groups—documents that promote open, specific communication about sexual likes and dislikes. Within a dozen sessions, this couple increased their frequency to about once every 6 weeks, using the women's new, freer definition of "having sex." They were both satisfied with this result.

Case Example: Complex Low Desire. Carole and Stacy have been involved sexually for only 8 months, although they had been casual friends for years. Carole sought EMDR treatment to uncover what she thought might be repressed memories of incest; her fear was not based on memory but on the fact that she had sexually withdrawn from several otherwise good relationships, and had begun to shut down sexually to Stacy. Carole did have some symptoms suggestive of abuse: aversion to sex with intimate partners; experiencing sexual touch as painful; positive sex followed by terror and the need to withdraw; having to be in control in sex; hypervigilance, and sleep disturbance.

EMDR treatment did not uncover repressed memories, but it did bring back incidents Carole had not thought about in years. These incidents were a series of sexual experiences with somewhat older boys that were exploitative and repulsive to Carole—she was purely lesbian, with no heterosexual attractions, from an early age. These memories were not repressed, but Carole had tried for many years to block them from her mind in order to avoid reexperiencing them. From an early age Carole had been a timid child, perhaps constitutionally fearful. When stressed, she became paralyzed and could neither fight nor flee; Carole always froze. Carole had frozen during the sexual incidents in her childhood, not even being clear about how much she said no, and that made her feel guilty. She feared remembering these events, and suffering through the attendant feelings of fear, revulsion, and shame. As Carole processed these memories through EMDR she "thawed out" a bit to Stacy.

Carole's fearfulness and compliance under stress made her the object of mild to moderate exploitation in many of her day-to-day relationships. This extended to her love relationship. Carole was unable to say no to some of Stacy's unwanted touching, which complicated the issue of her sexual desire. This was corrected in therapy with a couple session and homework; a follow-up visit revealed that Stacy had not kept her bargain to cease pressuring for the unwanted touching. Once Stacy became convinced that her behavior would impede the progress of the sex therapy, she moderated her behavior while at the same time, Carole developed the courage to say no.

Carole's temperament and background made it difficult for her to resist Stacy's entreaties to live together after only 8 months. Carole was feeling suffocated with the current frequency of togetherness, three nights a week. In the next couple session, both women were asked the following question: "On a scale of 1 to 10, where 1 represents you'd like your partner in your back pocket and 10 represents you'd like to live in New York and have her in San Francisco, where are you?" Carole laughed and gave herself a 7; Stacy gave a rating of 3. The scale, however, normalized for Carole that it was okay to want lots of separateness in the relationship, and rattled Stacy a bit in that it undercut her assumption that living together was the goal of dating.

Several more sessions of couple counseling helped the women work out the differences in their needs for closeness versus independence. Meanwhile, in individual counseling Carole worked on believing in herself and standing up for herself, with an emphasis on standing up for her desires around sexuality. Carole's sexual symptoms were dramatically reduced and she was able to give up some control in the relationship. The couple also worked out an arrangement that acknowledged the differences in their sex drive; sometimes Carole makes love to Stacy with no reciprocation, and no pressure to get aroused and orgasm. Both women enjoy this, and it has brought sexual frequency up enough for Stacy to feel better about their sex life without pressuring Carole.

Issues of Gay Men

Many gay men present with the same issues as heterosexual or bisexual men: problems of erectile dysfunction, inhibited sexual desire, or desire discrepancy between partners. However, some issues are different. Gay men, unlike purely heterosexual men, sometimes seek help because they are experiencing pain during receptive anal intercourse, or because they want to learn how to stifle the gag reflex that can interfere with the enjoyment of performing fellatio. Sex therapy with gay male couples often focuses on helping them negotiate relationship openness agreements, or working out HIV positive/negative issues. Additionally, counseling may in-

volve harm reduction work with men who bareback, or have condomless sex.

Case Study: Receptive Anal Sex. Dan and Peter, an HIV-negative couple, have been together for 2½ years. Since the onset of their relationship, both enjoyed performing as well as receiving oral sex. But anal sex was different: Peter was willing to penetrate Dan, but not to be anally receptive with Dan. The couple sought therapy because both partners wanted to change this situation. Anal penetration was problematic and painful for Peter. Peter had been anally date raped in college and that had been his only experience of receptive anal intercourse. The experience had been traumatic both emotionally as well as physically, and resulted in the need to be sutured in order to stem the rectal bleeding. Prior to starting couple therapy Peter never shared this experience with Dan. When Dan heard this story, he reassured Peter that as much as he wanted to expand their sexual repertoire, he had no interest in doing anything that would be physically or emotionally painful for Peter.

Several sessions were spent discussing the date rape and its impact on Peter's sexuality. Peter's reluctance to engage in a behavior that had the potential to retraumatize him was affirmed by both men, but Peter was eventually able to say that his love and desire for Dan were so powerful that he was willing to explore being the receptive partner in anal intercourse with Dan. He was frightened of the pain it might incur and had to overcome his basic aversion to the thought of anal intercourse.

In response to his concern about cleanliness, the therapist (Shernoff) educated him about various options that might reduce his negative feelings, such as how to anally douche himself. Once he had grown comfortable with these cleansing options he was asked if he was ready to explore the possibility of his anus becoming a erogenous zone. He was cautiously receptive. He was given the suggestion to first douche and then explore his own anus while sitting in a warm bath and simultaneously masturbating. If he was comfortable, he was invited to try inserting a finger.

The next week, Peter and Dan entered the session beaming. Peter started by reporting on how sexy it was to explore his butt while masturbating. At this point Dan cut in and described how Peter had called him into the bathroom, invited him into the tub, and asked him to touch his butt. Dan had penetrated Peter with one finger and they had sex in the bathtub that included digital penetration of Peter. I told them to continue experimenting with this and try inserting more than one finger as well. Once Peter was comfortable the next step was for them to go to a sex boutique to shop for what I called "marital helpers," a.k.a. dildos. I told them to buy several, in various sizes, beginning with the very smallest. At first the therapist suggested Peter experiment with using the smallest one on himself. Upon hearing this, Peter said: "No way. I want Dan to be the one

putting those inside of me." They were reminded to use plenty of lubrication, and to experiment with various positions, in order to determine the ones most comfortable and pleasurable. If pain was experienced, they were told to stop. Peter was also coached on how to do deep breathing to ease the discomfort of being penetrated. After about 3 months they decided they were ready to try the "real thing." On their first attempt, Dan was so nervous that he was unable to maintain his erection. But within a few days this was no longer an issue. Soon they were incorporating anal sex with both men being versatile.

Case Example: Learning How to Fellate without Gagging. Often when working with sexual minority individuals, sex therapy issues emerge as one component of a long-term psychotherapy. Such was the case for Rafael, a 35-year-old Latino man who had moved to New York from California to get some distance between himself and his family since they were not accepting of his homosexuality and refused to ever discuss his being gay after he disclosed it to them. He sought therapy for depression, which focused on helping Rafael become comfortable with accepting himself as a gay man despite his family's lack of acceptance and support. This was a slow process as initially he described feeling more sadness and pain about the shame that his being gay caused his family than any anger or sadness about their nonacceptance of it. As Diaz (1998) suggests, this is not an uncommon reaction on the part of Latino gay men to nonacceptance or silence about their sexuality by Latino families, and must be transformed in order for them to develop healthy identities as gay Latino men. One way therapy addressed this issue was to encourage Rafael to meet other Latinos who would accept him as a gay man so that he could develop an alternative family.

Since the desire to feel loved was a core aspect of developing a positive gay identity for Rafael, weaning himself from the anonymous sexual encounters that always followed a bout of heavy drinking, both of which he used as efforts to anesthetize his pain and loneliness, and learning to date was another focus of treatment. Spirituality was something Rafael explained that he missed, so his therapist (Shernoff) encouraged him to shop around for a church where he could meet other Latinos who would accept him for who he was. Additionally, he was encouraged to volunteer at gay organizations so he could learn how to meet other men in "homosocial" venues that were not highly sexualized. One issue that arose during his long-term psychotherapy was his inability to perform fellatio on another man without gagging and choking. The precipitating factor for Rafael raising this issue was that a man he was dating and romantically interested in found his initial unwillingness and then his unsatisfactory technique performing fellatio a problem if their relationship was going to grow. For many gay men the ability to "go down" on another man comes naturally, but for others, like Rafael, it is a skill that needs to be learned.

After Rafael reported that his boyfriend was complaining about how poor he was at "giving head," therapy explored whether performing fellatio was even something that he was interested in doing. He initially reported that he desired to do this in order to increase the sexual satisfaction of the man he was dating. But continued exploration allowed him to disclose that he loved men's penises and wanted to be able to make love to them for his own pleasure as well as that of his partner. Once it became clear that Rafael's desire to learn how to fellate another man was not an example of "sexual codependence," helping him overcome this difficulty was not complicated, and only took two or three sessions. He was an expert swimmer. When the therapist instructed him to use the same method he employed while swimming to keep from breathing in water, he first seemed perplexed. It was then that he was told he needed to learn to exhale while he was moving down on a penis and to inhale on the upstroke. This technique is similar to when a swimmer exhales while turning his face down, into the water, and inhaling while he turns his head sideways. After a few times of practicing this instruction, he was able to relax and enjoy performing fellatio. Once the therapist learned that Rafael loved to swim, he also suggested that he look into joining a gay swim team in order to both practice the sport and meet other gay men with this shared interest. Eventually his association with both the swim team and church allowed him to develop a family of friends that became a central part of his nonprofessional life. Largely due to the acceptance he experienced in the relationships he formed with men at the swim team and at church he found the strength to confront his family's silence about his being gay.

One of the major issues that comes up during sex therapy with gay men is helping couples negotiate discrepant desires regarding sexual exclusivity and nonexclusivity, and dealing with the lack of sexual interest on the part of one or both partners. Since the onset of AIDS the issue of whether or not to use condoms by men in relationships has emerged as a frequent presenting problem as well.

Case Example: Using Harm Reduction with a Sexual Risk Taker. Toby is a 30-year-old professional who had retested HIV negative 3 months prior to our initial consultation. He sought therapy because of concerns about barebacking with partners he met on the Internet. A friend of his had recently become HIV positive, was on combination antiretroviral therapy, and reported not having any adverse side effects. Using a motivational interviewing approach (Miller & Rollnick, 2002) we explored his ambivalence about his behavior. Toby perceived that the major advantage of barebacking was that by not insisting on condoms, he increased his sexual currency. Thus he was able to have sex with men he deemed more attractive than himself who he feared might not be interested in him were he to

insist on safer sex. Obviously these concerns raised issues regarding body image, self-worth, and self-esteem. But to explore them fully in therapy would take a long time, during which Toby would most likely still be engaging in high-risk sex.

Motivational interviewing is an ideal tool for use with men who are barebacking. Motivational interviewing is a therapeutic approach based on the stages of change model, developed by Prochaska, DiClemente, and Norcross (1992). The stages of change approach to treatment posits that people go through the following stages in the process of changing: precontemplation, contemplation, determination/preparation, action, and maintenance, and that motivational interviewing helps a person explore his or her ambivalence about changing any particular behavior and then helps the client move through the stages of change at whatever pace he or she is ready to embrace. The great gift of using motivational interviewing as a way to approach harm reduction is that it enables a therapist to assess where the individual is in his or her process of approaching change, which translates into therapy that is on target for where the client is, instead of where the therapist wishes the client would be.

Toby reported not being ready or willing to regularly use condoms or confident of his ability to do so. The therapist suggested he try the harm reduction approach known as "serosorting" (Suarez & Miller, 2001), where men have unprotected sex with other men of the same HIV status in an effort to remain uninfected by HIV, which was Toby's expressed preference. Early in treatment we worked on his asking potential partners about their HIV status prior to arranging a sexual liaison, and have sex only with men who identified as being HIV negative. Prior to starting therapy this was not something he did.

Toby felt unable to raise the topic of HIV status with any man he was chatting with online that he was attracted to, from fear of being sexually rejected. In response to hearing this the therapist suggested that in order to develop the psychic muscle necessary to learn this skill, he begin by asking men he was not attracted to whether or not they knew their HIV status. After being successful at this, he was then coached to try inquiring about the HIV status of men he had only a moderate attraction to. Eventually after about 3 months he was able to ask all the men he flirted with online their HIV status, and had sex only with men who identified as being HIV negative. Clearly, this is not a foolproof method for remaining HIV negative, but it does take a step toward reducing the possibility of seroconverting.

Bisexuality and Fluidity of Orientation

In a culture that stigmatizes same-sex behavior, one would expect the incidence of same-sex attractions to be higher than the incidence of same-sex

behavior, and both should be higher than the number of people who self-label as gay. Indeed, every study from Kinsey to the present day has found this. Virtually all studies from the 1950s (Conrad, 2001) to the present (Bell & Weinberg, 1978; Jay & Young, 1979; Laumann et al., 1994; Roberts et al., 2000) have found that the vast majority of self-identified lesbians and gay men have had heterosexual sexual experience.

However, the reality is complicated. Recent evidence suggests that women may be more physiologically "wired" for bisexuality than men (Chivers, Rieger, Latty, & Baily, 2002). When presented with lesbian and heterosexual visual erotica, women of all orientations show physiological arousal to both, whereas men's arousal is targeted. Heterosexual men respond to heterosexual erotica and gay men respond to gay male erotica. This confirms what a number of theorists already believe: that women may have a more fluid sexual orientation than men (Peplau, 2003, 2001, 2000; Diamond, 2003a; Weise, 1992). Diamond (2003b) found that a significant number of lesbian-identified college women change their self-labeling to bisexual or heterosexual over a 5-year period. Moreover, these women do not disavow their former lesbian identity and are open to the possibility of sexual change in their futures. While the leadership of the bisexual movement has often come from "former lesbians," gay men redefining themselves as bisexual are more and more common, and both men and women who defined themselves as heterosexual before relabeling as bisexual usually feel comfortable within the LGBTQ community. A greater degree of fluidity of sexual orientation appears to exist. In practical terms, it is clear that self-identification is at best an incomplete description of self-orientation, which makes it imperative that a sexual health practitioner not make any assumptions about the sexual behavior of a client without a careful history that includes questions about contact with both men and women regardless of the patient's expressed identity.

It is also apparent that there is substantial overlap between the bisexual, BDSM, and polyamory communities. Moreover, it may be true that bisexuals are more sexually active than their gay or hetero counterparts (Weinberg et al., 1994). The IPG Internet study found that bisexual women were more sexually active, had more sexual thoughts and more sexual partners, and masturbated more than other women.

Case Example: Sex between a "Gay Man" and a "Lesbian." Anthony and Rachel were gay male and lesbian identified when they met at an AIDS activist group. There was an immediate attraction on a number of levels that soon blossomed into an affair. They consulted with one of the authors (Shernoff) as a couple after having fallen in love and deciding they wanted to begin living together. Each wanted to be able to have "hit and run" sex with same-sex partners, but they also wanted an emotionally monogamous relationship with each other. They were struggling to figure out how to de-

fine themselves. Were they still gay and lesbian if they were involved in an opposite-sex love affair? Some of their friends were nonsupportive of the relationship and accused them of straddling the fence or going back into the closet. These accusations made them sad and angry. They finally just decided that they were "queer," in a very "queer" relationship.

Another issue common to some bisexuals is how to be in an intimate committed relationship and still "exercise the bisexual option."

Case Example: Incorporating Bisexuality into a Marriage. Terry and his wife, Nydia, both self-identified as bisexual from adolescence. For the first 10 years of their marriage they were monogamous, not from moral principles but because they felt their relationship needed stability before they could "open" the relationship without damage. Terry is probably a "Kinsey 4" or a 5: more gay than straight. However, he is deeply in love with Nydia and feels no conflict about giving up the possibility of a primary relationship with a man. Nydia is most likely a Kinsey 2—mostly straight, but with significant attractions to women, always in the context of a relationship.

Soon past the 10-year mark in their marriage, Nydia and Terry came to therapy for help negotiating the change in the relationship. With a counselor's help, they decided that it would be less threatening for them to "open" the relationship by incorporating extra people into their couple sex, rather than by having separate sexual liaisons. They located their first outside sexual contact, a bisexual man, at a support group for bisexuals. Terry, Nydia, and Luis met for sex and friendly companionship several times and the couple successfully negotiated feelings of jealousy, exclusion, and insecurity. They found that these feelings were triggered when the sexual pleasure seemed unbalanced, that is, if one member of the couple seemed to be getting more during a sexual encounter—for instance if Luis seemed uninterested in one of them; or if one of them felt something sexual was happening in his or her absence. By talking openly about their insecurity the couple was able to negotiate agreements that made the sexual triad viable.

However, Nydia was unhappy because she wanted same-sex contact herself. Through the Internet they located other couples who desired this kind of sexual contact. Here, however, they discovered that most "bisexual couples" were in fact heterosexual men with bisexual women, and Terry became frustrated. During this entire period of time, their therapist helped them deal with the feelings of frustration, resentment, and jealousy that arose occasionally as well as helping them brainstorm what kinds of situations would work best for them. After a year of experimentation, they finally began to locate couples where both partners were bisexual and, to their delight, found two such couples who were not only good sexual partners but became good friends as well.

Transgender Issues

An in-depth discussion of transgender issues, including assessment and gender identification, can be found in Chapter 16, by Richard Carroll.

KINK AND BDSM

"Kinky sex," "leathersex," S&M, or the more current "BDSM" sex has been one subculture of the gay male community for at least 30 years. Kinky sexual activities are commonly practiced among gay men who also enjoy so-called vanilla sex, and even men with no interest in leathersex are rarely extremely judgmental about it. Similarly, kinky sex has been normalized within much of the lesbian community. A lesbian learning of her partner's BDSM desires might decline to participate, and the issue might even break up the relationship—but she rarely will consider her girlfriend pathologically disturbed because of her kinky proclivities. Moreover, the various BDSM communities have begun to overlap more and more. In New York, for example, TES, the oldest straight BDSM organization in town, now labels itself as a pansexual group, and it is not unusual to find self-defined lesbians, bisexuals, and gay men at meetings. The major gay male and major lesbian BDSM groups in New York sponsor some joint events.

Among knowledgeable mental health professionals there is now a movement to remove the category of paraphilias from the DSM (Moser, 2001). As the manual currently stands, many consensual BDSM acts are de facto evidence of psychopathology and thus provide the basis for discrimination against kinky people. The National Coalition for Sexual Freedom describes hundreds of people who have been arrested on domestic violence charges, lost their homes, or lost custody or visitation of their children because of discriminatory laws. Empathic professionals working with this population need to recognize the very real danger kinky people may be in regarding the law.

The most common problems the sex therapist encounters from members of the BDSM community are identity confusion, and shame and self-loathing, particularly among heterosexual kinky people. In addition, many people, especially heterosexuals, are married and have children by the time they come out to themselves, making the actualization of their sexual orientation that much more complex. When counseling kinky couples, script discrepancy can be a problem. The examples we give represent these issues. There are, however, many other sexual issues unique to this population. It is beyond the scope of this paper to explore these. Readers are referred to Kleinplatz (2001); Moser & Kleinplatz (2006), and Wiseman, (1996).

Case Example: Discrepant Desire with a BDSM Sexual Script. Aurora and Shelley, both attractive women in their 20s and together for 3

years, sought treatment because of discrepant sexual desire. These women began sex therapy because Shelley seemed to have lost nearly all her interest in sex with Aurora. They were encouraged to make dates and do sensate focus exercises. But they reported never doing any of their homework because Shelley sabotaged their attempts. After several months of treatment, Shelley finally admitted that she had consuming fantasies of S/M sex and felt compelled to try it, although she had not yet acted upon her fantasy. Shelley's fantasies had been present since childhood, but because they seemed freakish and "sick" to her, she had always tried to push them to the back of her mind. But over a period of years the S/M fantasies became stronger and eventually pushed away any desire Shelley had for vanilla sex. Shelley's lack of sexual attraction to Aurora was partly a genuine aversion to non-BDSM sex, and partly the result of generalized repression of all sexual feelings triggered by the highly ego-dystonic nature of Shelley's fantasies. Once it became clear that Shelley was in the midst of embracing her kinky desires, therapy focused on normalizing her sexuality for both members of the couple, and trying to get both women to be accepting of BDSM as a sexual variation that is in many ways a sexual orientation in itself. Nichols, the therapist, made her views very clear. She held strongly to the position that nothing in BDSM is inherently pathological, and that "kink" is a natural, if statistically nonnormative, sexual variation.

But Aurora was an incest survivor who was horrified at the thought of sex that involved dominance and submission. Aurora was not able to validate or accept Shelley's sexual orientation, and was unwilling to vary their sexual repertoire to include even the mildest kind of role-playing or dominant/submissive games. In a heterosexual couple, the person in Shelley's position is usually the male, and might feel deep shame about his impulses. His wife might be repulsed by his desires even if she is an incest survivor. But because Shelley and Aurora are lesbians, the social context was different. Alternative sexualities are fairly common, visible, and accepted. Thus Shelley found emotional support as well as outlets for her sexual interests with no trouble. Because the women were young, and they had been together only 3 years and were not financially intertwined nor raising children, there was little reason for them to stay together given their insurmountably discrepant sexual scripts. Ultimately, they separated, and Shelley became active in what is sometimes called the leatherdyke community. A healthy woman, Shelley was able to quickly absorb the support of her peers and friends and shed her self-hating attitudes.

Case Example: Discrepant BDSM Roles in a Couple. Mark and Kelly, both long term HIV-positive men in their 50s, had been partners for 15 years when they sought therapy. From their first meeting in a leather bar, the men had an S/M sexual relationship with Mark as the dominant (top)

partner and Kelly the bottom, or submissive. They sought therapy because sexual activity between them had first diminished and then completely stopped over the last 3 years. During their first consultation neither reported any sex drive, which bothered Mark a great deal, but not Kelly, who reported suffering from a lifelong depression for which he was being medicated. Kelly agreed to come for counseling out of concern for Mark's feelings, even though he reported no desire for sex. He had stopped mas turbating, never fantasized about sex, and was comfortable with this, except for the discomfort it caused Mark. Shernoff, the therapist, suggested that they both get their serum testosterone levels checked, as hypogonadism is often reported in men living with HIV and AIDS. The results surprised them. Kelly's levels were normal, but Mark's were low, and his physician prescribed testosterone replacement gel in addition to steroids as he was suffering from mild wasting.

As therapy progressed, Mark began to regain weight as well as his sex drive. He began to discuss how confining being an exclusive top was for him. He expressed a growing number of fantasies that involved exploring being submissive. However, Kelly had never been interested in the dominant role even when he was feeling sexual. He certainly wasn't interested now. Up to this point the men's relationship had been sexually exclusive, and very physically affectionate even though now asexual. Mark raised the possibility of opening up their relationship now that he once again had a sex drive. Initially Kelly talked about his fears that with Mark looking outside the relationship for other partners and his not being at all sexual Mark would leave him. Mark spent several sessions empathizing with these fears and reassuring Kelly that he had no desire to leave him even though they were no longer sexual as a couple. His feelings were that the security and safety they shared was bedrock and would allow him to learn about an aspect of his sexuality that he had never previously had the opportunity to explore. Therapy was very brief and they agreed that it was acceptable for Mark to seek out partners for S/M sex where he could explore his bottom fantasies. In response to this Kelly told Mark that though he was not feeling sexual, he missed their S/M play sessions and still did desire nongenital S/M scenes where Mark could still be his top. Mark said that this really turned him on, but while respecting Kelly's lack of desire for genital sex, asked if it would be agreeable if during these scenes he used Kelly to achieve his own sexual release. Kelly was amenable to this. This case illustrates how S/M sex, while being erotic, may sometimes not have genital sex or even penetration as components of a bondage or flogging scene that both partners still experience as highly satisfying and sexy. In addition, its successful resolution was due in part to the fact that the clients were gay men, and thus reasonably ready to consider nonmonogamy as an alternative to a discrepant desire script.

Nonmonogamy and Polyamory

While gay men have been experimenting with nonmonogamous relationships for 30 years or more, and heterosexuals experimented with open marriage during the 1970s, there has been a recent upsurge of interest in nonmonogamy among people of all sexual orientations. One form of nonmonogamy is called polyamory (Anapol, 1997; Ravenscroft, 2004). Polyamory literally means many loves, and in its purest form is a movement promoting multiple, concomitant sexual, loving relationships. In reality "poly," as it is called, can range from a type of "swinging" to multiple relationships. Much of the energy driving the current polyamory movement is heterosexual and bisexual. In fact, bisexuals are prominent in the polaymory community, thus leading to stronger ties between poly people and gays, lesbians, and transgendered people. In addition, many lesbians have embraced poly (Munson & Stelboum, 1999) because it epitomizes a form of nonmonogamy more palatable to women than the recreational sex often practiced by gay men.

Gay men, on the other hand, do not usually identify as polyamorous but in many ways they are the pioneers of contemporary nonmonogamy. The nonmonogamy of gay men is sometimes similar to polyamory but often involves negotiated agreements between partners that allow each the freedom to pursue more casual sexual relationships, rather than ongoing love affairs. Before AIDS, nonmonogamy was arguably the norm among male couples (McWhirter & Mattison, 1984), and in many areas it is still the norm today, at least for couples who have been together more than a few years.

Nonmonogamy challenges many basic assumptions about love and commitment. There is some data suggesting that sex outside a male couple's relationship may be related to dissatisfaction about the partnership (Saghir & Robins, 1973; Bell & Weinberg, 1978; Kurdek & Schmitt, 1985/1986). Yet, other studies find no significant differences in relationship quality or satisfaction between samples of sexually exclusive and nonexclusive male couples (Blasband & Peplau, 1985; Kurdek, 1988; Wagner, Remien, & Carballo-Dieguez, 2000; LaSala, 2004). There is research confirming that nonmonogamy in and of itself does not create a problem for male couples when it has been honestly negotiated (Mendola, 1980; Silverstein, 1981; Blumstein & Schwartz, 1983; McWhirter & Mattison, 1984). Wagner et al. (2000) and LaSala (2004) found that in the second decade of AIDS, monogamous as well as self-described "open" male couples demonstrated higher levels of relationship quality and lower levels of psychological distress compared to couples who had not negotiated nonmonogamy but reported secret outside sexual activity.

When working with polyamorous/nonmonogamous clients, the most

common problems one will encounter are helping couples negotiate nonmonogamy, and issues of jealousy and insecurity.

Case Example: Nonmonogamy and Sexual Risk Taking. Willis and Larry were both HIV negative African American attorneys in their mid-30s and had been together for 3 years. They had just bought an apartment together prior to their first consultation and came to therapy to talk about how living together was affecting their relationship. Among the issues they raised was the possibility of stopping their use of condoms with each other. They reported being monogamous for the past 2 years and each had recently retested negative for HIV. Having worked with numerous couples who have elastic definitions of monogamy, the therapist (Shernoff) knew there was the possibility that, like many male couples, Larry and Willis might be practicing what Morin (1999) has labeled "modified monogamy." Morin defines modified monogamy as a situation where a couple negotiates accommodations that reflect the tension between their desire to be sexually exclusive and practical realities, that is, the wish to have more than one partner (Morin, 1999).

One example of modified monogamy is when a couple who define themselves as sexually exclusive have sex with a third person or a group of other people. With Morin's work in mind, Shernoff asked if their definition of monogamy encompassed having sex together with another person or with other people. At this point, they became noticeably uncomfortable. In an uncharacteristically sheepish manner, Willis asked: "Are we monogamous if we occasionally have played together with another guy?"

When asked if they had done that, both nodded affirmatively. The therapist responded: "The rules and definitions of your sexual relationship are up to you to decide. But this raises an important issue about safer sex that we need to talk about."

The concept of "negotiated safety" was then explained to them. Negotiated safety is an agreement between two gay men in a relationship to go through the process of getting ready to stop using condoms when they have anal sex. The basis is an explicit understanding that both know each other's HIV status and are both uninfected. The only time they do not use condoms is when they have sex with each other (Kippax et al., 1993). They were given the Web address (www.freedoms.org.uk) for a negotiated safety agreement that it was suggested they read, discuss, and bring in to a future session. Willis said, "While we're talking about condoms, what about Dan?" Dan was a semiregular third partner, also HIV negative, when they occasionally invited into their bed. Willis wanted to know if there was a point at which they could stop using condoms with Dan. Hearing this, Larry became angry. "Are you nuts? If he's screwing around with us, we can only assume there are other men he's sexual with as well. Even if he

tells us he's uninfected, I, for one, am not willing to trust either my health or yours to some other guy. I don't even want us to go there."

Case Example: Counseling a Three-Person Relationship. Bert and Ted had been partners for 14 years when they sought counseling. They reported feeling more in love with each other than at any time in their relationship. Both felt that their sex life has steadily improved over the years and is more exciting and satisfying now than ever before. They were sexually nonexclusive for only a short time, which ended as the AIDS crisis began to escalate. Both have tested negative for HIV antibodies. With the onset of AIDS, they decided to discontinue any independent extrarelationship sexual activity. They sought counseling because 4 months previously, while out dancing, they ran into Michael, a man with whom Ted had occasionally had sex. All three went home together that night. They have been spending Saturday nights together dancing and going home for exciting "threesomes" once or twice a month since. They agreed that the relationship with Michael is much more than merely sexual. The previous week they had all admitted to being in love with one another and had begun discussing whether or not Michael should move in with them. After three sessions of discussing how expanding their relationship and home to include Michael might affect them, it was suggested that Michael be asked to accompany them for a form of "prenuptial" counseling. Therapy took place weekly for 6 months, during which time these three men used therapy as a place to help them talk through a variety of emotional and practical issues including:

- How would they be ready to decide whether or not they were ready to live together?
- If they decided to live together, would they all share a bedroom or have separate bedrooms?
- What would the rules be if any of them wanted to have sex outside of the relationship?
- How were they going to insure legal protections for all of them if they decided to merge their finances or buy property jointly?
- What steps do they each need to take to strike the right balance of togetherness and autonomy?

They all agreed that in spite of the increased complexity, there were definite benefits to having a polyamorous relationship. Interestingly, one of the benefits they cited to forming this kind of a relationship was security. When one partner was not available emotionally or physically, there would always be a third person to turn to for support. Bert and Ted shared their concerns about learning not to exclude Michael and no longer relying entirely on one person for all of their needs.

After 6 months of working together, during which time Michael moved in with Bert and Ted, the frequency of sessions was reduced to once monthly. Before they ended counseling, Bert suggested, "Although there is the heightened opportunity for conflict, there is also another set of eyes and ears to help and understand what the basis of conflict truly is. So often in a traditional couple the partners become so overwhelmed by what they 'think' the problems are that they do not take the extra effort to really look deep inside and see what might be the true underlying problem." Michael reported, "The feeling of security with two amazing men laying on either side of you when you are feeling weak or vulnerable is unmatched by anything that I can think of—their warmth and love keeping the world away. I am not sure that I can ever be one-of-two again."

SUMMARY AND CONCLUSIONS

Although work within the queer community challenges the therapist to learn things not usually taught in graduate school, the clinician is enriched by exposure to such variety and uniqueness of sexual and gender expression. Practical things can be learned that generalize to all clients. For example, after several years of working with members of the S/M, or "leather" community, the staff at IPG noticed that S/M partners often had unusually good communication with each other about their sexual likes and dislikes. IPG therapists now teach some of their vanilla sex therapy clients how to use BDSM-style data-gathering interview techniques to learn about their partners.

Certain attitudes and behaviors are useful in working with sexual minority clients. First, one must erase all preconceptions about "normal" and "abnormal" sex. The therapist must be open to all possibilities of erotic variation, and be willing to suspend judgment. According to the authors' criteria, lack of consensuality and clear destructiveness are the only definite characteristics of "pathological" sex.

The therapist must also remember that work with this population requires suspending preconceived notions of gender and relationships as well as biases about sexual acts. Many clients who live on the sexual fringe desperately need to have their lifestyle validated by an "authority figure." This validation is surely a major aspect of the therapeutic experience for most clients who are socially stigmatized.

Although this chapter of necessity emphasizes differences, it is useful to remember that we are all more alike than we are different. Colorful and unusual differences in behavior and style may be prominent in sexual minority clients; nevertheless, most therapeutic interventions will not vary that much from interventions used in a more mainstream population.

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CHAPTER 14

Sexuality and Culture

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Let's talk about sex . . .
Now we talk about sex on the radio and video shows
Many will know anything goes
Let's tell about how it is, and how it could be
How it was, and of course, how it should be
—SALT-N-PEPA, *Let's Talk about Sex*

Couples from differing cultural and ethnic backgrounds are appearing increasingly often at the offices of sex therapists. Nevertheless, as McGoldrick and her colleagues observe, clinicians tend to be most familiar with treating a white middle-class population. The values and expectations that inform and dictate sexual behavior within that population often do not translate well across cultural groups. The situation becomes even more complicated when couples themselves come from differing ethnic and cultural backgrounds. Almost every aspect of sexual behavior may be affected by cultural norms, from displays of affection to sexual initiation—indeed, everything from the when to the what and how of sexual exchange. Even the attributes of an appropriate or ideal sexual or marital partner vary across cultures.

Religious values, too, inform sexual practices and the major world traditions differ in how sexuality is viewed—whether as a positive force to be enjoyed and cherished or as something dangerous to be controlled and proscribed, at least outside of marriage. Historically, if not recently, many non-Western cultures regarded sex as both spiritual and sacred, although sexual repression remains the norm in many societies.

Even within the same religious group there are striking differences. McGoldrick

and her colleagues note that while the Irish, for example, have historically been known for their sexually repressive society, Catholics of other cultures, such as the Italians, are quite open about both sexuality and emotions. These differences influence how comfortable couples may be when negotiating or even raising sexual problems. Italian men and women are more likely to be outspoken about their sexual thoughts and feelings whereas German or Irish Catholics may be less comfortable discussing sex freely, even with individuals of the same gender.

Across ethnic groups, couples are expected to marry within their race, class, and religion and when they do not, both immediate and extended family members may react negatively, which can contribute to relationship tensions and conflicts. Yet, curiosity about individuals different from oneself is a major ingredient of sexual attraction—for many individuals, the exotic is erotic. McGoldrick, Loonan, and Wohlsifer remind therapists that they need to be proactive not only in inquiring about cultural differences but in helping clients identify the stereotypes and prejudices that may have affected their choice of partners. The authors note, "White men or women may be sought out for their access to white privilege, Asian women for their compliance, African Americans for their sexual prowess, Latinos as passionate lovers, etc." These stereotypical expectations can later undermine relationships.

Therapists must be willing to explore their own cultural beliefs, assumptions, and stereotypes as well as those held by the cultural groups with which they practice if they are to become culturally competent. McGoldrick, Loonan, and Wohlsifer provide a provocative and comprehensive set of questions to consider when trying to understand our own and our clients' cultural expectations. Finally, they recommend the use of a sexual genogram to help codify significant symptoms, fears, and relationship problems of the partners in a dyad and of their family members. They illustrate the value of doing so in two fascinating case examples involving individuals from very different cultural backgrounds.

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Sexuality is typically described in highly individualistic terms, although sex norms, practices, and preferences are strongly shaped by culture, class, race, and gender (Mahay, Laumann, & Michaels, 2000). Given the enor-

mous diversity of ethnic groups in the United States, it is surprising that the clinical community has paid so little attention to the importance of cultural differences in values and attitudes surrounding sex.

Cultural issues are always relevant in clinical work. Given the increasing cultural diversity of the United States and the increasing number of multicultural couples, cultural understanding is especially pivotal in therapy when partners are of different cultural backgrounds. At the same time, racial and social segregation are still pervasive in the United States, meaning that the vast majority of sexual partnerships do not cross racial and social class barriers (Laumann, Ellingson, Mahay, Paik, & Youm, 2004). Racial and class segregation exist also in our institutions and therapies, and thus most psychotherapies, including sex therapy, have not attended to the importance of culture until recently. We as professionals have mistakenly considered white middle-class values to be the norm and have largely ignored those who did not fit into our construct. While people from certain cultural groups tend to make up the majority of psychotherapy consumers, we as therapists still have a responsibility to expand our theories and practice to reflect the needs of all our clients.

In this chapter, we highlight some key considerations regarding the interface between culture and sexuality, suggest a method of assessment using a genogram so that therapists are able to solicit sexual information from clients in a culturally sensitive manner, and examine how these dynamics impact therapy. In order to achieve greater insight into the relationship between culture and sexuality, we then offer a series of questions and methods that help the therapist explore issues from a culturally informed place in sex therapy.

THE INTERFACE BETWEEN SEXUALITY AND CULTURE

Sexuality from a cultural perspective seems full of paradoxes and contradictions. Sexual values, beliefs, traditions, and norms often contradict one another even within the same culture. For example in many cultures, women are to be virginal until married and sexually uninformed until their husbands educate them. In this context sex is seen as a man's right taken in marriage. Ironically, in the same cultural context, men are expected to be sexually experienced, full of sexual prowess and power, sexually pleasing, and sexually proficient. However, considering that the societies subscribing to the above beliefs usually have strong prohibitions against homosexuality, who are the men having sex with before their wives? Sexuality from a cultural framework is laden with inconsistencies and contradictions. It is key to treatment for the therapist to be able to understand the culturally based sexual belief system of the client.

While particulars of cultural practice may vary, all cultures have pro-

foundly different rules and values for male and female sexual behavior. To quote Michael Kimmel (1993):

> The difference between male and female sexuality reproduces men's power over women and, simultaneously, the power of some men over other men, especially of the dominant, hegemonic form of manhood—white, straight, middle-class—over marginalized masculinities. Those who dare to cross over—women who are sexually adventurous and men who are sexually passive—risk being seen as *gender*, not sexual, nonconformists. And we all know how homophobia links gender nonconformity to homosexuality. The stakes are high if you don't play along. (p. 123)

These differences in gender expectations are often the result of an overwhelmingly patriarchal worldview, which has existed across almost all cultures and throughout history. This pervasive patriarchal perspective has promoted women's sexual objectification and abuse around the world. Indeed it is estimated that between one-third and one-fourth of all women have been sexually abused by the age of 18 (Benson, 1990; Finkelhor & Dziuba-Leatherman, 1994; Phillips, 2000). Societal rules influence how men and women think about themselves and each other on every dimension, but most of all around sexuality. Exploring the intersection of culture and gender in dealing with sexual issues is a primary task for sex therapy.

RELIGION/SPIRITUALITY AS A CULTURAL INFLUENCE ON SEXUALITY

More than any other institution, religion has had a tremendous impact on the shaping of culturally based sexual norms, practices, and beliefs. Although sexuality is biologically influenced, there are wide variations in attitudes and values about sexual behavior. Michael Kimmel (1993) puts it thus: "As social scientists now understand, sexuality is less a product of biological urges and more about the meanings that we attach to those urges, meanings that vary dramatically across cultures, over time, and among a variety of social groups within any particular culture" (p. 122). For example, it has been said that Islamic cultures are "sex-positive" (Al-Sawaf & Al-Issa, 2000, p. 295), whereas most Christian cultures have traditionally depicted sex as sinful or dangerous. For the most part Christians—above all, Irish Catholics—have viewed celibacy as the ideal and have viewed marriage as "permission to sin" (McGoldrick, 2005). Even within marriage sexuality was endorsed primarily for the purpose of procreation. Given the rigid traditions of Irish Catholicism, sex has, perhaps not surprisingly, been referred to as "the lack of the Irish" (Messinger, 1971). A book humorously entitled *Brace Yourself Bridget: The Official Irish Sex*

Manual (Feeny & Plaid, 1982) is filled with empty pages because of the sanctions against sexual expression in Irish culture. These patterns have been changing dramatically in recent years, though perhaps less quickly for the Irish in the United States. The Irish have also often avoided tenderness, affection, and intimacy of all kinds (McGoldrick, 2005).

In contrast to the rigidity of Christianity in the West, cultures of the East, while patriarchal, have celebrated the joy of human sexuality, though it should be noted that this is limited to heterosexuality. Muslim culture has viewed monogamy as the ideal, polygamy as "a concession to human nature" (Pickthall, 1953), and celibacy as having no value at all. The positive Muslim attitude toward sexuality is evident in the Koran, the sacred text of Islam, in which Mohammed, the father and premier prophet of the faith, teaches that sexual intercourse preserves human health. Indeed sexual behavior and sexual instructions are explicitly described in folktales such as the Arabian Nights, as well as in sex manuals that circulate to this day throughout the Muslim world, even in poor villages (Al-Sawal & Al-Issa, 2000). In other parts of the Eastern world sacred books and traditions exist with regard to sexuality, such as the ancient Indian Kama Sutra, the Hindu guide to lovemaking, which is still in wide circulation today. Tantra, an approach to sex that comes out of India, literally means "tool for expansion" (Anderson, 2002, p. 10). Tantra views sexuality as sacred, and in practicing it one is in essence worshipping the male and female energy that exists equally in each of us (Anderson, 2002).

In Jewish culture, the ideal marriage includes a healthy and fulfilling sexual relationship. According to rabbinical law, it is the husband's obligation to provide his wife with sexual satisfaction. In fact Jewish law encourages sexual fulfillment for both partners and dictates that refusing sex is synonymous with annulling the marriage. The sexual act, which ideally occurs in the context of a religiously sanctioned marriage, is considered "beneficial to the soul" (Cantor, 1995). Sexual fulfillment is thought to be an essential human need (Blech, 1999). As Dr. Ruth Westheimer, the famous sex therapist, has put it: "Part of my being able to talk about issues of sexuality has to do with my being Jewish. Because for us Jews there has never been a question of sex being a sin, but of sex being a mitzvah (good deed) and an obligation" (Blech, 1999).

For the Chinese, sexuality was never associated with feelings of sin or guilt (Wolf, 1997; Van Gulik, 2003). Sexual behavior in ancient China was regarded as an indispensable activity, philosophically done in order to reach harmony in the universe through the unity of the two opposing forces of yin and yang. Yin was thought of as female, cold, and the negative aspect of nature and yang as the male, hot, positive component. Imbalance of yin and yang led to illness. Regulation of sex life was one of the major ways to promote health. Appropriate sex methods were viewed as a means of achieving immortality. Taoist handbooks on sex encouraged pro-

longed sexual intercourse and advised males to give the female an orgasm while avoiding loss of the male seminal essence through ejaculation. This is another example of a paradox about sex because while sexual pleasure is seen as positive, the loss of semen is seen as weak. The men in ancient China who followed the Tao were intent on learning how to give their lovers as many orgasms as possible. The terms the Taoists used to describe women's genitals were metaphors of beauty, sweetness, artistry, rareness, and fragrance. The Tao of loving taught men "to minister to female desire." No matter how young or old the woman, sex with orgasm was always healthful. It was sexual frustration, they held, that was the health threat for women. Among the seven Tao instructions to men about good sex, four involve teaching the male student how to kiss, appreciate, and arouse his female partner. Twentieth-century sexologists' descriptions of a four-stage model of female desire and satisfaction—arousal, plateau, climax, and resolution—seems crudely oversimplified when compared to the nuances of the Tao's descriptions of female desire (Wolf, 1997, p. 185).

These non-Western attitudes toward sex are clearly divergent from the Christian traditions that view sex as sinful, dirty, or wrong. The Taoists, Hindus, Jews, and Muslims all share the common belief that God created human beings with sexual organs and sexual desires, and not only for procreation. In these cultures sex is spiritual and sacred.

There is a strong intersection between religion, spirituality, culture, and sexuality just as there is between gender, culture, and sexuality. At the same time, even cultural groups sharing the same religion may have profound differences regarding sexuality. For example, Orthodox Jewish beliefs and practices regarding sexual issues are very different from those of non-Orthodox Jews. Orthodox Jewish practice requires a high degree of sexual segregation between men and women. Casual physical contact, even a handshake, is prohibited between the sexes except with a parent, spouse, child, or sibling. Sexuality, and even touching, are not allowed when a woman is having her period, until she has gone through the *mikva* (a ritual cleansing bath) after her menstrual cycle. Non-Orthodox Jews do not practice such rituals and tend rather toward a high degree of reciprocity, collaboration, and verbal communication in couple relationships.

There are similarly large differences among various Roman Catholic cultures. While the Irish have a strong history of sexual repression, other Catholic cultures, such as Italians, are much more sexually expressive. Italians tend to view sex as important for your health, at times attributing mental or physical maladies to a lack of sexual activity. Italian women are likely to view catcalls, sexually flirtatious comments, and even a degree of sexual touching by men as a matter of course, while such behavior might be highly distressing for women from other cultures. Italian women and men as well are very expressive of their thoughts and feelings about sex (especially in a same-sex situation), whereas in Irish and German Catholic

cultures, such openness in talking about sex, even in a same sex group, might create great anxiety and discomfort. Italians tend to have a positive attitude toward the human body and toward sensuality, where other Christian groups, from Irish Catholics to Lutherans, may be suspicious of sensuality as leading one to sin.

RACISM, SEXISM, OPPRESSION, AND SEX THERAPY

Expectations regarding sexuality are impacted not only by one's own culture but also by the dominant culture's stereotypes about each cultural group. Such stereotypes include the idea that Latinos are "hot blooded" or passionate, African Americans are highly sexed, and Asian women are "exotic" and/or submissive. We must consider the cultural context in which such stereotypes have developed and be ready to challenge them in our therapy by helping clients explore their meaning. For centuries, Europeans have viewed the native peoples of Africa, Asia, and the Americas as "racialized, sexually exotic Others" (Nagel, 2003, p. 91). The Hopi Indians viewed female sexual desire as the engine that would bring about the recreation of cosmic harmony each year, but Europeans who witnessed native women's assertion of their sexuality saw not divinity but depravity. Since European Christian cultures viewed human beings as redeemed by shame, and especially female shame, they tended to see hell where the Pueblos saw pleasure (Wolf, 1997). Where Pueblos saw sexuality as part of the sacredness of nature, Spanish priests saw "naked," "promiscuous," and "lascivious" Pueblo women as incarnations of the devil who celebrated the pleasures of the flesh (Wolf, 1997). As McClintock (1995) puts it:

> For centuries, the uncertain continents—Africa, the Americas, Asia—were figured in European lore as libidinously eroticized. Travelers' tales abounded with versions of the monstrous sexuality of far-off lands, where as legend had it, men sported gigantic penises and women consorted with apes, feminized men's breasts flowed with milk, and militarized women lopped theirs off. Africa and the Americas had become what can be called a pornotropics for the European imagination—a fantastic magic lantern of the mind onto which Europe projected its forbidden sexual desires and fears. (p. 22)

There are several pervasive stereotypes and myths, the consequence of slavery and a long history of racism, that have contributed to negative perceptions and maltreatment of black women in America (Jones & Shorter-Gooden, 2003). African American women are bombarded with messages that they are not good enough (or as good as their white counterparts),

while at the same time they are expected to be strong and unshakable, and to persevere through the most challenging life events and circumstances emotionally unscathed. This may lead many African American women to feel unable to allow themselves to be vulnerable in intimate relationships (Jones & Shorter-Gooden, 2003). Perhaps the most damaging myth that persists in our society is that African American women are promiscuous, sexually loose vixens. This stereotype of African American women as hypersexual is particularly dangerous because it leaves them vulnerable to sexual harassment, sexual violence, and abuse. Moreover, they may suffer in silence more than their nonblack counterparts when they have experienced abuse and/or sexual violence for fear of proving these stereotypes true (Jones & Shorter-Gooden, 2003).

While many of these stereotypes are also true for black men, African American women also face gender inequality, making it even more challenging for their voices to be heard. Both African American women and men are likely to have incorporated such myths into their identities, in an insidious type of internalized racism, perpetrated by both overt and covert racism that persists throughout our society. It is important for us, as therapists, to consider the impact of internalized racism and racial oppression on both biracial and African American couples.

The result of such sexual projections intertwined with racism is, as Cornel West (1993) describes it, that black sexuality has become a taboo subject in the United States. "The dominant myths draw black women and men either as threatening creatures who have the potential for sexual power over whites, or as harmless, de-sexed underlings of a white culture" (p. 83). Black women are in double jeopardy, because of both racial and gender disadvantage. While black women are seen as sexually desirable, the desirability is diminished by racism. As a racist as well as patriarchal culture, our society tends to value the beauty of white women over that of black women. As West puts it:

> The ideal of female beauty in this country puts a premium on lightness and softness mythically associated with white women and downplays the rich stylistic manners associated with Black women. This operation is not simply more racist to Black women than that at work in relation to Black men; it is also more devaluing of women in general than that at work in relation to men in general. (p. 90)

The situation is even bleaker for most black gay men, who, as West says, reject the option of black macho identity, and are thus marginalized within white America for their race and penalized in black America for rejecting the prescribed black male identity. Black lesbians suffer even more, principally owing to their lower economic status (West, 1993).

SEXUAL IMPACT OF THE DOUBLE STANDARD

The double standard for male sexual behavior when compared to the sexual behavior of women represents another example of paradox and contradiction. For example, in the Mexican American community, men are expected to have multiple sex partners, while women are expected to be faithful (Horowitz, 1983; Mahay et al., 2000). When a young Latina is in love she is often obliged to give in to her boyfriend's sexual demands, since femininity requires submission (Horowitz, 1983; Mahay et al., 2000), but using birth control is seen as providing evidence of an unmarried young woman's impurity (Horowitz, 1983). According to traditional Latino values, "when two unmarried people engage in sexual intercourse, a man's gain is a young woman's loss" (Horowitz, 1983, p. 117).

Female circumcision, also referred to as genital mutilation, which has been a practice in parts of the Middle East and Africa for centuries, is another illustration of double standards carried to the extreme. Although a culturally reinforced tradition, it is seen by many as barbaric cruelty and a violation of human rights, threatening the emotional, social, sexual, and physical well-being of girls and women. According to a report by Amnesty International in 1997, an "estimated 135 million of the world's girls and women have undergone genital mutilation . . . approximately 6,000 per day." The age of circumcision seems to depend on the culture. In some places it is done in infancy, more commonly just before puberty, and in other areas even later. Often it involves ceremony and celebration and many young women undergo the procedure at the same time (El-Gibaly, Ibrahim, Mensch, & Clark, 2002).

Among the Japanese, there has been extensive segregation of boys and girls from earliest childhood and this has continued into marital roles (Hatano & Shimazaki, 2004). Historical evidence of the separation of the sexes, particularly in the upper classes, is evident in the Japanese traditional role and function of the geisha. These women were not "sex workers," but rather daughters of the upper classes themselves who were often highly talented and trained hostesses and entertainers, as well as sexual partners for men, filling the void of female company that resulted from Japanese culture's separation of the sexes (Francoeur, Perper, & Sherzer, 1991).

The Japanese do not generally have religious constraints against sexuality, but a recent comparison of men's and women's views in 37 countries suggested that Japanese men and women are the least similar in their views of sex, religion, ethics, and social issues of all the groups studied. Because of the historically disparate social and power positions of men and women and the general suppression of emotion in Japanese culture, couples have very little experience relating to each other and seem to have difficulties in

developing satisfactory relationships (Hatano & Shimazaki, 2004). At the same time Japanese culture allows an extensively elaborated sexual fantasy world, particularly for men, though occasionally also for women, in "love hotels" or clubs where one may play out particular sexualized fantasies without emotional involvement.

LOVE, SEX, AND INTIMACY IN CULTURAL CONTEXT

Falling in love is almost a universal experience (Root & Suyemoto, 2005) but families, communities, and societies do not always agree with couples' choices. Ethnicity and sexuality generally join together to form a barrier that holds some people in and keeps others out. It influences:

- notions of sexual desirability and aversion (e.g., fat or thin, strong or weak, black or white)
- approved kinds of sexual desires for approved numbers and types of sexual partners (e.g., a monogamous relationship with an opposite-sex, same-race partner)
- approved sorts of sexual activities at approved times and places (e.g., vaginal–penile intercourse in the bedroom, out of public view (Nagel, 2003).

Cultural differences must always be understood in relation to the social location of each group within the larger context. Contrasting the esteemed sexuality of the dominant cultural group with the sexuality of the marginalized group is part of cultural narratives of sexuality around the world. As Nagel observes, "sexual stereotypes commonly depict 'us' (the dominant culture) as sexually vigorous (usually our men) and pure (usually our women), and depict 'them' (the marginalized group) as sexually depraved (usually their men) and promiscuous (usually their women)" (Nagel, 2003, p. 10). These narratives of privilege and marginality are always relevant in working with clients. Every assessment involves gaining an understanding of the experience of each partner in terms of his or her social location and its effect on the couple's sexual relationship.

Families generally support their children's choices only as long as they conform to several caveats: Marry within your class, your race, and your religion, and marry someone of the opposite sex (Root, 2001; Root & Suyemoto, 2005). Generally women are expected to marry someone of the same ethnicity and religion who is taller, older, smarter, and of higher social status. In heterosexual relationships, it is generally the man's social status that defines the couple's social status, as the woman is expected to take on the characteristics and values of her husband's social context. The taboo

against interclass relationships may be just as strong as the taboo against interracial or interreligious relationships but more often goes unspoken (Root & Suyemoto, 2005). In many cultures women have no choice about this, just as they have no control about their sexuality. As Babatunde Osotimehin (2005) writes about girls in Nigeria:

> Many . . . are married off . . . as young as 13 or 14, long before they are psychologically or physically ready. Abstinence is not an option for these girls, nor is getting their partners to use condoms. It is unacceptable for a woman or girl to ask her partner to use one in our part of the world. . . . We are painfully aware that girls and women typically cannot negotiate when, where, or with whom they have sex. (p. A19)

In Asian Indian cultures, marriages are arranged by parents and love has nothing to do with it, although these concepts have been modified in recent times. For many Asian Indian families in the United States, there is a more modern version of arranged marriage, called assisted marriage, a combination of love plus arranged marriage, whereby, aided by the Internet, the parental engineering of marriage has been reinvented. Parents may now screen partners for caste, lineage, geography, education, and so forth, but then the partners get to choose among possibilities and factor love into the arrangement (Bellafante, 2005).

Curiosity about difference is always a factor in sexual attraction. In interracial and intercultural relationships, curiosity, attraction to the "exotic," or wish to distance from one's own cultural background may play an even greater part in the initial attraction than it does normally in sexual attraction (Root & Suyemoto, 2005). Where curiosity, fantasy, and projection are rooted in cultural or racial stereotypes, discrimination will be embedded in the romance or courtship and the relationship is likely to become problematic eventually. Thus therapists should be proactive in their inquiry about cultural differences to help clients recognize stereotypes and prejudices that may underlie their choice of partner. White men or women may be sought out for their access to white privilege, Asian women for their "compliance," African Americans for their "sexual prowess," Latinos as "passionate lovers," and so on. Such factors in attraction may later undermine the relationship, just as they undermine harmonious relationships in society.

In any case, one's own cultural identity in terms of race, culture, sex, gender, sexual orientation, and class is almost always made clearer through the experience of loving someone who is different. This is not only because one must deal with family and community responses to choosing someone out of one's own group, but because the partners themselves must come to acknowledge, respect, and negotiate these cultural differences. How part-

ners honor each other's cultural differences is crucial to their potential for intimacy. As one therapist described her own relationship:

> My partner identifies as heterosexual, but I identify as bisexual; the meaning of my identity claim and whether I should or should not "come out" in social conversations became part of our relationship conversations . . . as I challenged him to see how not doing so would not only negate my own identity, but also maintain heterosexist oppression. Within our relationship my race has been an issue with particular members of my partner's white family; our class differences and values became part of our discussion over time as we merged our financial and career realities; . . . and the values and interaction styles rooted in our differential experiences with privilege related to the intersections of gender, race, and culture have had to be named and negotiated within our relationship. (Root & Suyemoto, 2005, p. 114)

Cultural differences between partners may create problems. For example, in Japanese culture, and in many other groups, a man is expected to be very attentive and romantic during courtship. But once he is married, it is expected that his entire focus will be on his job, with little emotional energy invested in maintaining the romance with his wife. A woman from a different culture who experiences such attention during courtship is likely to be disillusioned and baffled by such postmarriage changes (Root & Suyemoto, 2005).

This problem is compounded for partners from cultures that do not expect much couple communication. A Jewish partner, for example, who anticipates emotional sharing and communication, may have greater difficulty with a Scandinavian or Japanese partner than might an Irish partner, who has lower expectations for emotional communication in the first place.

Even within the same culture, the intersection of cultural values regarding expressiveness and gender may have a major impact on relationships. Japanese children generally grow up with so much focus on education and so little on playing that they–especially males, for whom the educational requirements are the strictest—may be uncomfortable in any role except work. Japanese men are often characterized by Japanese women as uninteresting. Japanese views of sex have been summed up as "repressed, embarrassing and simply not talked about" (Hatano & Shimazaki, 2004, p. 65). There is much discussion of the "7–11 husband," who leaves at 7 A.M. and returns at 11 P.M., so he is never home, and the "Narita divorce," referring to couples divorcing upon return to Tokyo's Narita Airport after their honeymoon, because the wife has discovered that her husband is a bore. He is intimidated by the honeymoon trip abroad, while she has already traveled abroad with her friends; she wants to disco and

scuba dive and he scarcely wants to leave the room (Kristof, 1996). How this plays out for Japanese Americans is unclear, but undoubtedly, as for all immigrants, they bring a large part of their culture with them.

As a result of their overall difficulty in dealing with feelings, and in spite of their reputation as a highly verbal culture, the Irish may have trouble in close relationships, especially marriage. They have placed less emphasis on marriage than other cultures, romance not being a central concept, and partners have tended to resign themselves to emotionally distant relationships. Until recently, divorce was forbidden by the Irish, although emotional distance and lack of sexuality, often referred to as the "Irish divorce," were not. Pregnancy prior to marriage was not unusual. A moment of "sin and weakness" was less unacceptable than taking precautions against pregnancy and engaging in coitus, another of the paradoxes of sexuality, gender, and culture. Traditionally, more Irish men and women remained unmarried than in other cultures. Irish distancing may be baffling or frustrating for spouses from more expressive groups. For example, an Irish woman married to an Italian man may run into intense cultural misunderstandings, since Italians tend to use words for emotional release, while the Irish response to distress is usually distance. For the Italian spouse distance (implying cutoff) is what is feared most, any level of dramatic expression being preferable. While the Irish may see distancing as merely the best temporary solution to interpersonal problems, Italian spouses may see it as abandonment. Irish couples may become emotionally isolated from each other, and the whole family atmosphere may become sullen, dour, and puritanically rigid. For the Irish spouse the first recourse to stress is withdrawal, for fear of saying something regrettable. For the Irish wife, the Italian's dramatic barrage, with threats and exaggeration, may be completely overwhelming. She then holds on to the painful words of her husband, to bring them up at some later point in recriminations. The Italian spouse is often baffled by such accusations because for him words are just an emotional release, and not meant literally. Such cultural misunderstandings are commonplace. Emotional intensity and pitch of speech, the use of dramatic words, closeness or distance, silence or explosive anger may all create considerable misunderstanding if not clarified contextually.

The rules of marital fidelity can also vary by culture and are important to assess. Absolute marital fidelity and sexual monogamy cannot be assumed. In some cultures extramarital affairs are not discussed but are an accepted practice at least for men. In other cultures marital infidelity is punishable by death. Again there is the paradox that in many patriarchal cultures men's affairs are tolerated, while women's are seen as wrong. Silence about affairs can be a means of self-protection, protection of one's partner, or avoidance of conflict (Scheinkman, 2005). While cultures may have different responses to affairs, in the United States "absolute honesty in dealing with disclosure of affairs" is the overt expecta-

tion, though the reality may be quite different (Scheinkman, 2005, p. 241).

CULTURE AND THE LESBIAN/GAY/ BISEXUAL/TRANSGENDERED COMMUNITY

Although there are strong heterosexist values in virtually all cultures, groups vary in their response to homosexual and bisexual sex. How different ethnic groups may respond to a lesbian/gay/bisexual/transgendered (LGBT) family member depends on their cultural background as well as on their particular sociopolitical values and family dynamics. It is always important in working with LGBT couples to inquire about their family's specific ethnic and religious values and attitudes.

In working with LGBT clients, it is important to understand how the clients perceive their homosexual behavior. In other words, is homosexual sex something they engage in, or is homosexuality an identity or a community with which they identify? As Nichols and Shernoff discuss in Chapter 13, many people who have sex with others of the same gender may not consider themselves "gay." This is the case in the African American community with men who are on the "down low," or "DL," a phrase used primarily in the African American community to refer to men who have sex with other men but otherwise lead heterosexual lives (Denizet-Lewis, 2003). Beyond that definition there appears to be much inconsistency as to what actually characterizes a man on the down low (Osborne, 2003). Some have girlfriends, others use the term to avoid identifying as homosexual (Osborne, 2003). Men live on the "down low" because they may feel shame due to widespread homophobia in the black community. Lately a great deal of controversy has been made about men on the down low because their secrecy has been linked to an increase in HIV infections in their African American heterosexual female partners.

In Latino communities in the United States, as well as throughout much of Latin America, men having sexual relations with other men does not necessarily mean that these men identify as gay or are part of the gay community. One is considered "homosexual" only if he is the insertee in anal or oral sex (Carrier, 1985). This is another example of a paradox when dealing with a sexual issue. Men are having sex with men in this situation, yet who is considered homosexual depends on what one is doing sexually. In this context the inserter is still considered to be heterosexual, or at least not homosexual. The insertee, in the "female" role, so to speak, is often the target of homophobic ridicule since he is seen as having lost his maleness. While homophobia is deeply embedded in most cultures, it is not a stagnant concept. Many families have found a place for their LGBT relatives within the family system as well as within the greater cultural frame-

work. Currently the Reform and Reconstructionist movements in Judaism honor same-sex marriages, as do some of the more liberal Christian denominations. Many institutions have sprung up in LGBT communities that take cultural norms and traditions from mainstream society and modify them. For example, it is now possible to have a marriage contract or, *Ketubah*, written for a same-sex Jewish couple.

Therapists should inquire about the HIV status of their gay clients. HIV is a disease that has not only greatly impacted the gay male community but has also marginalized other groups such as Latinos, African Americans, West Africans, and Haitians.

THERAPY FOR SEXUAL ISSUES

Therapists' own beliefs, assumptions, and understanding of sexuality, like the assumptions of their clients, are influenced by own culture, class, race, gender, and sexual orientation and will influence how they define, understand, ask about, and respond to sexual issues. Developing cultural competence requires exploration of one's own cultural beliefs, assumptions, and stereotypes as well as those held by the dominant culture. It is wise to incorporate such understandings into culturally sensitive interventions (Kress, Erikson, Rayle, & Ford, 2005). Therapists should familiarize themselves with different cultural values by asking questions of clients and coworkers, as well as by reviewing the published literature to gain insight into cultural dimensions that have implications for sexual dysfunction and sex therapy. Table 14.1 presents issues that may be pertinent to ask about.

Using sexual genograms (Hof & Berman, 1986) and cultural genograms (Hardy & Laszloffy, 1995; McGoldrick et al., 1998) can be very helpful in understanding the function of symptoms, fears, and sexual relationship problems. Sexual problems evolve within the context of relationships as we move through the life cycle and must be considered within this context. Therapists may benefit from constructing their own sexual and cultural genogram to highlight values they bring to their therapeutic work. Genograms map family history and relationships in a way that enables the clinician to view clients in context. They usually include family members as far back as patients' grandparents, aunts, uncles, cousins, parents, and siblings, as well as previous partners and social network. The genogram incorporates significant dates in the family history—births, deaths, marriages, divorces, and moves in or out of the household, along with the ethnic and religious background of family members. To this framework are added particular aspects of the individual, couple, and family history that have relevance to the situation: medical and psychological history, education and occupational history, and issues in the family history that may have particular relevance to sexual themes. Constructing sexual and cul-

TABLE 14.1. Questions to Ask about Cultural Issues

- Is it possible for a man and woman to have a peer friendship that is not sexual? Does the culture allow intimate male–female relationships between people married to others?
- Is sexual pleasure an expectation for women as well as for men? In intercourse? In other sexual experiences?
- At each life cycle stage do women and men express their sexual selves in different ways (Rossi, 1994)? Cultures differ in their definition of the norms for different life cycle stages. What are the sexual norms for men and women at particular ages and life cycle stages: adolescent sexuality, young adults, middle age, sex in later life?
- Is it permissible within the culture for men and women to speak openly about sexual feelings to each other? To same-sex peers? To outsiders? To the opposite sex?
- Is sexual involvement with more than one partner at one time acceptable within the culture? Is it acceptable to have multiple partners over the life span? Or only for males?
- To whom does one turn when there is a sexual difficulty? Family? Religion? The partner? Traditional healers? A sex therapist?
- Are there particular cultural values or beliefs about sex that may require modification of accepted sex therapy practices? For example, sensate focus exercises may need to be modified for ultra-Orthodox Jewish couples to take into account the fact that such couples have rarely experienced nudity prior to marriage and have a prohibition against sexual contact during a woman's menses and for a week afterwards. While various sexual techniques such as the "squeeze" technique and masturbation are commonly recommended, they do not appear to be culturally acceptable for Saudis and other Arabs (Al-Sawaf & Al-Issa, 2000). Educational techniques, especially about the positive sexual attitudes of Islam, and encouraging modified Masters and Johnson (1970) techniques of mutually pleasurable sexual activities appear to be more acceptable (Al-Sawaf & Al-Issa, 2000).
- How do people in the culture enter marriages? By choice? By arrangement?
- What are the rituals or customs in the culture regarding the body, particularly regarding sexuality (e.g., circumcision, scarification, rules about menstruation)? How are male and female bodies viewed?
- What is defined as sexual expression in the culture? What is acceptable? What is taboo?
- What is the power relationship between the partners? Who has the power to decide when, how, and whether a sexual encounter will occur? How are decisions made about birth control and reproductive rights? By mutual agreement? By the man only?
- How are sexually transmitted diseases treated in the culture? Which partner is responsible for protection from disease?
- How do racism, sexism, and heterosexism affect sexuality? How do they affect the sexual experience of those oppressed by these constructs? How do they influence our cultural views of what is sexually desirable or abhorrent?
- How does each culture respond to homosexuality, bisexuality, and transgendered individuals?
- What are the mores regarding expressions of sexuality? When is it permitted and with whom? What forms of sexuality are taboo? Is sex permitted before marriage? Only for men? Is the use of birth control allowed? What about masturbation, oral sex, anal sex, affairs, sex with partners of the same gender, etc.?
- What are considered "appropriate sexual boundaries"? Looking? Touching? What about privacy?
- What is considered an appropriate age to begin to have sex? For males? For females? How does the society respond to women or men who are in the "sex market" later in the life cycle, as is happening increasingly in the United States?

tural genograms is an extremely useful way to help couples understand themselves and each other in a sexual and cultural context. It will help clients become aware of the values they have grown up with and recognize how these influence their sexual values, behaviors, and anxieties.

Table 14.2 provides a list of sexual genogram questions (amplified from Hof & Berman, 1986). Exploring the genogram from a sexual and cultural perspective can provide the therapist with a picture of the issues from a family context, as the following case examples illustrate.

Case Example 1

Clair, 32, an architect of German American descent, came for couple therapy with her husband, Jose, 33, a software engineer of Mexican American background. After 8 years of a healthy and fulfilling sexual relationship, they were having increasing trouble being intimate with one another. Eight months earlier, Clair had a miscarriage. About a month after the miscarriage she developed vaginismus. She met with her gynecologist, who told her that she was fine medically and that the reasons had to be psychological. She went home to tell Jose what the doctor had said. He listened quietly and then gave her a hug but did not say anything else about the issue.

The next weekend Jose's parents came to visit. While clearing the table with Clair, Jose's mother spoke to her privately in the kitchen. She told Clair how sorry she was about their losing the baby. She then told Clair that she thought she and Jose could work out "their problem in the bedroom." Jose had evidently told his mother about their sexual problems. Clair listened respectfully but then excused herself, saying she was not well, and she remained in the bedroom for the rest of the parents' visit. She did not say anything to Jose about her conversation with his mother but felt very angry with him for sharing what she regarded as a private issue with his mother.

Over the next few months Clair continued to pull away from Jose without discussing why. The couple stopped having sex and barely spoke. Both were aware of the changes and the tension but felt unable to address it. They came to therapy only upon the gynecologist's recommendation. Clair came from a German Lutheran family that had lived in rural Pennsylvania for generations. She was an only child, raised by a homemaker mother and automobile salesman father. Her parents were both only children themselves. Her maternal grandfather had died early, and she had learned not to ask her mother about the difficult childhood she had had with her hardworking single-parent mother. She picked up the message not to ask about the father's family either. She knew her paternal grandfather had been harsh and that her father never spoke of him. She had known only one of her grandparents, her father's mother, a stern, unaffectionate woman who had worked extremely hard on the farm all her life. She was

TABLE 14.2. Sexual Genogram Questions

- What were the overt and covert messages partners received from their families regarding sexuality? Intimacy? Masculinity? Femininity? What might other members of the family say about these issues?
- Who was most open sexually? Emotionally? Physically? Who was most closed? How did that affect other family members?
- How was sexuality or intimacy encouraged? Discouraged? Controlled? Taught? Did previous generations differ in the messages they gave?
- Were there ways that members of your family did not conform to the sexual or intimacy mores of their religious background? What was the impact of this?
- Were there secrets in your family regarding intimacy, sex, or abuse? (Incest? Other sexual abuse? Unwanted pregnancies? Extramarital affairs? Pregnancy before marriage? Abortions? Marriage of cousins?)
- What questions might you have been reluctant to ask about sex or intimacy regarding your family's genogram? Who might have answers? How could you approach people?
- How was the concept of birth control dealt with?
- How was erotic material such as books or magazines with sexual content dealt with?
- How were stronger sexual media such as pornography dealt with? How do you deal with sexual media now in your relationship?
- What were the rules about monogamy in the relationships you saw? Was attraction to other people and talking about it all right?
- Were extramarital affairs or visits to prostitutes tolerated or discussed? How are these issues dealt with now in your relationship?
- Were there family members in previous generations who had an intimate relationship you would want to emulate? Were there members who had relationships you would not want to emulate?
- How do you feel your family members' sexual or intimate relationships were influenced by their ethnicity? Poverty? Success? Gender? Sexual orientation? Immigration? Language difficulties? Race?
- Have members of your family married out of their ethnic, class, or religious background? How did that impact others in the family? How do you think that impacted their sexual and intimate relationship?
- How do the values of your religious or cultural background influence your own views of sexuality and intimacy? Are there ways in which they are different?
- Were there people whose pattern of sexuality or intimacy did not conform with your family's cultural or gender norms? How were they reacted to by others in the family?
- What traditions or customs regarding sex or the body did your family adhere to that were culturally or religiously based?
- How would you want to change the messages you give the next generation regarding sexuality and intimacy from the messages you received in your family?
- How were the norms in your family similar to or different from the norms in your partner's family of origin? How do you think those differences may affect your sexual and intimate relationship?
- How do you think you have done as a couple navigating the differences? What shared values have you arrived at about sexual issues?
- How did factors such as prejudice or oppression affect your family and your personal development as a sexual person?
- What were your first sexual experiences like? How did you feel about them then? How do you feel about them now?

taught that it was best to solve your problems yourself. Conflicts and confrontations were not tolerated in her family. Her parents never fought in front of her, though at times she could hear them arguing at night, behind closed doors, which scared her, because she could only hear their angry tone. At present, Clair and her parents see each other infrequently and have a polite but not very personal relationship.

Jose grew up in a large extended family in Philadelphia. He was the youngest of four, with three older sisters Maria (38), Juanita (36), and Julia (35). His father was a dentist and his mother was a homemaker. Both parents came from upper-class Mexican Roman Catholic homes. Family was central to his life growing up. His entire extended family lived within a few blocks of one another. The sexes were segregated. His closest friends throughout childhood were his male cousins. As with Clair's family, image was very important. People had to maintain the appearance that they were "getting along." Discord and strife within the family were seen as inappropriate and were not tolerated. Personal information was not to be shared outside the family, but within it. The parents were seen as having the answers for their children, regardless of the child's age. The parents, as well as all older relatives, were seen as deserving respect and remained an integral part of the children's lives and decision making into adulthood. Jose and Clair live 20 minutes away from Jose's parents. He speaks to them daily and sees them, with Clair, at least weekly, and often several times a week on his own, when he visits to assist them with chores or meets them for lunch during his work day.

In therapy Clair was challenged to share with Jose how she felt about his interaction with his mother. She told him that she was ashamed and embarrassed that his mother would know about their sex life. She assumed his parents, who she cared for a great deal, would think less of her for having a problem. Furthermore, the miscarriage had affected her deeply and she was afraid that, if she got pregnant, she would lose the baby again. She came to realize that this fear was the cause of her vaginismus. She did not want to tell Jose because she knew he wanted a family and worried that he would leave her. She had learned well the lesson from parents and extended family that it is shameful to complain, no matter how difficult your situation.

Jose told Clair he had no intention of leaving her. He had trouble understanding why she felt so violated by his telling his mother of their issues. He responded, "This is a woman's issue. I did not know what to say. So I asked my mother to talk to you. I wish you were more able to talk to your mother, but I know it is not like that in your family. I was just trying to help."

In therapy the couple were helped to understand the differing boundaries they had with their parents. They needed to work on establishing rules for the managing of information in their relationship. Jose never

thought that Clair did not want children. He knew she was upset about the miscarriage but did not realize the extent of her pain. He felt uncomfortable discussing these issues with his wife because he felt vulnerable.

The therapist was able to validate Jose's insecurity about discussing feelings, given his cultural beliefs, and was able to help Jose work through his discomfort about discussing sensitive issues with Clair that he had termed "women's issues."

He was also helped in finding gentle ways to set some limits on his mother's involvement in their relationship. Clair was able to recognize the central role Jose's parents played in his life and recognized that his connectedness with his family had been a major attraction for her because she had often felt isolated and alone in her own family. With ongoing therapy, sensate focus exercises, and relaxation techniques the problem with vaginismus was resolved, and they again were able to enjoy a healthy sexual relationship.

The therapist was able to help the couple understand how their cultural differences as well as their similarities affected their relationship. In the sessions where the genogram (Figure 14.1) was discussed, Clair was able to see that Jose had been raised in a culture in which issues related to what were seen as "women's concerns," such as pregnancies or sexual problems in a relationship, were not discussed with members of the opposite sex. Furthermore she was able to see that from a cultural perspective when Jose involved his mother by telling her about their sexual problems, he was adhering to not only the norm with regard to gender issues but also to the custom of respecting and turning to elders in the family regardless of

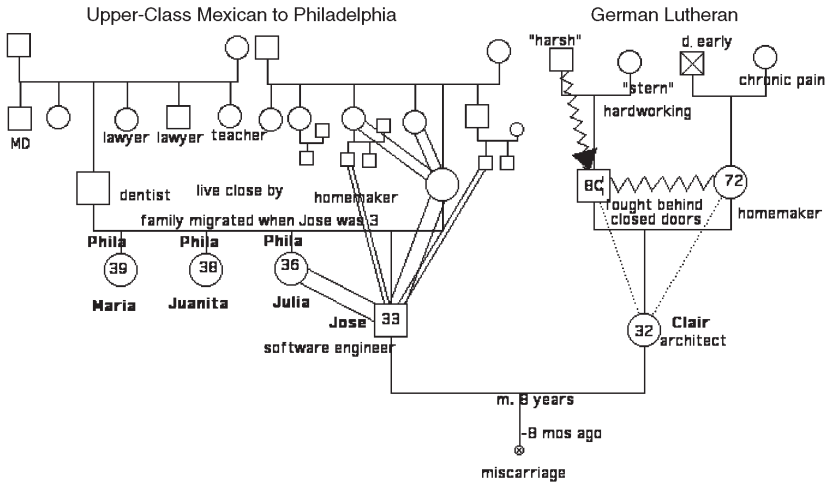

FIGURE 14.1. Genogram for the case of Clair and Jose.

how personal the issue. Jose was able to understand why Clair felt uncomfortable with his mother's involvement. He came to understand that Clair's mother's lack of involvement with her miscarriage, as well as with other issues in the past, was not because she did not care about Clair, but rather because in the culture Clair came from any such involvement by a mother would be seen as inappropriate and intrusive. By examining their cultural backgrounds, the couple was able to see that even though they were from very different cultures, they shared some common dynamics. For example, they were both raised to believe that direct communication and conflict were inappropriate. They worked with the therapist to overcome this shared struggle so that they could communicate better in the future. Had the couple and the therapist not taken the time to explore the dynamics and interface of culture and sexuality, many of the problems underlying their sexual dysfunction would have not been addressed and problems would have likely continued.

Case Example 2

Larry Cohen, 44, a computer programmer, sought help for anxiety, but it quickly became evident that his relationship with Peter McCarthy, age 47, also a computer programmer, was central to his distress. Larry and Peter had met and quickly begun cohabitating 10 years earlier, but after a short period of exciting and frequent sex, their sexual relationship had become infrequent. They had become virtually celibate for the past 6 years. Larry could not understand why but felt inhibited about asking, because, he said, "Peter can give you a look that conveys a topic is off limits and that was definitely true about sex."

Larry had always been the initiator sexually, but in their nonsexual relationship he felt Peter was "in control." Peter made twice the income he did, and Larry felt "a failure" financially and thought this must be why Peter had withdrawn physically. He said he loved Peter and was afraid of being left alone.

In Larry's family of origin, confrontations had always led to angry blow-ups and cutoffs. He had been devastated by his parents' divorce when he was 7, and by his mother's second divorce when he was 14, because he had become very attached to his stepfather. His father, after 4 disastrous marriages, finally seemed stable with his current wife. Larry's mother has been alone since the second divorce, but Larry said her stormy relationships with friends, siblings, and her parents were always in turmoil. He described himself as "a conflict avoider" and thought his anxiety was related both to financial insecurities in his childhood and to his parents' conflicts, which always ended badly. He did not have the courage to be open with Peter about his distress over their nonexistent sexual relationship. He wondered if Peter masturbated. When questioned about his own

sexuality, he said he thought about it all the time and felt extremely depressed at the idea of never having sex. He said he masturbated frequently but did not let himself fantasize about other men because he thought it was "disloyal."

In therapy, Larry was challenged to raise the issue of the lack of sex with Peter. For some weeks he was too anxious to do it, but he finally decided he would start with an e-mail, fearing to make Peter uncomfortable by raising the issue more directly. Peter responded with an e-mail as well, admitting that he too was uncomfortable, but said he had concluded that Larry was no longer attracted to him, because he never approached him anymore. After a few conversations they agreed to come for therapy. We did their cultural and sexual genograms (Figure 14.2) and it was clear they had come from significantly different backgrounds. The grandparents on both sides of Larry's family had immigrated from Eastern Europe to the Lower East Side in Manhattan and had been in business ever since. The parents had initially wanted Larry to be a doctor, but after some struggles they had accepted his being a math major at a small New England college. When he came out to his parents soon after college, they had both accepted his sexual orientation without too much difficulty, and both said they had suspected he was gay since childhood. Larry's parents generally discussed sex frankly. There had been much discussion of his maternal grandfather's affairs, and at one point his grandmother had actually confronted a girlfriend directly.

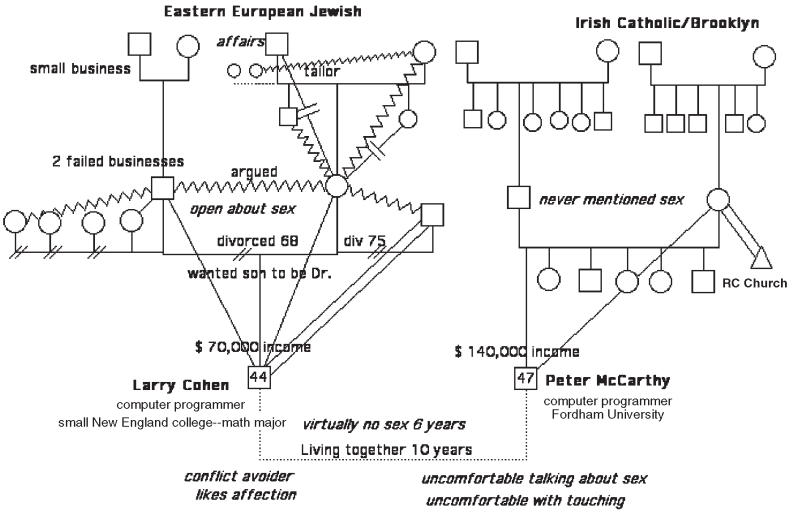

FIGURE 14.2. Genogram for the case of Larry and Peter.

Peter, the oldest of six siblings, was fourth-generation Irish, and grew up in Brooklyn. He went to Fordham University for his undergraduate and graduate studies. His family was, he said, "very Catholic" and he had never come out to them. In fact he couldn't remember a single time his family had even spoken about sex. He said that once when he was visiting his family, they sat through the entire news report about Monica Lewinsky's relationship with Bill Clinton in silence, and at the end his father abruptly asked if anyone wanted another beer and left the room. There was no mention of the dramatic details they had just heard about semen and oral sex. Peter's mother spent a great deal of her energy doing things for the church, but in recent years she had been distressed that the church was being taken over by "those people," meaning the Latinos who were attending church. Even though one of the local priests had been charged with sexual abuse, she would never make a single mention of it.

Peter, an outstanding student, had had no relationship longer than a few months before meeting Larry and wanted very much to stay together. He was surprised that Larry had been so afraid to speak with him about the problems but had little to say about having completely misunderstood Larry's distance himself.

After a few brief sessions focused on their backgrounds, their relationship, and what each of them wanted sexually, Peter withdrew from the therapy, saying he thought things were better and saw no need to meet again. They had had sex twice at Larry's initiative, and Peter thought they would be fine together. Larry decided to continue to come to therapy occasionally. At a follow-up session a year later, Peter acknowledged that the conversations about sex in therapy were the first he had ever had. He said he felt they had made a big difference in his relationship with Larry. Sex was still not as frequent as Larry would have wished and he was still the initiator, but he said he was no longer as afraid to create a "storm" by raising an issue with Peter. He also no longer felt responsible for the sexual difficulties that he and Peter had.

Constructing both Larry's and Peter's cultural and sexual genograms enabled the therapist to extract, explore, and understand a large amount of information in an efficient manner. The use of genograms helped to demonstrate that the two men had come from significantly different cultural backgrounds, which had impacted their expectations and beliefs regarding sex as well as their interactions and communication as a couple.

By focusing clearly on the cultural backgrounds of both partners and articulating how their backgrounds influenced their behavior and fears, the therapist was able to help the couple see each other's reactions in a completely different light and not take the other's "difference" as a personal attack. It was perhaps also relevant that the therapist did not press the Irish partner for more therapeutic conversation than he wanted. The cultural differences do not go away just because they are discussed, but partners are

able to make more informed choices about each other, and Larry was able to see that while he was much more comfortable analyzing relationship patterns than Peter was, Peter's discomfort was not about him. Had he become disgruntled when Peter decided he had had enough therapy, it is likely that Peter would not have returned for the follow-up the next year, but he accepted the cultural difference between them, though he wished that Peter had wanted to stay longer to work on their emotional relationship.

CONCLUSION

To practice effective sex therapy the clinician must have insight into the interface between culture and sexuality. People learn about sex and develop their sexual selves in the context of their ethnicity, race, gender, class, sexual orientation, and other sociocultural dimensions. Cultural values, beliefs, and preferences have profound influence on a couple's sexual relationship. They are essential for assessment and can provide important avenues for intervention. These dimensions cannot be learned cookbook style, but should be incorporated into our theories, training, research, and clinical practice at every level. The question should be, How does this person or couple's culture influence his/her/their sexual experience? And what are the implications of their culture for sex therapy intervention? This chapter has attempted to provide clinicians with some interventions regarding incorporating culture into the assessment process as well as some suggestions of the richness of cultural understanding for sex therapy.

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CHAPTER 15

Paraphilia-Related Disorders

The Evaluation and Treatment of Nonparaphilic Hypersexuality

MARTIN P. KAFKA

As Kafka points out in this original, thorough, and clinically comprehensive chapter, paraphilias and paraphilia-related disorders have tended to be ignored and neglected in the literature on sex therapy. Their relative neglect is due partly to the dearth of prevalence and treatment outcome studies and partly to the hidden nature of these conditions in contrast to other disturbances of human sexuality. Nevertheless, these conditions may lead to shame, guilt, depression, and often, to negative economic and interpersonal consequences. It is for this reason that it behooves the sex therapist to inquire as to their existence and to offer assistance, where appropriate and desired.

Historically, hypersexuality has been regarded as both an addiction and an impulse control disorder. Kafka rejects these terms, noting that they "miss a central concept: sexual behavior, especially in males, is driven in large part by biology. Now, people with excessive sleep or thirst would not be best described as 'addicted' to sleep or fluids, even though they might engage in self-soothing behavioral excesses. Just so with sexual behavior."

Kafka defines paraphilia-related disorders as recurrent, intense sexually arousing fantasies, urges, or behaviors involving essentially normative aspects of sexual expression that cause distress or significant psychosocial impairment. They include compulsive masturbation, protracted promiscuity, dependence on pornography, telephone sex, or cybersex, and severe sexual desire incompatability. Kafka suggests that the major distinction between paraphilias and paraphilia-related disorders is that the

former behaviors are considered socially unconventional or deviant in their object of sexual arousal while the latter are not.

Like paraphilias, paraphilia-related behaviors tend to be more common in males than in females, tend to wax and wane over time (often increasing with stress or anxiety), and are experienced as obligatory and insistent. In particular, Kafka recommends that clinicians assess Axis I diagnoses in detail as many clients with this disorder experience comorbid mood disorders (e.g., dysthymic disorder, bipolar spectrum disorders, major depression), anxiety disorders, substance abuse, and other impulsive disorders such as attention-deficit/hyperactivity disorder. In addition, their relationships should be evaluated because paraphilia-related disorders typically have negative consequences on couple intimacy, and the strength of the partner relationship can be materially important in determining the success of therapy.

In terms of treatment, Kafka recommends an integrated and comprehensive approach. Control over the hypersexual behavior, along with a focus on current life issues, is important. While psychodynamic or group therapy alone will typically not eliminate the behavior, it can be helpful along with cognitive-behavioral interventions. Psychopharmacological interventions are especially important for gaining initial control over the driven behavior. Kafka provides an updated and useful review of the latest pharmacological options, recommended dosages, and side-effect considerations.

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HISTORICAL OVERVIEW

Nonparaphilic hypersexuality disorders are disinhibited or exaggerated expressions of human sexual arousal and appetites. The modern clinical view of these disorders dates from the late 19th century, with the pioneering work in Europe of Richard von Krafft-Ebing (1886/1965), Havelock Ellis (1905), and Magnus Hirschfeld (1948). These investigators observed a spectrum of persistent, socially deviant sexual behaviors that we now call *paraphilias*, or *PAs*. They further noted clinical examples of males and females whose nonparaphilic sexual appetites, including compulsive masturbation, appeared insatiable. Their clinical characterizations were amplified in the 20th century with other disorders such as protracted promiscuity, identified as "Don Juanism" (Stoller, 1975) or satyriasis (Allen, 1969) in men and nymphomania (Ellis & Sagarin, 1965) in women.

In organized American psychiatry, sexual deviations were recognized as personality disorders in the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II; American Psychiatric Association, 1968), but that document made no mention of nonparaphilic hypersexuality disorders. By 1980, however, DSM-III (American Psychiatric Associa-

tion, 1980) had subclassified paraphilic disorders as distinct pathologies, that is, as sexual disorders. Don Juanism and nymphomania were included as psychosexual disorders not otherwise specified. This marginalization of nonparaphilic hypersexuality has persisted in more recent American Psychiatric Association diagnostic manuals, primarily from a lack of empirical research that would assist the identification of specific nonparaphilic behaviors as distinct diagnostic categories. In the most recent manual, DSM-IV-TR, there are no specific designations describing paraphilia-related disorders, although sexual disorders not otherwise specified (302.9) includes a condition described as "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (American Psychiatric Association, 2000 p. 582).

CONTEMPORARY CLINICAL CONCEPTUALIZATIONS

The "sexual revolution" in the United States and Western Europe was in part a product of medical progress, following the discovery, production, and distribution of oral contraceptives. From the late 1960s to the early 1980s, the social changes associated with that "revolution" helped to deemphasize the idea of hypersexual behavior as a pathology and contributed to its reconceptualization as a variant of normative sexual expression (Levine & Troiden, 1988; Rinehart & McCabe, 1997). This rethinking was advanced by the depathologization of homosexuality in the United States and, among some male homosexuals, the destigmatization of promiscuity. But the revised attitudes about hypersexual behavior may have come at some cost. They may be correlated with higher divorce rates during those same decades, and with a resurgence of sexually transmitted diseases. Some of these diseases have devastating emotional consequences (e.g., herpes genitalis, gonorrhea), as well as substantial morbidity and mortality (e.g., cervical carcinoma, hepatitis B and HIV/AIDS) (Holmes, Mardh, Sparling, & Weisner, 1990). The fact that these illnesses are more prevalent among people with multiple sexual partners has had a sobering effect and has contributed to a general reevaluation of contemporary sexual mores.

In 1978, J. Orford suggested that excessive sexual appetites and activities, including promiscuity, could be understood as a syndrome with many resemblances to addiction, even in the absence of an actual substance being abused (Orford, 1978, 1985). The clinical concept of "sexual addiction" was further popularized by the publication of P. Carnes's descriptive book *Out of the Shadows: Understanding Sexual Addiction* (Carnes, 1983) and other publications (Carnes, 1989, 1990, 1991). The clinical term has been enthusiastically embraced by the popular press. It has particularly struck a

chord with people who feel themselves subject to either repetitive paraphilic or nonparaphilic hypersexual behaviors that they find difficult to control and that lead to undesirable and significant psychosocial consequences.

The term "sexual compulsivity" was introduced by Quadland (Quadland, 1983, 1985) around the time of Carnes's first publication. He suggested this term to describe volitional impairment associated with nonparaphilic hypersexual behavior. His term has subsequently been taken up as a descriptor for both paraphilic and nonparaphilic sexual behavior disorders by a number of investigators (Coleman, 1986, 1987, 1992; Anthony & Hollander, 1993; Black, 1998; Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Travin, 1995). The applicability to both paraphilic and nonparaphilic disorders has been the subject of some debate (Coleman, 1986) with the upshot that a hybrid term, "sexual compulsivity/addiction" (or the reverse), is now used to cover both cases (Shaffer, 1994).

The debate continues as to the "form" of psychopathology associated with nonparaphilic hypersexual behaviors (Goodman, 1997). There has been conceptual progress since this text was last published. For example, I have identified these conditions as dysregulations of sexual appetite characterized by disinhibition or "hypersexual desire" (Kafka, 1997a, 2000; Kafka & Hennen, 1999). Under that model such descriptors as addiction or compulsivity miss a central concept: sexual behavior, especially in males, is driven in large part by biology. Now, people with excessive sleep or thirst would not be best described as "addicted" to sleep or fluids, even though they might engage in self-soothing behavioral excesses (Kafka, 2001). Just so with sexual behavior. In addition, my model emphasizes which specific sexual behaviors, as paraphilia-related disorders (PRDs), characterize these conditions, and it highlights how paraphilia-related disorders are coassociated with and related to paraphilias and to other psychiatric diagnoses (Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998). We will come back to this point.

Kinsey Institute researchers have outlined a theoretical model for sexual appetite and have illustrated its applicability to nonparaphilic "out of control" sexual behaviors (Bancroft & Vukadinovic, 2004). Bancroft and associates put forward a dual-control model of sexual arousal (Bancroft & Janssen, 2000) that postulates a centrally mediated homeostasis between sexual excitation and sexual inhibition in males and females. They have developed a validated scale of proneness to excitation and inhibition to assess how social or clinical groups might differ in these regards. In this view, "sexual risk takers" would show low inhibition or high excitation or both, and would thus tend in particular toward promiscuous behavior. They concur with other investigators (Carnes, 1989; Coleman, 1990; Kafka, 1991) that "negative" mood states, especially anxiety and depression, can be associated with both sexual promiscuity and increased masturbation

(Bancroft, Janssen, Strong, Carnes, et al., 2003; Bancroft, Janssen, Strong, & Vukadinovic, 2003).

CLASSIFICATION

I have suggested the term "paraphilia-related disorder" (PRD; Kafka, 1993, 1994a, 1995a; Kafka & Prentky, 1998) for specific nonparaphilic hypersexual conditions. Unlike "impulsivity," "compulsivity," or "addiction," this term is not bound to explanatory models for these specific actions and behaviors. Nevertheless it acknowledges that such behaviors, while not socially deviant, may share many of the same clinical characteristics as the family of paraphilic disorders.

Following the DSM nosology, PRDs, like PAs (American Psychiatric Association, 2000), persist for at least 6 months, are manifested by intense and arousing sexual fantasies, urges, and activities, and produce personal distress or significant psychosocial impairment (Kafka, 1994a, 1995b). The big difference between PAs and PRDs, then, is that PAs encompass behaviors regarded as more socially unconventional or deviant in their object of arousal.

Table 15.1 presents an operational definition for paraphilia-related disorders (Kafka, 1994a, 1995b; Kafka & Prentky, 1992a) conforming to the DSM-IV-TR criteria for sexual disorders.

In support of this diagnostic designation, the distinction between "normal" and "deviant" sexual behavior has been subject to social, religious, and scientific traditions (Marmor, 1971). For example, both masturbation and homosexuality were considered socially deviant within the past century in both Western Europe and the United States. They are still regarded as such in some non-Western cultures. On the other hand, homosexual pedophilia, a contemporary paraphilia, was culturally permissible at the height of ancient Greek culture (Greenberg, 1988). These examples

TABLE 15.1. Operational Definition for Paraphilia-Related Disorders

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving culturally normative aspects of sexual expression that increase in frequency or intensity so as to significantly interfere with the expression of the capacity for reciprocal, affectionate activity.

B. These fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. These fantasies, urges, or activities do not occur exclusively during an episode of another primary Axis I psychiatric condition (e.g., bipolar disorder, hypomanic episode), psychoactive substance abuse (e.g., alcohol, cocaine, amphetamine), or a general medical condition (e.g., brain injury, dementia, prescription drug use).

suggest that some contemporary, culturally adapted sexual activities can become "paraphilic-like"—repetitive, intrusive, and troublesome to relationships, even when the activities are not especially anomalous at the time.

In men, and presumably in women, paraphilia-*related* disorders share many clinical characteristics with purely paraphilic disorders. First, although the male–female prevalence ratio of PRDs, estimated at 5:1 (Black et al., 1997; Carnes & Delmonico, 1996; Schneider & Schneider, 1996), is not as high as the estimated ratio for paraphilias (20:1) (American Psychiatric Association, 1987, 1994), PRDs are still predominantly male disorders. Second, PAs and PRDs both show themselves during adolescence (Abel, Mittleman, & Becker, 1985; Black et al., 1997; Kafka, 1997a). Third, several empirical studies have reported that people presenting for treatment of sexual impulsivity disorders (Abel, Becker, Cunningham-Rathner, Mittelman, & Rouleau, 1988; Buhrich & Beaumont, 1981; Freund, Sher, & Hucker, 1983; Rooth, 1973; Carnes, 1983, 1989, 1991) commonly report having multiple rather than single hypersexual outlets over their lifetimes. These studies reveal a general diathesis or vulnerability to PAs and/or PRDs. Fourth, although many studies of paraphilic sex offenders do not systematically assess PRDs, nevertheless PRDs may be common among males with PA (Anthony & Hollander, 1993; Black et al., 1997; Breitner, 1973; Gagné, 1981; Kafka & Hennen, 2003; Kafka & Prentky, 1998; Levine, Risen, & Althof, 1990; Prentky et al., 1989; Travin, 1995). Fifth, men and women with PRDs as well as those with PAs describe their sexual behavior as obligatory, repetitive, and stereotyped at times. In addition, sexually arousing fantasies, urges, and behaviors can be time consuming, often occupying several hours per day (Black et al., 1997; Carnes, 1983; Kafka, 1997a). Sixth, like paraphilic arousal (American Psychiatric Association, 2000), PRDs can wax and wane, be either ego-syntonic or ego-dystonic, and are more likely to occur or intensify during periods of "stress" (Black et al., 1997). Seventh, men with PAs or PRDs are equally likely to report periods of persistently heightened sexual behaviors leading to orgasm, compared to the general population (Kafka, 1997a; Kafka & Hennen, 2003). Last, as with PAs, people with PRDs may come to prefer unconventional sexual activities to sex with a partner. This may lead to extramarital activity, reliance on masturbation, and /or relationship problems.

WHAT ARE THE COMMON CONTEMPORARY PRDs AND HOW MIGHT THEY BE RELATED TO PAs?

The lack of a consensus among investigators has hindered scientific scrutiny. I have a database of nearly 900 men and women who have sought evaluation and treatment for either PAs or PRDs. This database is summa-

rized below. Although other investigators use different terminology, these conditions are generally clinically consistent among investigators.

Compulsive masturbation, the most common paraphilia-related disorder, was found in 70% of a large clinical sample (Kafka & Hennen, 1999). Despite its prevalence, compulsive masturbation rarely occurred in isolation and was associated with the least distress or psychosocial impairment. Occasionally compulsive masturbation was associated with genital injury or abrasion. It was statistically significantly associated with other paraphilia-related disorders except protracted promiscuity and was significantly associated with paraphilic disorders, most especially telephone scatologia (obscene phone calls). Indeed, in males with PAs or PRDs, masturbation is the most common sexual outlet over the course of a lifetime, regardless of marital status (Kafka, 1997a). This is a distinctly different pattern from what appears in large community surveys of sexual behavior. In such studies, sexual intercourse is the most prevalent sexual outlet over a lifetime (Seidman & Reider, 1995).

Protracted promiscuity can be subdivided into heterosexual, bisexual, and homosexual subtypes. In the aforementioned report, protracted promiscuity was identified in 50% of males seeking treatment for PAs and PRDs. Protracted promiscuity is associated with the dispersion of sexually transmitted diseases (Holmes et al., 1990) and severe disruption of human pair-bonded relationships (Schneider & Schneider, 1991, 1996). Although it is not associated with any specific paraphilic disorder, more than 33% of the paraphilic group reported this paraphilia-related disorder. Heterosexual promiscuity was statistically significantly associated with telephone sex dependence.

There may be clinical instances when the designation of a paraphilia-related "disorder" such as protracted promiscuity needs to be carefully assessed before diagnostic criteria can be met. For example, professional sex workers certainly engage in sex with multiple partners. In such circumstances, when the primary motivation to do so is not sexual (e.g., obtaining money for illicit drugs, escaping from poverty, forced into sexual slavery), a diagnosis of protracted promiscuity is not appropriate. More commonly, young males may try to "score" as many male or female partners as they can, but it is equivocal whether this results in psychosocial adjustment difficulties.

Pornography dependence, like protracted promiscuity, was reported by 50% of the sample (Kafka & Hennen, 1999) and was statistically significantly associated with compulsive masturbation and telephone sex dependence. The recent advent of Internet-related pornography has greatly increased its accessibility and affordability while maintaining anonymity (Cooper, 1998). It is of interest that pornography dependence was statistically significantly associated with mild sexual sadism and masochism but not with any specific sex-offending paraphilia. It is common for males with

pornography dependence to lose sexual interest in their primary partner. In my most recent database of 180 males (Kafka, 2006, unpublished data), pornography dependence had significantly increased to nearly 70%, about the same prevalence as compulsive masturbation! This increase is explained by one social change: the growth of the Internet. Indeed, not only has pornography dependence (and child pornography dependence) increased as a result, but in addition, the use of Internet pornography in the workplace has provoked a variety of industry-based responses (Cooper, Golden, & Kent-Ferraro, 2002).

When pornography dependence is associated with persistent (6 months) sexual arousal to prepubertal children, the diagnoses of pedophilia and pornography dependence (and likely, compulsive masturbation) are appropriate.

Telephone sex dependence had a 25% sample prevalence (Kafka & Hennen, 1999). It was associated with significant debt and phone blocks. Telephone sex dependence was statistically significantly associated with compulsive masturbation, pornography dependence, and protracted promiscuity. Interestingly, it was also significantly associated with the paraphilia telephone scatologia. There is very little empirical literature describing phone sex dependence. Based on my most recent clinical database (Kafka, 2006), telephone sex dependence is declining.

Cybersex (Kafka, 1999) was not specifically examined in the aforementioned sample. Cybersex has been most extensively studied by Cooper and colleagues (Cooper, 1998; Cooper, Delmonico, & Burg, 2000; Cooper, Delmonico, Griffin-Shelly, & Mathy, 2004; Cooper, Scherer, Boies, & Gordon, 1999). In those studies, however, Internet pornography users (mostly men) and chat-room participants (mostly women) are combined in the "cybersex" sample. Newsgroup and e-mail group participants tend to be males looking for specialized pornography forums. It is likely, then, that each of these Internet-related domains could represent different populations of male and female users (Cooper et al., 2000). In addition, it is imperative to be clear about what motivates the cybersex user. Women first seeking relationships and "connection," with sexual behavior as a secondary factor, are very different from men looking first for genital arousal. The differences between men and women in computer relationships is a subject of current research. For these reasons, I suggest considering those who seek pornography through the Internet as representing a subtype of pornography dependence. I suggest maintaining cybersex as a distinct category of paraphilia-related disorder, which can include explicit sexual behavior, in concert with chat rooms (analogous to telephone sex), or as a precursor to either dating or promiscuity. Indeed, frequent users of cybersex are more likely to acquire sexually transmitted diseases associated with seeking sex (McFarlane, Sheana, & Rietmeijer, 2000). In my current database (Kafka, 2006), about 20% of men seeking treatment for paraphilias or paraphilia-

related disorders reported clinically significant problems from persistent use of cybersex chat rooms and nonpornographic e-mail groups.

It is also noteworthy that both males and females who identified themselves as compulsive toward computer sex and relationships were engaging in such behavior at least 1–2 hours per day (11 or more hours per week) (Cooper et al., 1999). This is the same amount of time consumed by males who seek outpatient help for PA and PRDs (Kafka, 1997a). The comorbidity of sexual disorders with cybersex chat rooms has not been reported, although this is a vehicle for some pedophiles to meet and groom possible victims (Nordland & Bartholet, 2001).

Severe sexual desire incompatibility was found in 12% of the sample (Kafka & Hennen, 1999). By definition it is associated with pair-bond dysfunction. Severe sexual desire incompatibility was statistically significantly associated with compulsive masturbation and the PA sexual sadism. It is important to emphasize that this disorder is not confined to married males who want partnered sex two or three times a week. Most men and women who report this PRD have periods of wanting or demanding near daily sex (or more), and the affected partner feels sexually exploited, demeaned, or angry. In some instances, severe sexual desire incompatibility may be associated with date rape. This incompatibility disorder is typically associated with seeking couple psychotherapy or is a significant factor in the termination of a relationship.

PRDs not otherwise specified include nonparaphilic hypersexual conditions lacking in empirical validation. The concept of "love addicts" or "relationship addicts" especially is in need of clarification. If, for example, the primary motivation for a relationship-dependent man or woman is to avoid being alone or to assuage severe depression or anxiety, it may be difficult to categorize these conditions as primarily sexual disorders. On the other hand, if men or women who seek such relationships engage in repetitive sexual behaviors with multiple partners, such persons could be diagnosed with protracted promiscuity.

Sexual harassment in a workplace setting, including frank boundary violations, may be another PRD not otherwise specified (Lybarger, 1997; Shults, 1995). Indeed, in the past decade in particular, sexual boundary violations and institutional policies responding to legal complaints of persistent sexual harassment have received increased attention in the United States (Lavelle, 1998).

The frequency distribution of PRDs in females is less thoroughly studied, although compulsive masturbation, protracted promiscuity (including prostitution), severe sexual desire incompatibility, and the paraphilia sexual masochism have been reported. Carnes, Coleman, and others describe pathological "crushes," "obsessional fixations," or "love addictions" (Carnes, 1991; Coleman, 1992; Kasl, 1989; Schaef, 1989) as predominant female expressions of sexual compulsivity/addiction. Currently, however,

there is a substantial lack of empirical data on these conditions. For example, it is not evident whether these are primarily genital/sexual behavior disorders or, perhaps, attachment disorders or obsessional symptoms not primarily mediated by sexual appetitive behavior. More data are required before these conditions can be definitively considered as sexual disorders if we maintain the DSM-IV-TR nosology that limits sexual disorders to primary disturbances of genital/sexual behavior and desire.

THE CLINICAL AND DIAGNOSTIC ASSESSMENT OF PRDs

General Principles

Several principles are of particular relevance in the evaluation and treatment of paraphilia-related disorders. First, PA and PRD behaviors are secretive because they engender considerably more shame, guilt, and blame than other sexual disorders. Indeed, these sexuality disorders are arguably the most shame- and guilt-inducing contemporary psychiatric conditions. Sometimes it may take years before a person with these conditions acknowledges them to a professional or is "caught" engaging in an unconventional sexual behavior by a spouse or significant other. Thus, the first principle for the evaluation of paraphilia-related disorders (or paraphilias) is to ask specific clinically relevant questions and to inquire without a spouse or significant other present. In this regard, I always inform patients that when I ask them personal questions about sexual behavior, it is because sexual disorders are highly misunderstood by the lay public and are, in fact, readily treatable conditions. I suggest that the failure to address and diagnose these conditions during the early part of evaluation/treatment can lead to misdiagnosis, costly and unproductive psychotherapy, and an incomplete understanding of the causes of a person's suffering. This helps to establish a rationale for self-disclosure early in the process of evaluation or treatment of both PAs and PRDs.

Table 15.2 includes diagnostic screening questions that are relevant to diagnose either PAs or PRDs. If a person answers "yes" to one or more of these questions, I would recommend asking specifically about the presence of PAs and PRDs.

The Importance of Assessing Axis I Comorbidity

In the few studies that systematically evaluated Axis I diagnoses in "sexually compulsive" males and females (Black et al., 1997) or those with paraphilia-related disorders (Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998), one of the major findings is that most subjects with these disorders have multiple lifetime comorbid mood, anxiety, psychoactive substance abuse, and/or other impulse disorder diagnoses. For example, Black

TABLE 15.2. Screening Questions for the Diagnosis of Paraphilia-Related Disorders

1. Have you ever had recurrent trouble controlling your sexual behavior? (Bancroft & Vukadinovic, 2004; Carnes, 1989; Coleman, 1992; Kafka, 1997a)
2. Has your sexual behavior ever caused you persistent personal distress or caused significant consequences to you such as loss of a relationship, legal problems, job-related problems, or medical problems, including a sexually transmitted disease or unwanted pregnancy? (Carnes, 1989; Coleman, 1992; Kafka, 1997a)
3. Have you ever had repetitive sexual activities that you felt needed to be kept secret or that you felt very ashamed of? (Carnes, 1989; Coleman, 1992)
4. Have you ever been troubled by feeling that you spend too much time engaging in sexual fantasy, masturbation, or other sexual behavior? (Carnes, 1989; Coleman, 1992; Kafka, 1997a)
5. Have you ever felt that you have a high sex drive? For example, if we include both partnered sex and masturbation, have you ever been sexual seven or more times/week during at least a 6-month period since adolescence? When was that? Did it last longer than 6 months? (Kafka, 1997a; Kafka & Hennen, 2003)

reported, in 36 male and female respondents to an advertisement for "compulsive sexual behavior," a lifetime prevalence of any psychoactive substance abuse (64%, primarily alcohol abuse), any anxiety disorder (50%, especially phobic disorders), and any mood disorder (39%, major depression and dysthymia) and an unspecified but significant total incidence of impulse control disorders, including compulsive buying. Kafka (Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998), in three outpatient males samples, reported that the typical male with PRDs without PAs had multiple lifetime Axis I disorders including any mood disorder (61–65%, especially dysthymic disorder); any psychoactive substance abuse (39–47%, especially alcohol abuse); any anxiety disorder (43–46%, especially social phobia); attention-deficit/hyperactivity disorder (ADHD; 17–19%), and any impulse control disorder (7–17%), especially the atypical impulse control disorder reckless driving. It is of clinical interest that in both these studies, males with PRDs did not significantly differ from males with PAs in the lifetime prevalence of mood, anxiety, psychoactive substance abuse, or impulse control disorders. In the second and third reports, however (Kafka & Hennen, 2002; Kafka & Prentky, 1998), the addition of the retrospective assessment of ADHD, did statistically distinguish the PA (prevalence of ADHD 36–50%) from the PRD group (17–19%). It was also reported that the inattentive subtype was the predominant ADHD subtype in PRD males while the combined subtype was more prevalent in paraphilic men. In another study of sexually addicted males, ADHD was identified as a comorbid psychiatric condition in association with various forms of developmental trauma (Blankenship & Laaser, 2004).

Although I could not find a systematic study of Axis I disorders in the sexual addiction literature, it is noteworthy that several authors have reported "depression" (Blanchard, 1990; Turner, 1990; Weiss, 2004) in re-

covering sex addicts. In addition, as was mentioned earlier in this chapter, anxious and depressive affect (as opposed to specific clinical disorders) can be associated with sexual risk-taking behaviors and "out of control" sexual behaviors in both heterosexual and homosexual men (Bancroft, Janssen, Strong, Carnes, et al., 2003; Bancroft, Janssen, Strong, & Vukadinovic, 2003; Bancroft & Vukadinovic, 2004).

The clinical implications of these reports are significant for several reasons. First, these findings strongly suggest that all persons, male or female, who seek evaluation for a nonsexual psychiatric condition should be systematically queried (see Table 15.2) regarding their sexual behavior. Second, dysthymic disorder, bipolar spectrum disorders such as cyclothymia and ADHD in adults are not conditions that are routinely assessed by many clinicians. The appropriate assessment of these conditions requires retrospective as well as current symptom ascertainment. In addition, many persons with current psychoactive substance abuse may deny the severity of their use of these substances. Thus, the concurrent presence of these clinically significant and common comorbid psychiatric conditions may be undetected and then untreated. Third, comorbid psychiatric conditions may be risk factors that substantially contribute to the onset, severity, and social deviance of hypersexual behaviors, including PRDs (Kafka & Prentky, 1998).

Comorbidity with Other Sexual Disorders

The coassociation of PAs with PRDs has already been mentioned. In my study of 206 consecutively evaluated outpatient males with either PAs or PRDs (Kafka & Hennen, 1999), 86% of the PA sample, (especially men with multiple PAs) had at least one lifetime PRD, most commonly compulsive masturbation or pornography dependence. In addition, both PAs and PRDs males and females commonly report reduced sexual arousal to "conventional" partnered sex, especially when the initial infatuation phase of a relationship has passed. In these circumstances, patients with PRDs or PAs may present to psychotherapists and sex therapists with apparent hypoactive sexual desire disorder, acquired and situational subtypes. In addition, diminished sexual arousal in a current relational context could present as female arousal disorder, male erectile disorder, and, perhaps, sexual aversion. Thus, it is imperative to take a full sexual history of patients who present with these sexual dysfunctions as a primary complaint to rule out the presence of paraphilic or nonparaphilic hypersexuality disorders.

Case Example: Sally

Sally is a 45-year-old premenopausal married businesswoman who was referred by her therapist for an evaluation for "sexual anorexia." Despite describing a happy marriage with a caring, supportive husband, over the past

7 years, Sally had noticed an insidious waning of her interest in sexual relations with him. At the time of the evaluation, she described feeling a physical discomfort about being touched in an affectionate manner. She felt "frightened . . . uncomfortable . . . repulsed" by sexual contact. Her marked lack of interest and anxious discomfort regarding sexual activities distressed both her and her spouse. Prior to the onset of sexual dysfunction, Sally described a "normal" sexual appetite with her spouse during most of their marriage. Indeed, from adolescence until her late 20s, Sally had been "a sex addict out of control." She described multiple brief affairs and "one-night stands" with approximately 100 different males during those years. As a consequence of protracted promiscuity, she had had two abortions and had contracted both gonorrhea and pelvic inflammatory disease during her 20s. She attributed her recovery from protracted promiscuity to individual psychotherapy, a women's psychotherapy group, and abstinence from alcohol and marijuana.

Axis I nonsexual disorders included:

Dysthymic disorder, early onset subtype
Attention-deficit/hyperactivity disorder, combined subtype
Psychoactive substance abuse, alcohol and marijuana, in remission

Axis I sexual disorders diagnoses included:

Sexual disorder not otherwise specified: the paraphilia-related disorder protracted promiscuity, heterosexual subtype, in remission
Hypoactive sexual desire, generalized, acquired subtype
Sexual aversion disorder

CLINICAL TREATMENT

Sally's current sexual dysfunctions were successfully treated with a combination of supportive psychotherapy, sensate focus exercises with her spouse, a selective serotonin reuptake inhibitor, and a psychostimulant. The antidepressant diminished her anxiety and discomfort about sexual arousal and the addition of the psychostimulant helped her to be less distracted during sexual relations with her spouse. Then, with the sensate focus exercises and supportive management, Sally reported a return of sexual arousal and activity with her husband during the ensuing 2 years.

The Pair-Bond

Although there are no compelling data showing that contemporary relationship dysfunction is a primary etiological factor for PRDs, the presence of a meaningful pair-bond can have profound effects on the clinical course

and outcome of treatment. Like PAs (Marshall, 1989), PRDs have been described as intimacy dysfunctions by many clinicians (Carnes, 1991; Coleman, 1995; Schneider & Schneider, 1991, 1996). At least some significant others, characterized as "codependents," suffer from low self-esteem, depression, overly dependent behavior, "enabling behaviors" (e.g., protecting the identified patient from the brunt of the consequences of his or her behavior), and comorbid impulse control disorders (Schneider & Schneider, 1991) prior to the disclosure or discovery of a PRD in their partner.

Certainly, the sudden personal disclosure or unexpected discovery of a nonparaphilic (or paraphilic) disorder in a partner during a stable pair-bonded relationship can have devastating consequences because mutual trust has been severely breached. It is clinically helpful, whenever possible, to include the significant other during the assessment process and/or early treatment phases to assess the impact of disclosure on the pair-bond and to attempt to contain the relationship crisis that invariably follows disclosure. It may be helpful to send the affected partner for individual or group therapy if conjoint treatment is not feasible. In particular, when protracted sexual promiscuity is an identified PRD, assessment for sexually transmitted diseases should be prescribed for the identified patient and, if indicated, the significant other, especially if identified problematic behaviors included unprotected sex. There may be certain clinical situations however, when the identified patient is unwilling to include the significant other. For example, he or she may still be unaware of the sexual disorder or too emotionally unstable to tolerate disclosure, or imminent disclosure would almost certainly be followed by divorce or its equivalent.

The assessment of the current pair-bond should include an assessment of the strength of the commitment of the couple, the impact of the current disclosure, the possible defensive role of the PRD in maintaining a power/control struggle in the context of the relationship as well as the impact of the PRD in producing or exacerbating an intimacy dysfunction.

The extent and timing of disclosure of nonparaphilic hypersexual behaviors in an intimate partnership should be subject to joint negotiation (Schneider & Schneider, 1996). Both Schneider (Schneider & Schneider, 1991) and Corley (Corley, Schneider, & Irons, 1998; Corley & Schneider, 2002) reported that the honesty that follows full disclosure is most likely to lead to the best marital outcome but that the reestablishment of trust might take years.

The quality of current sexual intimacy and interpersonal communication of the pair-bond can profoundly influence treatment outcome as well. The lack of a current partner, the presence of sexual dysfunction in the partner, especially hypoactive sexual desire or sexual aversion, or an asexual partnership are factors associated with the continued expression of paraphilia-related behaviors, albeit at a substantially lowered frequency after successful treatment.

Case Example: Tim

Tim was a 30-year-old married salesman who was referred for evaluation while he was receiving concurrent individual psychotherapy and aversive conditioning (ammonia aversion). Tim was still having a problem with continued use of visual pornography including videos and Internet pornography. This had significantly disrupted his marriage of 7 years when his wife discovered a large video pornography collection in his closet. Since that discovery, his wife had become much less interested in sexual relations and their marital communication was characterized by episodic verbal arguments without adequate resolution. The lack of sexual relations appeared to be a justification for Tim to continue to use pornography, which continued to aggravate marital relations in a vicious cycle. Tim had masturbated 1–2 times per day nearly every day since age 14 and enjoyed his intensified sexuality.

Tim came from a family that included a father who kept pornography around the house and a brother who had also used pornography extensively since adolescence. Although Tim reported no overt physical or sexual abuse in his family, he was distant from his father. Tim reported no experiences of physical or sexual abuse.

Tim's lifetime Axis I diagnoses included:

Axis I: Major depression, single episode, in remission
Sexual disorder not otherwise specified: compulsive masturbation, pornography dependence

CLINICAL TREATMENT

Despite treatment with a variety of antidepressants, marital therapy, and aversive conditioning, Tim continued a low level use of pornography. The combination of treatments given to Tim helped him to feel less guilty about his use of pornography so he continued to use pornography on occasion, especially when he felt disconnected from his wife or was by himself. Overall, his use of this was no longer considered "compulsive" or "out of control" by him and it was no longer associated with feeling anxious or depressed.

Case Example: William

William was a 25-year-old single homosexual male who was in a steady long-term relationship with his partner, John. Both were well-educated professional men. Prior to their dating, William had an extensive history of promiscuous behavior and use of pornographic videos. When they began living together and considered themselves as married, William promised to

give up his "philandering." After a brief period of abstinence, however, William discovered cybersex chat rooms and Internet pornographic websites. His promiscuous behavior resurged, accompanied by daily masturbation while viewing Internet pornography while John was at his office. After 6 months, William unwittingly gave John a sexually transmitted bacterial disease. John had no prior history of promiscuous behavior.

The effects on their relationship were immediate, precipitating volatile arguments and an erosion of trust. (Both were successfully treated with effective antibiotic therapies.) After the couple sought counseling with a gay therapist, William was referred to me for psychiatric assessment of his hypersexual behaviors. Despite the serious consequences of his behavior, Will was able to suppress promiscuity but not his surreptitious dependence on pornography.

William's lifetime psychiatric diagnoses included:

Cyclothymic disorder (a variant of bipolar disorder)
Alcohol abuse, in remission

Sexual disorders not otherwise specified included:

Protracted promiscuity, homosexual subtype
Pornography dependence
Compulsive masturbation

CLINICAL TREATMENT

In addition, to couple-based psychotherapy, William was encouraged to share with John that he still could not abstain from pornography. In conjunction with this discussion, William downloaded and purchased proprietary software to block his ability to access websites containing visual pornographic images. John was asked to enter the password for the program both as a gesture of rebuilding trust and helping John feel that he was a full partner in Will's recovery. In addition, it was agreed upon that John could review the log history of William's Internet use if he suspected that Will was becoming withdrawn from the communication pattern that they were actively reestablishing. Although this was never enacted, it was another indication of a collaborative attempt to promote their relationship's collaboration and trust rebuilding.

William was also encouraged to participate in a 12-step-based recovery program for sexual addiction, Sex and Love Addicts Anonymous. Although initially reluctant, he soon found the support and nonjudgmental attitudes of coparticipants quite helpful. Although he did not "do" the 12 steps or attend step groups, he found a gay sponsor and was able to call him at stress points.

William was prescribed a mood stabilizer, lamotrigine, and low doses of a serotonergic antidepressant, citalopram, for residual depressive phase symptoms. It took about 1 year for their relationship to begin to return to a relatively normal pattern as William's pornography use and compulsive masturbation abated.

TREATMENT MODALITIES FOR PRDs

Psychodynamic Psychotherapy

At present, there is no compelling empirically derived evidence to suggest that individual psychodynamic therapy as the primary or solitary treatment modality is effective for either PAs (Person, 1989) or PRDs. Psychodynamic psychotherapy, however, may help to synthesize the role of developmental antecedents, reduce current anxiety, depression, guilt, and shame and improve social adjustment. As is commonly the case for the treatment of PAs, multimodal treatment approaches utilizing behavioral, psychodynamic, group, psychoeducational, and pharmacological treatments are commonly prescribed and tailored to the specific needs of the patient or couple. The informed individual psychotherapist, regardless of theoretical persuasion, may function as a person to select and integrate different therapeutic interventions, akin to the model of "primary-care therapist" advocated by Khantzian (Khantzian, 1986) for the recovering substance abuser. In the sexual addiction literature, the most commonly prescribed combination of therapies associated with successful outcome are 12-step group therapy (see below) and individual psychotherapy with a clinician familiar with PRDs (Carnes, 1991; Corley et al., 1998; Swisher, 1995). This outcome literature, however, is based on skewed samples collected by surveys of self-selected 12-step attendees.

I would suggest that any psychological treatment(s) administered to a person with nonparaphilic hypersexuality disorders should include attention to several of the following domains listed in Table 15.3.

Group Psychotherapies

Men with PRDs have been treated with therapist-led group psychotherapy. Quadland (1985) reported favorable outcome in 30 gay or bisexual men enrolled in a semistructured 20-week group-therapy program with a goal of controlling protracted promiscuity. Earle and Crow (1989) and Turner (1990) report the use of outpatient group psychotherapy with "sexual addicts" but no outcome was included. A model for outpatient group therapy for the husbands and wives of bisexual men has also been published (Wolf, 1987), and a model combining psychodynamic and

TABLE 15.3. Selected Pertinent Psychological or Behavioral Domains for the Evaluation and Treatment of Paraphilia-Related Disorders

Gaining control over hypersexual symptomatology

- Psychoeducation about what we know and what we don't know about these conditions and their Axis I and developmental comorbidities
- Discussion of the range of available therapeutic strategies and selective referral to cognitive and behavior therapies, support groups, marital therapy, and/or pharmacotherapy
- Collaborative limit setting to establish a "bottom line" to hypersexual behavior that the patient can work toward
- Negotiating the use of phone blocks, discarding PRD paraphernalia such as pornography, canceling subscriptions for pornography, holding or discontinuing credit cards, using an Internet censor with password controlled by partner, family member, or therapist, moving a computer out of a private setting. Consider eliminating Internet access completely

Here-and-now issues

- Destigmatization: discussing the paradigm shift from "badness" to "illness" to diminish blame, shame, and guilt
- Clarification of thoughts, affects, behaviors, and common precipitating stressors that might precede hypersexual behaviors
- Developing alternative response strategies for managing dysphoric affects that precede both covert and overt problematic sexual behaviors
- Maintenance of interpersonal boundaries to reduce stressors: assertiveness training, social skills training, relaxation/meditation, recognition and modulation of stressful affects
- If involved in a 12-step group program: establishing a sponsor, monitoring attendance and a bottom line, encouraging and reviewing progress with the 12-step methodology
- Consideration of 6 months of celibacy as a personal growth experience
- Psychoeducation regarding a healthy sexual relationship: how to develop and maintain intimacy, how to remain single but not be depressed/lonely, what is healthy sexuality
- Mourning a lifestyle of hypersexual behaviors: the role of suffering, pleasure, and escape from painful affects
- If referred for pharmacotherapy: monitor changes in sexual arousal and impulse control, assess concurrent depressive/anxious symptoms, collaboration with other treaters

Developmental factors (issues preferably managed after symptom stabilization)

- Coming to terms with family dysfunction: identification of the role of psychiatric illness in family members
- Events that may have shaped early sexual behaviors including physical/sexual abuse/neglect, premature sexualization in relationships
- The development and elaboration of the "false self" to compartmentalize nonparaphilic hypersexuality and manage painful affects
- Possible psychodynamic or behavioral contexts for the meaning and perpetuation of sexual symptom formation
- Assessing the developmental effects of Axis I comorbid diagnoses

cognitive-behavioral techniques has been reported as well (Line & Cooper, 2002).

Since the formation of Alcoholics Anonymous and the articulation of the 12-step recovery program, self-help groups based on 12-step methodology have been formed for many forms of impulsive/addictive behaviors, including behavior involving drugs, sex, and food, as well as gambling, kleptomania, and others. These programs can have a profound effect on the process of recovery, especially if the program is zealously adhered to. For example, 12-step recovery programs commonly require daily attendance at a 12-step meeting for the first 3 months of recovery from alcoholism (Galanter, Talbott, & Gallegos, 1990), and recovery from bulimia nervosa (Malenbaum, Herzog, & Eisenthal, 1988) was associated with five or more 12-step meetings per week for at least 3 years.

There are now several different 12-step programs for recovering "sex addicts," some of which are distinguished by geographic location or differing philosophies as to what constitutes "recovery", "abstinence," and "bottom line" in the context of normalizing sexual behaviors (Salmon, 1995). Naditch and Barton (1990) and Carnes (1991) noted a positive long-term outcome associated with 12-step sexual addiction programs in conjunction with individual psychotherapy in a retrospective survey of men and women recovering from both nonviolent PAs and PRDs.

The self-help fellowships for treatment of PRDs can offer several important advantages (Salmon, 1995). First, these groups have become increasingly prevalent in many parts of the country, so they are generally readily accessible especially in metropolitan areas. Second, there is no financial burden associated with this form of treatment. Third, these groups are very helpful in lessening the shame, secrecy, stigmatization, and blame that accompanies nonparaphilic hypersexuality. Fourth, there can be a sense of "healing community" that includes fellowship, spiritual values, association with other persons in recovery, self-help support groups for the "co-addict," and the provision of a sponsor relationship that can include daily check-in phone calls and crisis management. Fifth, in many respects, the program offered by zealous adherence to the 12-step recovery model for PRDs bears some resemblance to a relapse prevention program based on cognitive-behavioral therapy, a model of psychological treatment prevalent for the treatment of sex offenders with PAs (Carnes, 1991; Laws, 1989).

On the other hand, 12-step programs such as Sex and Love Addicts Anonymous, Sexaholics Anonymous, and Sexual Compulsives Anonymous require an intensive evening/weekend time commitment, a sponsor, the regional availability of appropriate groups, and most importantly, a person who is willing to work in an intensive recovery program over a period of several years.

Case Example: Norman

Norman was a 42-year-old exclusively homosexual male who described himself as "living two lives." While he maintained a distinguished professional career as a physician, he reported that he was unable to stop himself from going to movie theaters where pornographic films were prominently displayed while men engaged in sexual activities, including unprotected anal sex. He reported no other lifetime PA or PRD behavior disorders but acknowledged a sexual outlet of 5–7 orgasms per week during the past decade, including sex with over 300 males. Prior to seeking treatment, Norman reported that he spent approximately 4 hours per day engaged in nonparaphilic hypersexual fantasies, urges, and activities. Norman had one partner whom he dated consistently for several years although he continued to be promiscuous during that partnership as well.

Norman reported attending religious schools through his teenage years and had a long history of social anxiety and reticence. While there was no apparent physical or sexual abuse, he had had more emotional connection to his mother, a nurturing but depressed woman who died when he was in his early 20s, than to his father. In fact, his relationship with his father was very conflicted because, especially after father losing his spouse, his father developed a chronic depression and was consistently demanding as well as hostile and rejecting toward his son. In part because of his religious training, Norman harbored intense fears that he would be humiliated and rejected by both his father and his peers if he were to openly acknowledge his homosexuality. Thus, he had remained basically "in the closet" regarding his sexual orientation prior to seeking treatment.

Norman met lifetime Axis I diagnostic criteria for:

Major depression, recurrent, nonpsychotic subtype
Dysthymic disorder, early onset subtype
Social phobia
Alcohol abuse, in remission
Sexual disorder not otherwise specified: the paraphilia-related disorder protracted promiscuity, homosexual subtype

CLINICAL TREATMENT

Norman was relieved to be able to finally confide in me about his hidden life for the first time. After several appointments and the development of a therapeutic alliance, I suggested that one of his current problems was that he had not fully acknowledged his homosexuality to peers. I suggested strongly that he begin to attend local 12-step support groups where he could maintain anonymity but meet other gay males in a nonsexual context. I was able to eventually give him the phone number of another patient

who had expressed an interest in helping hypersexual males to connect to the 12-step sexual recovery program. Since William had faithfully attended Alcoholics Anonymous for many years prior to his current treatment, he accepted help in attending his first meeting and then began to attend regularly on his own. Over the first 2 years of treatment, Norman attended 3–5 meetings per week, "worked the program," and obtained a sponsor. It took him 2 years to complete the 12 steps in the recovery program but then he started to lead recovery based groups for other gay men.

At the same time, he continued in weekly psychotherapy with me for 1 year and than met with me biweekly for at least another year. Themes relevant to his psychotherapy included identifying interconnections in his personal history of chronic low self-esteem, social reticence, and chronic depression. He began to feel less self-hate when he recognized that all of his first-degree relatives suffered from depressive disorders. Inasmuch as his hypersexual behavior rapidly diminished once he sought treatment, we focused on precipitants to his sexual promiscuity, including a hostile dependent relationship with his father, some work dissatisfaction, and his social isolation. William had to learn to let go of the expectation that his father would ever express love and acceptance of him and he was eventually able to do so. I advised against any dating or sexual activity and he was able to comply with this treatment suggestion as well during the first 2 years of treatment.

Case Example: Thomas

Thomas is a 42-year-old married male with two children. He had developed a technology-based business, was financially very successful, and described himself as an entrepreneur. As his business and net worth increased, so did work-associated stressors and he began to engage in near daily viewing of heterosexual pornography over the Internet. Although he had never engaged in sadomasochistic sex, some of the images that he relished included scenes of bondage. While he was careful to delete images from his computer, he did not "clean" the images from the hard-drive completely. After he left his screen saver on overnight, some provocative "hard-core" pornographic images were inadvertently discovered by his secretary. Unable to contain her disgust, she told coworkers and precipitated a business crisis. Thomas, who had been considered the CEO of a growing organization, was suspended by the newly established corporate board and then "retired" on his own volition.

Although he had no personal history of physical or sexual abuse, Thomas had reported a very perfectionistic and controlling father who was unfairly critical of both his schoolwork and his athletic skills. Perhaps because of his vulnerable self-esteem, Thomas had worked extremely diligently to be successful but had a very difficult time delegating responsibili-

ties. He had previously had a 1 year period of telephone sex dependence but used his home phone as the primary outlet for his behavior and paid the bills from his own account. The growth and success of his business was a source of pride but also left him emotionally depleted and depressed prior to the discovery of his pornography dependence.

He was referred to me for psychiatric evaluation and was diagnosed with:

Axis I: Dysthymic disorder, early onset subtype
Major depression, single episode, partial remission
Sexual disorder not otherwise specified, including pornography dependence, telephone sex dependence (in remission), and compulsive masturbation.

CLINICAL TREATMENT

Fortunately, Thomas's spouse and family stood by him and helped to cushion him from his financial and job loss. He sought psychotherapy from a sexual addiction–trained therapist although he did not want to actively participate in the 12-step recovery program. He was referred to a private practice group therapy program for males with Internet pornography problems and he found the support and identification of stressors very helpful. He participated actively for close to 2 years.

His chronic mood disorder required trials of several serotonergic medications, but finally one medication seemed to "fit" his mood disorder best. His mood and impulse control improved concomitantly.

His major problem in recovery (in addition to ameliorating his hypersexual behavior) was his inability to find gainful employment that he felt was commensurate with his skills. Eventually, however, with the help of his wife, his therapist, and his group, he began to gain a sense of self-esteem secured by non-work-associated achievements such as communicating more honestly, expressing his commitment and love to his children, and actively participating in the therapist-led group treatment. After 1 year, he understood that, for him, a career was only one means of enhancing self-esteem and he secured a job that was significantly less stressful.

Cognitive-Behavioral Therapies

Relapse prevention is an integrated cognitive-behavioral and group therapy treatment approach that was originally evolved from a theoretical understanding of, and treatment for, addictive disorders such as alcohol abuse, nicotine dependence, and compulsive overeating (Marlatt & Gordon, 1980). Several different techniques are used: (1) identifying and modifying cognitive distortions and beliefs that rationalize hypersexual behavior, (2)

helping the patient to recognize and then anticipate high-risk situations, (3) identifying specific behavioral/ affective/cognitive precursors to relapse, and (4) extensive behavior rehearsal of new comprehensive problem-solving techniques as well as social and sexual skills training.

The relapse prevention model and accompanying cognitive-behavioral and social learning techniques are now becoming commonly employed in specialized sex offender treatment programs in the United States and Canada (Marques, Day, Nelson, & West, 1994). To my knowledge, there are no published data on this comprehensive approach to the treatment of PRDs. Given the aforementioned similarities between PAs and PRDs, systematic and controlled clinical trials of relapse prevention group and individual therapy would be a definite contribution to the treatment literature.

Behavior Therapy Techniques

Behavior therapy techniques are used frequently in treatment centers specializing in the assessment and treatment of sexually aggressive persons with PAs. These techniques appear to be applicable to nonviolent PAs and PRDs as well. Aversive techniques, for example, can be applied to a wide range of human behaviors, including sexual behaviors, when accompanied by the voluntary consent and understanding of the patient. Maletzky (1991) provides a practical compendium of current theory and technique for the use of behavior therapy conditioning techniques applied to both sexually aggressive and nonviolent persons with PAs, as well as selected case examples of PRDs.

McConaghy (McConaghy & Armstrong, 1985) reported that imaginal desensitization was as effective as covert sensitization in reducing compulsive sexual behaviors in a group of 20 men with PAs and PRDs (promiscuity) at both 1-month and 1-year follow-up.

Olfactory aversion was designed to reduce unconventional sexual arousal with aversive smells, such as ammonia (Colson, 1972). The advantage of olfactory aversion is the immediacy of a powerful noxious odor that can be rapidly introduced during the repetition of specific sexually arousing fantasies. Ammonia aversion utilizes encapsulated ammonia ampoules that are portable and can be broken and inhaled in conjunction with both behavioral homework and *in vivo* practice in situations that trigger sexual urges. As is the case for any conditioning therapy, aversion therapy requires persistent and repetitive practice involving specific self-identified precursor situations that are sexually arousing.

Case Example: David

David was a 35-year-old divorced successful businessman who sought help for repeated visits to escort services (prostitutes) and massages parlors as

well as periods of extensive phone sex and pornography dependence. He decided to seek help when his second wife found his credit card receipts from escort services he used while he was on a business trip. When his wife threatened marital separation, David panicked and sought treatment.

David acknowledged a history of high sex drive since age 15 and was usually engaged in sexual behavior, primarily masturbation, 7–10 times per week. He estimated that sexual fantasies, urges, and activities consumed 1–2 hours per day prior to his seeking treatment. He reported compulsive masturbation with pornography dependence beginning during adolescence. During his first marriage, his use of escort services and pornography was eventually discovered by his wife and was a major factor leading to divorce. He had never acquired a venereal disease so he viewed his promiscuous behavior as "low risk." He had developed a penchant for phone sex services as well, at times costing him over $100 a week.

David described a caring mother who suffered from depressive nervous breakdowns and was hospitalized during his early childhood. His father was characterized as a distant loner who worked long hours and contributed little to child rearing. One older brother had a history of alcohol abuse. There was no history of physical or sexual abuse, early trauma, or premature sexualization in his family. Despite being a very bright student, David described himself as chronically depressed and began to abuse drugs and alcohol during adolescence. He graduated from college and established a very successful small business despite continued drug and alcohol use. He finally became abstinent of drugs and alcohol after his divorce.

David had received extensive individual psychotherapy with several prior competent mental health professionals and had cursorily attended AA during his early sobriety. When he came for help now, he initially did not want extensive psychotherapy or 12-step groups.

David meet Axis I lifetime diagnoses for:

Dysthymic disorder, early onset subtype
Major depression, nonpsychotic, recurrent
Social phobia, in remission
Psychoactive substance abuse, alcohol, marijuana, cocaine, in remission
Sexual disorder not otherwise specified: paraphilia-related disorders including compulsive masturbation, dependence on pornography, phone sex dependence, protracted promiscuity, heterosexual subtype

CLINICAL TREATMENT

Initially, I met with David and his wife to assess her perspective on his behavior. After she felt acknowledged in her distress and was provided with

an explanation that these behaviors were associated with her spouse's depressive condition, she withdrew her threat to leave David and became more supportive. She had previously encouraged David to seek medical treatment for depressive behaviors but he had resisted.

David met intermittently with me over a 2-year period, at first for pharmacological treatment. David did have a positive response to a selective serotonin reuptake inhibitor in high doses. His interest in phone sex, pornography, and compulsive masturbation were markedly diminished. Later in the treatment, when some tolerance seemed to develop to the therapeutic effect, bupropion-SR was added. David felt more resilient on this combination and his urges to visit prostitutes diminished again. He reported good communication and a healthy sexual interest with his wife. Although David had not initially expressed an interest in psychotherapy, when he had substantially recovered from his sexual impulsivity and dysthymia, he began to express more interest in meeting with me individually for psychotherapy as well. He realized, in retrospect, that previously psychotherapy had been "too painful" for him. Now, with his newly enhanced emotional resilience, he was interested in understanding more about his affective life. Over a period of about 1 year, David discussed his long history of low self-esteem, harshly internalized self-standards, and his need to appear "in control" at all costs, including lying to his wife and closest friends about his previously hidden sexual impulsivity. He was able to begin forgiving himself for having previously abused alcohol to numb his intensely negative affects. Insights gained from these discussions as well as his ability to withstand and then modify his internalized self-hate helped him to assume a more self-nurturing and empathic stance toward himself and, in particular, toward his wife.

Despite these significant gains, David occasionally still visited prostitutes, especially when traveling without his wife. Over time, he began to feel anxious and guilty about his continued occasional use of escort services. He no longer felt depressed and reported that his promiscuity, in contrast to his previous history, seemed unrelated to his mood state.

We discussed the possible use of behavior therapy techniques for his residual sexual symptom. By that time, he and his wife were trying to have children, so I instructed him daily to vividly imagine, and then write down in exquisite details, the consequences to his marriage if his hidden sexual life were again discovered by his wife, especially in light of all the progress he had made. In addition, he was instructed to practice daily imagining becoming sexually aroused by a prostitute and then use ammonia smelling salt capsules when he felt any arousal. The combination of the smell aversion and vividly imagined aversive consequences (covert aversion) had a profound effect on David's residual promiscuity and he ceased calling escort services. He stated he realized how much he stood to lose as a result of "choosing" sexual pleasure when he was alone. I believe these techniques

helped to markedly reduce the compartmentalization of affects that were previously associated with his continued ability to deny potentially devastating consequences for episodic and discrete episodes of promiscuous behavior.

Psychopharmacology

As is the case for the previously mentioned psychological treatment modalities as well, published data supporting a pharmacological approach for the amelioration of nonparaphilic hypersexuality disorders are scant, but encouraging. A persuasive rationale for the use of psychopharmacological agents for these conditions can be based on several lines of clinical evidence. First, there is the aforementioned association between specific Axis I disorders such as chronic mood and anxiety disorders and ADHD and nonparaphilic hypersexuality disorders (see section on Axis I comorbidity). Second, there is the rationale that both increased sexual arousal and disinhibited sexual appetitive behaviors may be mitigated by pharmacological agents that enhance central (i.e., brain) serotonin (Kafka, 1997b). Third, there are case reports and case series supporting the use of serotonin reuptake inhibitors for PRDs even in the absence of significant depressive or obsessive–compulsive disorder comorbidity (Kafka, 1991, 1994b; Kafka & Prentky, 1992b). Fourth, there is a developing scientific literature on the indications for and use of serotonergic (Greenberg & Bradford, 1997) and antiandrogenic medications (Prentky, 1997) for the PA disorders.

Fifth, at least in my clinical experience with the pharmacological treatment of over 250 males with PRDs who have failed a panoply of psychological treatments, the use of serotonin reuptake inhibitors, mood stabilizers, psychostimulants, and an orally administered antiandrogen, medroxyprogesterone, alone or in various combinations, can have profound effects in ameliorating nonparaphilic as well as paraphilic hypersexuality disorders in nonpsychotic males. We do not currently have sufficient outcome data to determine whether these agents need to be prescribed for the short term (e.g., 1 year) while other psychological therapies are ongoing, or whether pharmacological therapy requires longer-term prescription for the successful continued management of nonparaphilic hypersexuality disorders.

In my own clinical experience, psychopharmacological treatment for PRDs should not be reserved only for situations where other therapeutic endeavors have either failed or been only partially successful. Instead, the careful diagnosis of chronic psychiatric disorders that have been empirically demonstrated to have a genetic/biological component should be followed by a discussion of all available treatment modalities, both psychological and biological. In addition, any patient with a persistently high weekly total sexual outlet or hypersexual disorders that could severely dis-

rupt or endanger a stable pair-bond should be evaluated for pharmacotherapy as well as psychotherapy and/or group therapy.

In my clinical practice when I administer pharmacotherapy, my first step is to try to establish a current of former psychiatric diagnosis with particular emphasis on mood disorders (unipolar and bipolar with particular attention to dysthymia and bipolar variants) and ADHD, especially childhood onset of the inattentive subtype. In a nonpsychotic, nonbipolar male or female who was currently or recently sexually preoccupied or engaging in frequent sexual activities (including masturbation), I would initiate pharmacotherapy with a serotonin reuptake inhibitor, prescribed in the usual antidepressant dosage ranges. Such ranges would include fluoxetine (Prozac) 20–80 mg/day, fluvoxamine (Luvox) 50– 300 mg/day, paroxetine (Paxil) 20–80 mg/day, or citalopram (Celexa) 20–80 mg/day. Inasmuch as these medications are now available as generics at a lower cost, they would be my logical starting place. Two additional SRIs are also available but are nongeneric: Zoloft (sertraline) 50–200 mg/day and Lexapro (escitalopram) 10–40 mg/day. Effexor-XR (venlafaxine) 75–350 mg/day and Cymbalta (duloxetine) 20–60 mg/day are "dual action" antidepressants, serotonergic antidepressants that also raise brain norepinephrine levels. These medications may also prove helpful for sexual impulsivity disorders. If a particular person has responded to an SRI but is still symptomatic at the higher end of the dose range, I have pushed the dose as long as side effects have been manageable. If a more selective SRI has not helped, a "dual-action" serotonin/norepinephrine medication may prove helpful.

I generally monitor both anxious and depressive symptoms if they have been reported, as well as the amount of sexual preoccupation and total sexual outlet per week. There are some data on total sexual outlet/week (TSO) available from population-based studies suggesting that most males engage in sexual behavior from 0 to 4 times per week and this frequency diminishes as a function of age (insidiously after age 35–40) and duration of a partnered and secure relationship. Inasmuch as most men or women seeking treatment with me are or were recently engaging in sexual behaviors leading to orgasm 5–25 times per week, my pharmacological goal is to diminish their TSO to 1–3 times per week, depending on their age and relationship status. If they have a steady partner, my goal is to eliminate or markedly diminish the frequency of masturbation, whenever possible. This is not done for "moral" purposes, but rather because for the majority of men with PRDs, masturbation has been their primary sexual outlet and abstinence from that behavior establishes a clear marker for recovery and self-control. For reasons that are poorly understood, some persons benefit more substantially or have a reduced side-effect profile from one of the members of this class of SRI medications in comparison to others. Thus it may be necessary to try several different ones before abandoning them as a therapeutic intervention. When persons afflicted with PRDs are relieved of

these symptoms, it is rare that they miss their sexual impulsivity. They are most often relieved to be more productive, feel less sexually preoccupied, and have more emotional resilience. There is generally no "symptom substitution" but, rather, a sense of feeling unburdened, perhaps for the first time in many, many years.

Side effects are generally benign from the SRIs and at this writing, there are no known long-term consequences associated with remaining on these medications as long as a beneficial effect continues to be sustained. One has to be careful because sometimes SRI antidepressants can induce apathy and fatigue that was not previously associated with the underlying mood disorder. In those circumstances, either dosage reduction or dopaminergic augmentation (see below) produces the right balance between activation and relief from depression, anxiety, and/or nonparaphilic hypersexuality.

Psychostimulants and bupropion (e.g., Wellbutrin-SR) work on different neurotransmitters, for example norepinephrine and dopamine, and thus have a different effect on depressive, attentional, and sexual symptoms. They can be thought of as more "activating" in comparison with SRIs and should be administered only in the morning, whenever possible. One of the major shortcomings of stimulants was their relatively short duration of action, necessitating dosing every 4–6 hours for some patients. Fortunately, we now have available several longer-acting psychostimulant medications, available both as generics and by brand name. Generics include Ritalin-SR (methylphenidate 20–80 mg/day), Dexedrine spansules (dextromethamphetamine 10–50 mg/day), mixed amphetamine salts (Adderall) 10–50 mg/day, and bupropion-SR (100–400 mg/day). There are three name-brand psychostimulants whose duration of action is even longer than the aforementioned medications, including mixed amphetamine salts (Adderall-XR, 10–50 mg/day) and special encapsulated forms of methylphenidate called Concerta (18–72 mg/day) and Ritalin-LA (20–60 mg/day). Last, there is now a nonstimulant pharmacological treatment for ADHD called Strattera (20–100 mg/day). This agent specifically enhances attention by enhancing norepinephrine neurotransmission.

Because dopaminergic medications can also "activate" sexual motivation, I usually prescribe these medications after I have established a response to an SRI that has diminished sexual motivation. In some nonbipolar men or women who have not responded well to SRI antidepressants, I might prescribe nefazodone 200–600 mg/day or even try a dopaminergic drug as the first line of treatment. I would just warn the patient that sometimes sexual motivation might be increased in the latter instance. In my experience, this is more likely to occur with bupropion or psychostimulants when anxiety or latent bipolar symptoms are activated by these medications. I have coprescribed bupropion-SR, in particular, as an agent to augment SRI antidepressant response even without any diagnosis of ADHD.

The decision as to whether to continue medications, even indefinitely in some cases, versus deciding on a medication taper is a complex issue and depends on factors such as the severity and risks associated with a recurrence of PRD (or PA) behaviors, the severity of concurrent Axis I comorbidity, and the length of sustained remission and emotional growth garnered during the effective treatment period. Medication should never be tapered abruptly and the patient's prescribing physician, psychotherapist, and intimate partner should be informed as these persons can sometimes be the first to notice behavioral change or regression, if it were to occur during a taper.

A further detailed description of the additional intricacies of pharmacological treatments is beyond the scope of this chapter but the above examples are my most common practices.

Although the pharmacological outcome of SRI treatment of PAs and PRDs is comparable, I have noticed several clinical situations where the apparent mitigating effect of medication is less robust for PRDs. This outcome can be noted in psychological treatments as well. On closer inspection of patients whose outcome is less robust, I have repeated observed several common clinical concomitants. First, such patients no longer feel as intense an urgency to their sexual desire after pharmacotherapy. For example, many are able to willfully control themselves when requested to do so for a period of several weeks. Second, many patients with PRDs may continue to maintain a reduced frequency of a nonparaphilic sexual behavior when they have no current or regular sexual partner, when the financial cost of the specific outlet is modest, when a sexual dysfunction in a partner precludes sexual intimacy, or when pair-bond intimacy dysfunction that affects sexual relations is apparent. In these situations, the PRD is no longer described as ego-dystonic. I see this most commonly with continued pornography use.

CONCLUSION

In contrast to other disturbances of human sexuality, the status of PRDs remains controversial because we lack sufficient empirical studies of these behaviors and their treatment outcome. As a result, these serious conditions are only cursorily addressed in most textbooks and academic courses teaching about human sexuality disorders. Despite the lack of empirical information regarding nonparaphilic hypersexuality disorders, there is certainly clinical lore that they are prevalent conditions that may remain hidden from spouses and family members.

It is imperative to form a trusting and collaborative therapeutic alliance and offer hope and effective treatment modalities to persons impaired by these conditions. As demonstrated by the case examples in this chapter,

the successful treatment of these conditions commonly requires more than one type of mental health intervention. As clinicians then, it behooves us to sustain collegial relationships with a collaborative network of resources and specialized clinicians who may share differing competencies but can work collaboratively.

The healing and recovery period that is necessary when PRDs disrupt the pair-bond should be measured in years, not months. Marriages and other intimate partnerships need time to heal and reestablish a trusting bond, even if problematic sexual behavior ceases early in treatment. In most cases, especially during the first few years of treatment, we need to speak about "effective treatment" or "control" rather than "cure" as an outcome measure. In kind, we can analogously think of the successful amelioration of other chronic medical conditions such as psychoactive substance abuse, obsessive–compulsive disorder, diabetes mellitus, atherosclerotic vascular disease, and hypertension in similar terms.

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CHAPTER 16

Gender Dysphoria and Transgender Experiences

RICHARD A. CARROLL

Gender identity is a fascinating clinical conundrum. While the vast majority of individuals experience little doubt or ambivalence about their gender, increasing numbers of men and women have a more fluid sense of gender identity and clinicians are faced with what Richard Carroll calls a "bewildering array of individuals with transgender experiences, including transsexuals, transvestites, she-males, queers, third sex, two-spirit, drag queens, drag kings, and cross-dressers." In this chapter, Carroll reviews the variety of transgender phenomena, etiological theories, treatment approaches, and treatment outcome for those individuals seeking help with gender dysphoria.

He points out that, like it or not, the clinician often functions as a gatekeeper for individuals desiring gender reassignment. And this is where the wishes of the patient and the responsibilities of the clinician may diverge. While the transgender person is typically motivated to deny problems in order to obtain approval for surgery and/or hormones, the clinician seeks to uncover the extent of the patient's mental distress or problematic functioning. Consequently, Carroll advises clinicians to clarify their role from the outset in order to minimize later problems.

Most important, with those patients seeking actual gender reassignment, clinicians should adhere to the Harry Benjamin International Gender Dysphoria Association Standards of Care recommendations. These include accurate diagnosis, patient and extended family/partner education, determination of eligibility and readiness for hormone and surgical therapy, recommendations to colleagues in surgery and medicine, documentation of patient history, and the provision of follow-up.

Assessment is crucial and includes a detailed gender history with attention to such issues as type of childhood play, desired mode of dress, feelings about one's body and reactions to puberty, history of cross-dressing, early and later sexual experiences, sexual fantasies, and reactions of friends and peers to the wish for gender change.

Carroll points out that gender dysphoria usually takes one of three forms: female-to-male gender dysphoria, male-to-female gender dysphoria (androphilic type), and male-to-female gender dysphoria (autogynephilic type). He describes the characteristics of each.

Finally, Carroll discusses the four main goals of psychotherapy with gender dysphoric patients: (1) helping patients understand themselves better, (2) making them aware of available options for resolving their gender dysphoria, (3) treating other psychological issues that might exist such as substance abuse or depression, and finally, (4) determining life goals and how the patient can meet them. Given these objectives, treatment can be extended and quite meaningful. When these guidelines are followed, the outcome is usually very good and individuals who undergo complete gender reassignment are typically satisfied and grateful. Nevertheless, it is also possible for individuals who do *not* wish surgical gender reassignment to find comfortable ways of expressing their gender—whether it be by cross-dressing, attending support groups, having flexible sexual roles, and so forth. It is the clinician's job to facilitate the search for authenticity and identity without preconceived notions or judgment.

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Gender is the ground out of which sexuality grows. Most people assume that the various aspects of gender and sexuality develop in a predictable trajectory. Specifically, that genetic gender determines the physical aspects of gender, which leads to an unambiguous assigned gender, which leads to gender-consistent gender behavior and gender identity, attraction to the opposite gender, and finally, a trouble-free sexual response during socially acceptable sexual behavior.

The health or mental health professional who deals with sexual difficulties must understand the common and uncommon variations of this development. For example, genetic variations may lead to conditions that may alter gender and sexual development (e.g., Turner's or Klinefelter's syndromes). Fetal development may result in gender-inconsistent appearance or behavior (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia). Various genetic or fetal developmental variants may lead to ambiguity or confusion regarding the assignment of gender (e.g., intersex conditions). A person's sexual attraction may be primarily toward

those of the same gender or toward inappropriate people or objects (e.g., pedophilia or fetishism).

The phenomenon of interest here occurs when one's internal sense of gender does not match one's genetic gender, body, or gender role. Historically this mismatch of gender identity and physical or social gender has been pathologized and/or condemned. The clinician is now confronted with an often-bewildering array of individuals with transgender experiences, including transsexuals, transvestites, she-males, queers, third sex, two-spirit, drag queens, drag kings, and cross-dressers. The phrase "transgender experience" is currently used to refer to the many different ways individuals may experience a gender identity outside of the simple categories of male or female. It should be remembered that there are many individuals who have blended genders in some way, who never seek treatment, and who may be very comfortable with their atypical gender identity.

This chapter focuses on those individuals who come to clinicians for help with their transgender experience. The problem most likely to be presented by transgender individuals is gender dysphoria, which is defined as unhappiness with one's given gender. DSM-IV-TR defines the criteria for gender identity disorder as (1) "a strong and persistent cross-gender identification," (2) "persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex," (3) the problem is "not concurrent with a physical intersex condition," and (4) "clinically significant distress or impairment" (American Psychiatric Association, 2000). It is of note that this diagnosis requires evidence that the gender dysphoria leads to psychological distress and/or social, vocational, or other forms of impairment in functioning. This replaces the old diagnosis of transsexualism, although the label "transsexual" is still commonly used to refer to an individual who desires a full gender change. DSM-IV also includes a diagnosis of gender identity disorder not otherwise specified, which includes those who have intersex conditions and gender dysphoria, intermittent cross-dressing behavior, or who may want genital surgery without a goal of changing their gender.

Gender dysphoria has existed throughout recorded history. Ancient and current mythologies abound with descriptions of individuals who, for various reasons, take on the body or role of the other gender. Bullough and Bullough (1993) cite a wide variety of historical accounts of cross-dressing, male and female impersonation, and gender change. Attitudes toward transgender persons in the history of Western culture have generally been highly negative up until very recent times. Modern sexologists, beginning with Havelock Ellis and Magnus Hirschfeld, have attempted to bring a more scientific and humane approach to understanding these phenomena.

It has been difficult to establish the prevalence of gender identity disorder in the adult population, given the stigma attached to it. The best estimate comes from a study conducted in the Netherlands, which found that

about 1 in 11,000 men (0.009%) and 1 in 30,000 women (0.003%) sought treatment for gender identity disorder at a specialized clinic (Bakker, van Kesteren, Gooren, & Bezemer, 1993). A study of primary care physicians in Scotland found a roughly similar prevalence rate of 8.2 per 100,000 (0.008%) with four times more males than females (Wilson, Sharp, & Carr, 1999). They also found that the number of patients presenting with gender dysphoria was increasing over time. However, these numbers are significant underestimations of the number of adults who experience some form of gender dysphoria, because the majority of such individuals do not seek treatment. In contrast, it has been estimated that 2.8% of men have had at least one occasion of sexual arousal while cross-dressing as a woman (Langstrom & Zucker, 2005).

GENDER DYSPHORIA IN CHILDHOOD AND ADOLESCENCE

While this chapter will focus primarily on gender dysphoria in adults, a brief description of gender identity problems in children and adolescents is warranted. For a more in-depth understanding of this topic see the review by Zucker and Bradley (1995). The diagnosis of gender identity disorder is essentially the same in children, adolescents, and adults: a discomfort with one's given gender and a desire to become the other gender. However, the phenomena are strikingly different in several ways. First, the prevalence of gender dysphoria is much higher in children than adults. For example, on the Child Behavior Checklist, a widely used measure of childhood problems (Achenbach & Edelbrock, 1981), about 1–2% of mothers of a male, nonclinical norm group reported that their son, "wishes to be of the opposite sex" and about 3–4% of mothers of a female norm group reported that their daughters expressed a wish to be a boy (Zucker & Bradley, 1995). Gender dysphoria in children, therefore, does not appear to be the relatively rare phenomenon that it is in adults.

This leads one to question what happens to the many children who express a desire to be the other gender in childhood but do not grow up to be adult transsexuals. In a seminal study, Green (1987) followed up on 66 boys who had been brought to a child mental health clinic because they had expressed a desire to become girls. Surprisingly, only one (about 2%) of the original group of female-identified boys manifested significant gender dysphoria as an adolescent or young adult, although this is likely to be an underestimate of the proportion of gender-dysphoric boys who grow up to be gender dysphoric adults (Bailey, 2003). Seventy-five percent of the boys manifested a homosexual orientation. These findings indicate that the majority of gender-dysphoric children do not grow up to become gender-dysphoric adults, although why this lack of continuity occurs is unclear. They also highlight an important connection between early cross-gender identification and adult homosexuality.

Some researchers in the field of sexuality have argued that since cross-gender behavior and identification is commonly seen in the histories of homosexual men and women, it represents a normal developmental path for many people, rather than a disorder (LeVay, 1993). They believe that the label of gender identity disorder pathologizes and stigmatizes gender-nonconforming children. There is significant merit to this case, since, as pointed out earlier, the phenomenon is not uncommon in children. However, it is also clear that gender dysphoria in children is frequently distressing for both the children and their families. Treatment should be available to such families, if only to help them accept their child as different.

A related question is whether children simply grow out of their gender dysphoria or if early intervention actually prevents them from developing adult gender identity disorder. A wide variety of interventions have attempted to treat childhood gender identity disturbance, including behavioral, psychodynamic, group, and family treatments. Zucker and Bradley (1995) conclude, "A sizable number of children and their families achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggests that gender identity issues remain problematic" (p. 282). The Harry Benjamin International Gender Dysphoria Association (HBIGDA) Standards of Care (HBIGDA, 2001) state that hormonal or surgical interventions should not be done for children in order to effect a gender reassignment, but rather, psychological treatment should be offered to assist the child's and the family's adjustment.

Zucker and Bradley (1995) also found that children (both male and female, ages 6–11) with gender identity disorder are more likely to demonstrate mental health problems than are matched controls, primarily in the area of internalizing symptomatology (e.g., depression or anxiety). What remains unclear is whether this associated psychopathology is the result of, the cause of, or unrelated to the gender identity disturbance. It does strongly suggest, however, that these children need and will benefit from psychological interventions, whether or not these interventions are focused on their gender dysphoria.

Gender identity problems in adolescence are not so readily resolved or outgrown. Gender identity disorders during this period, especially later adolescence, resemble adult forms of gender dysphoria more than childhood forms. During adolescence, clinicians also begin to see a different phenomenon, which is transvestism, or sexual arousal to the act of cross-dressing. This, as discussed below, corresponds to one form of adult gender dysphoria. Zucker and Bradley (1995) found that these transvestic adolescents had high levels of behavioral disturbance, especially conduct disorder, attention-deficit disorder, and overanxious disorder.

The recent HBIGDA Standards of Care (HBIGDA, 2001) recommend against hormonal interventions before the age of 16. They also recommend that surgery be performed only after the age of 18 and after the individual

has lived in the desired gender role for at least 2 years. However, it is now considered appropriate to give puberty-delaying hormones to adolescents, in order to give them time to come to a resolution of their gender dysphoria before the physical effects of puberty become pronounced (Cohen-Kettenis & van Goozen, 1995).

ETIOLOGY

The etiology of transgender experiences remains unknown. Part of the difficulty is that etiological theories have to account for such diverse phenomena as cross-dressing, androphilic and autogynephilic male-to-female gender dysphoria, drag queens, and gynephilic female-to-male gender dysphoria. It is very unlikely any one etiology will explain all of these phenomena.

Much current debate in the field of sexuality focuses on whether gender identity is the result primarily of nature (biological influences) or nurture (experiential or social influences). For 50 years, it has been believed that gender identity is determined predominantly by socialization (e.g., Money & Ehrhardt, 1972). More recently, evidence has been gathering that suggests that a number of biological factors have important influences on shaping gender identity and gender dysphoria (Bailey, 2003).

Some data suggest that a genetic factor might be involved. For example, case reports that have examined families of those with gender dysphoria have found higher rates of co-occurrence of these conditions than would be expected by chance (Green, 2000). However, empirical genetic studies of gender dysphoria have not yet been done. Other evidence points to possible brain differences. Higher incidences of temporal lobe abnormalities have been found in transgender individuals (Hoenig, 1985). A study of the brains of male-to-female transsexuals found that a small region of the brain that is associated with sexual behavior (the bed nucleus of the stria terminalis) is "female-sized" rather than "male-sized"(Zhou, Hofman, Gooren, & Swaab, 1997).

Based on animal models of sexuality–hormone relationships and studies of various intersex conditions (e.g., congenital adrenal hyperplasia or hermaphroditism) hypotheses have been generated regarding the possible impact of the fetal hormonal environment on the development of gender disorders. A study of 243 individuals who had been exposed to anticonvulsants prenatally found that they were more likely to report cross-gender behavior and gender dysphoria than matched controls and had gone through gender reassignment at a much higher rate than expected (Dessens et al., 1999). However, a study of 43 girls with congenital adrenal hyperplasia, which exposes girls to high androgen levels in utero, did not find a strong impact on gender identity, although the condition has been shown to result in more masculine behavior in affected girls (Berenbaum & Bailey, 2003).

A study examined 16 genetic males with cloacal exstrophy, which results in the absence of a penis, who were assigned and raised as girls (Reiner & Gearhart, 2004). They found that the majority (8) of these "girls" declared themselves to be male, often before they were told of their genetic gender. It has been hypothesized that the brains of these children were "masculinized" and therefore led to male gender identity, despite the anatomical problems. It should also be noted, however, that the vast majority of gender dysphorics do not have any genetic or intersex abnormalities.

For many years, psychoanalytic theories have argued for a psychological origin. One theory argues that gender identity problems are due to a symbiosis between the child and the opposite-gender parent (Stoller, 1985). More recent theorists have drawn on object relations and self-psychology theory to develop new models of gender disorder that suggest that the gender dysphoric boy develops an all-good image of the mother, which becomes merged with his self image and then becomes split off (Beitel, 1985).

Behavioral theorists have applied learning theory to gender disorders and have speculated that gender identity follows from gender role behavior, which, they argue, is shaped by external contingencies. The socialization of gender categories and behavior in children has been shown to begin at birth. Behavioral theory hypothesizes that, in order for gender dysphoria to develop, cross-gender behavior and identity must be reinforced and gender congruent behavior must be punished (Rekers, 1985). Empirical support, however, for this theory has not been forthcoming for adults manifesting gender dysphoria.

THE ROLE OF THE CLINICIAN

Before exploring the assessment and treatment of individuals seeking help for their gender dysphoria, it is important to consider the role of the clinician in working with transgender individuals. Prior to the development of gender reassignment as an intervention for gender dysphoria, the therapist's only option was to help patients cope with their difficult dilemma.

As evidence began to accumulate that gender reassignment could relieve the suffering of transsexuals, therapists were thrust into the role of gatekeeper to these desired interventions. This was often due to the physician's reluctance to provide medical treatment to individuals who were considered unstable or disturbed. It was also due to the physician's fear of malpractice suits if the patient was unhappy with the surgical results. Therefore, approval for medical treatment from mental health professionals was seen as an important legal and clinical safeguard for medical care providers. This role was subsequently built into all versions of the HBIGDA Standards of Care (HBIGDA, 2001).

This presents the mental health professional with a challenge. Unlike most patients, the transgender person seeking treatment is often motivated

to present in a psychologically healthy manner in order to obtain approval for surgery and/or hormonal treatment. The clinician must seek to uncover the extent of the patient's mental distress, both related and unrelated to the gender dysphoria.

In order to establish a productive clinical alliance, clinicians are advised to clarify their role with the patient from the outset. This can be done by clearly acknowledging the dual roles of attempting to help patients resolve their distress, as well as helping to assess the appropriateness of medical interventions. Currently, professionals who work with gender dysphoria patients believe that it is the patient's right to resolve his or her gender dilemma without undue influence from the clinician, who now acts as a consultant with expertise in gender dysphoria. Clinicians must provide careful assessment and recommendations as to what they think will be most helpful to the patient in dealing with the gender dysphoria and any other psychological issues that may exist. Clinicians must also describe their responsibility to judge the suitability of individuals for hormonal or surgical intervention, which may involve refusing to write a letter of approval for such treatment.

Very often patients are frustrated by the recommendation to engage in therapy before any medical treatment begins. They may be angered initially by what they see as an unnecessary obstacle to their desired goal (i.e., a quick gender transition). In most cases, however, a supportive attitude and reference to the HBIGDA Standards of Care will allow the patient to accept the recommendations and to use therapy productively. On a few occasions, even after a course of psychological treatment, the therapist may feel that the patient is too unstable or confused to proceed with medical treatment. While this situation is difficult for the patient and clinician alike, it must be accepted as part of the responsibility of professionals who work with gender dysphoric patients.

The HBIGDA Standards of Care summarize the 10 tasks of the mental health professional:

1. to accurately diagnose the individual's gender dysphoria;
2. to accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
3. to counsel the individual about the range of treatment options and their implications;
4. to engage in psychotherapy;
5. to ascertain eligibility and readiness for hormone and surgical therapy;
6. to make formal recommendations to medical and surgical colleagues;
7. to document their patient's relevant history in a letter of recommendation;

8. to be a colleague on a team of professionals with interest in the gender identity disorders;
9. to educate family members, employers, and institutions about gender identity disorders;
10. to be available for follow-up of previously seen gender patients. (HBIGDA, 2001, p. 6)

Due to the difficulties of work with transgender patients noted above, clinicians who work with these individuals should have both general knowledge of psychopathology and special training in gender disorders. It is strongly recommended that mental health professionals who wish to work with gender dysphoria become members of the Harry Benjamin International Gender Dysphoria Association or, at least, have a thorough knowledge of its Standards of Care.

THE ASSESSMENT OF GENDER DYSPHORIA

Attempts to accurately assess the transgender individual begin with an awareness of the heterogeneity of the phenomenon itself. Some have suggested that cross-gender experiences constitute more of a continuum than a discrete phenomenon (Blanchard, 1985; Docter & Fleming, 1992), or a multidimensional matrix, which includes at least four dimensions, including (1) the body, (2) the social role, (3) sexuality, and (4) gender identity (Carroll, 1999).

A thorough assessment of someone presenting with gender dysphoria should include a medical evaluation that focuses on genetic, congenital, or other conditions that might account for the phenomenon, although this is rare. For example, occasionally adults with gender dysphoria are found to have had intersex conditions from birth that were unknown or hidden from them.

The goal of the psychological assessment is similar to that for any other patient, that is, to understand the presenting problem (gender dysphoria) in the context of the person's life and to make recommendations as to appropriate treatment. What is different about the assessment of gender patients, however, is the need to focus specifically on understanding both gender history and sexual history. Taking a gender history involves exploring the various manifestations of gender identity over time. This will include questions about such topics as:

1. Type of play as a child (gender conforming vs. nonconforming).
2. Dress or desired dress as a child.
3. Gender identity as a child, adolescent, and adult (assessing changes over time).

4. Reactions from family, friends, peers, and others to the child's gender behavior.
5. Feelings about one's body and reactions to puberty.
6. Onset of gender dysphoria.
7. History of cross-dressing (and whether it was associated with sexual arousal).
8. Other cross-gender experiences as an adult (e.g., passing in public as other gender).
9. attempts to adopt a cross-gender role (e.g., name change, electrolysis).
10. Contact with transgender groups or individuals.
11. Masculine and feminine aspects of themselves.
12. Goals for gender transition.

In addition to this information, a careful sexual history is also necessary, including the following:

1. First sexual experience.
2. Attitudes regarding sex.
3. Sexual abuse or trauma.
4. Earliest sexual fantasies and masturbation patterns.
5. Any experience of sexual arousal associated with cross-dressing.
6. Number and pattern of sexual experiences with both genders.
7. Nature of any significant romantic/sexual relationships (including marriage).
8. Content of current sexual fantasies (especially the genders of those involved).
9. Current and desired sexual script.
10. History of sexual problems.
11. Presence of paraphilias (especially domination or masochistic fantasies).

TYPICAL PRESENTATIONS OF GENDER DYSPHORIA

There are three primary forms of gender dysphoria for which individuals seek treatment.

Female-to-Male Gender Dysphoria

Female-to-male gender dysphoria patients present strikingly consistent histories. These individuals were almost always identified as masculine in appearance and/or behavior beginning early in childhood, often as young as 3 years of age. They enjoyed rough-and-tumble games and sports.

They preferred the company of boys to girls. They hated to be put into dresses or other "girlish" clothes. They usually verbalized early on their wish to grow up to be a male. In adolescence, they reacted with disgust to the physical changes associated with puberty. Their sexual attraction was to females and they developed crushes on girls or women even in childhood. They may have tried to fit in socially by dating boys, but this was ultimately frustrating. They have almost never experienced sexual attraction to males. In adolescence or young adulthood, they often tried a lesbian solution to their dilemma, but this failed because they did not want women to be attracted to them as women. Rather, they wanted women to be attracted to them as males. They may have been able to develop relationships with female partners who are attracted to their masculinity and support their desire to transition to male. Often these female partners are women who do not see themselves as lesbian, but rather view themselves as heterosexual, although they have had negative experiences in relationships with men. At some point in adulthood, female-to-male patients become aware of the possibility of gender reassignment and seek treatment.

Male-to-Female Gender Dysphoria: The Androphilic Type

In contrast to female-to-male transgender individuals, there are two distinct histories of men who desire to become women. The androphilic (attracted to males) type, also known as the homosexual type, is the classic picture of the transsexual, in that this individual was the person described in the early literature on transsexualism. This form of gender dysphoria is in many ways the reverse of the female-to-male pattern.

These boys were almost always viewed as effeminate, pretty, and "gentle" from birth. They avoided rough games, sports, and masculine play. They liked to dress up as girls from a young age, but this was never associated with sexual arousal. They cross-dressed in order to adopt the identity of girls or women. They often had a particularly strong bond with their mothers. There may have been some encouragement from others for their effeminate behavior, dress, or looks, but this is not typical. From a young age, they were attracted predominately to males. They almost never experienced sexual attraction to females. They usually experienced harassment from others, including family or peers, due to their effeminacy. In adolescence they came out as homosexual and developed homosexual relationships. They may have been involved in prostitution or in a drag queen lifestyle. In young adulthood they became frustrated with gay relationships, because they wanted to be with heterosexual men who were attracted to them as women. In early adulthood they decided that they had to make a full transition to female.

Male-to-Female Gender Dysphoria: The Autogynephilic Type

The second form of male-to-female gender dysphoria is remarkably different from the androphilic type. This form has also been called the heterosexual or transvestic form of male-to-female transsexualism. In the past this person was usually labeled a transvestite or "secondary" transsexual and was not considered appropriate for surgery. Currently, however, professionals understand that this person may also benefit from gender reassignment. In fact, the majority of men seeking treatment for gender dysphoria are of this type.

To understand this form of gender dysphoria, one must understand the phenomenon of autogynephilia. The term refers to the experience of sexual arousal (philia) to the fantasy of oneself (auto) as being a female (gyne). Blanchard and colleagues (Blanchard, 1989) have convincingly demonstrated that it is this sexual arousal pattern that underlies most cross-dressing in men, many of whom become gender dysphoric. Most men who receive a DSM-IV-TR diagnosis of transvestic fetishism will manifest autogynephilia as a prominent form of sexual arousal.

Persons with autogynephilic gender dysphoria were not usually effeminate as boys, but rather, were typically masculine. They frequently report that they began dressing in female clothing, usually their mother's or sister's clothes, before the onset of puberty. They will describe this experience as pleasurable or comforting, but not sexual. With the onset of puberty, these cross-dressing experiences become sexually exciting and usually were the predominant source of sexual excitement. As adolescents, they typically developed sexual attractions toward girls and women. They will note, however, that, in addition to be sexually attracted to girls or women, they would imagine having feminine bodies or looking like women.

They usually dated females during adolescence and young adulthood. During this time, they also struggled with their transvestism and made attempts to stop it by purging their female wardrobes. In order to suppress their feminine identification, they often forced themselves into stereotypical masculine behavior or roles (e.g., weightlifting, aggressive behavior, or joining the military). Over time, however, their urge to cross dress and their fantasies of becoming female became stronger. They often manifested depression and/or substance abuse as a result of the internal gender identity conflicts. Eventually, they felt that they must follow their desire to become female and sought treatment. This may not be until middle age. Sometimes, they resisted the urge to become female due to fears of losing their wife, children, or job. When they present for treatment, they are often desperate to make a quick change and may be impulsive in their efforts to change gender. Further insight about the difference between autogynephilic and androphilic gender dysphoria can be found in a review by Bailey (2003).

TREATMENT OF GENDER DYSPHORIA

If the core dilemma for transgender persons is the incongruity between their internal sense of gender identity and their external role or physical presentation, then two treatment options become obvious. One can either (1) change the identity to match the body or (2) change the body to match the identity. However, clinicians, and transgender individuals themselves, are finding that these options do not represent the full variety of resolutions to cross-gender experience. It is becoming clear that there is a range of successful outcomes for individuals who present in a clinical setting with unhappiness with their biological gender. The treatment of gender dysphoria now depends primarily on the patient's desired outcome.

This raises the first important question that clinicians must resolve when confronted with a transgendered patient: When is a transgender experience a disorder? A prime example of this is the male, heterosexual cross-dresser. We know that most men who cross-dress do not seek treatment and are usually content living as male, often in a stable sexual relationship with a woman, but derive pleasure (usually sexual) from dressing as a woman. These individuals only appear for treatment in the following situations: (1) they feel that the behavior is "out of control" (e.g., taking up more and more time, energy, or money), (2) their partner is upset by the behavior, (3) the cross-dresser requires cross-dressing in order to become sexually aroused with the partner, leading to sexual dysfunction or problems in the person's sexual relationship, or (4) the cross-dresser decides that he wants to live full-time as female and to pursue gender change.

The simplest answer to whether a transgender experience is a disorder is that it is when it creates a significant problem in the person's life. The important implication is that transgender experiences are not inherently mental disorders, just as homosexuality and attraction to particular sexual behaviors (e.g., cross-dressing) are not inherently pathological. Another implication for clinicians is that the goal of treatment may not be to change the behavior but to reduce the problem that the behavior may create, for example the guilt associated with cross-dressing, or to help others adjust to the behavior (e.g., the spouse of a cross-dresser).

Possible Resolutions to Gender Dysphoria

There are many possible resolutions to the gender dysphoric dilemma due to the various combinations of physical changes, lifestyle choices, sexual orientations, and ways of manifesting the transgender part of oneself. Physically, patients may undergo any number of medical interventions to create changes in the body, including hormonal treatment, genital surgery, electrolysis, chest/breast surgery, or other cosmetic surgery. The person

may decide to live in the other gender role part-time or full-time. In terms of sexuality, individuals may prefer sex as a woman or as a man with a female, male, both or neither. Their sexuality may or may not include cross-dressing or other preferred sexual activity (e.g., domination). Individuals may view themselves as male, female, both, a third gender, a transsexual, a transvestite, or a transgender person.

The most common outcomes of treatment for gender dysphoria may be summarized as follows: (1) an unresolved outcome, (2) acceptance of biological gender and role, (3) engaging in a cross-gender role on an intermittent or part-time basis, or (4) adopting the other gender role full-time (i.e., gender reassignment). Each of these options has several possible variations as well.

Treatment Dropout

The least understand outcome is that of patients who leave treatment after an evaluation or period of mental health intervention. The proportion of these apparent dropouts can be quite high, often on the order of 50%. Due to a lack of clinical or research follow-up, we have no way of knowing what the ultimate outcome of their gender dysphoria might be. Patients who leave organized gender identity programs often do so because they are not willing or not able to engage in a structured long-term program of psychological and medical treatment. Some are angered by the recommendation for psychological treatment, feeling that they know what they want and do not need therapy. Others appear unable to accept the delay or possible denial of medical treatment. Some treatment dropouts leave to find an easier path to their goal of quick gender reassignment, such as black market hormones or surgery done without regard for the HBIGDA Standards of Care (HBIGDA, 2001). Patients may also leave treatment because they are unable to afford services.

Yet another reason for treatment dropout may be the patients' underlying ambivalence about pursuing a resolution to their gender dysphoria. Even though they have made the initial effort to seek help, they may experience considerable doubt about their identity and, rather than explore these issues in therapy, they may seek to reduce their distress by avoiding the exploration of their internal gender conflicts.

Patients may also leave treatment because they are unable to overcome the obstacles created by their marriage, children, job, or other external circumstances. Interestingly, many patients return to treatment years after an initial contact. A return to treatment may be the result of a change in the individual's life such as a divorce, children leaving home, change in job or home, or death of a parent. Another problem stems from the fact that many gender dysphoric patients are also depressed (Lothstein, 1984). After years of struggling with their gender conflict, as well as with the gen-

der role expectations in their social world, they may experience a pervasive sense of hopelessness and powerlessness.

Acceptance of Given Gender

The second treatment outcome with gender dysphoric individuals is the patient's acceptance of his or her original gender and a reduction in his or her gender dysphoria. Mental health professionals for many years have desired such an outcome for their patients. There have been a number of case reports from both the behavioral and psychodynamic perspectives that suggest that patients may resolve their gender dysphoria psychologically, that is, by removing the desire to be the other gender (e.g., Barlow, Abel, & Blanchard, 1979; Lothstein & Levine, 1981). However, these claims have not been supported by controlled group studies. It appears now that the majority of adults with gender dysphoria can not, or will not, completely accept their given gender through psychological treatment.

One population in which the acceptance of natal gender and the cessation of cross-gender behavior appears to be a possibility is a subgroup of male cross-dressers with gender dysphoria (Carroll & Donahey, 1994; see also the third case below). These individuals present to clinicians with a desire to end their cross-dressing, while they also experience varying degrees of gender dysphoria, with at least occasional desires to become female. The most common motivation for giving up cross-dressing is the fear of losing their marriages, families, or other valued parts of their lives. Some of these individuals have been able to abandon cross-dressing completely and experience a decrease in, or cessation of, gender dysphoria by approaching their transvestism from the perspective of a paraphilia or sexual compulsion and using standard behavioral and cognitive interventions (e.g., covert sensitization or stimulus control techniques), psychotherapy, and couple therapy.

Part-Time Cross-Gender Behavior

The most common resolution to cross-gender feelings for men is living part-time as female in the form of episodic cross-dressing. Most of these men do not seek psychotherapy for their gender dysphoria. The majority of these men are heterosexual, often married, usually vocationally stable or successful. The cross-dressing is, or was, usually associated with sexual arousal (i.e., autogynephilia). Psychological evaluations of cross-dressers suggest that they are not more psychologically disturbed than the normal population (Docter, 1988).

Others have addressed the same issue of diversity in cross-gender identification for females. Devor (1989) has suggested the term "gender blending" to describe the diverse ways that women may incorporate masculine and feminine aspects of self through the physical body, gender identity,

gender role, sexual practices, and sexual orientation. Likewise, there is a continuum of female behavior, presentation, and identity in homosexual men, ranging from effeminate homosexuals, to drag queens, to transsexuals.

Gender Reassignment

The fourth possible resolution to gender dysphoria is to make a full transition to the desired gender. The HBIGDA Standards of Care (HBIGDA, 2001) present very clear guidelines for the process of gender reassignment. These include:

1. A psychological evaluation performed by a gender disorder specialist focusing on both mental health and gender identity.
2. If needed, appropriate psychological treatment (although psychotherapy is not an absolute requirement).
3. Evaluation for, and continued use of, appropriate hormones.
4. A period of 1 year (minimum) of living full-time as the desired gender (the real-life experience) and continuous use of hormones.
5. An evaluation by a second gender disorder specialist supporting the person's readiness for gender surgery.
6. Gender reassignment surgery (genital, breast, or other surgery designed to change primary gender characteristics).
7. Follow-up care.

The Standards of Care present these steps in greater detail and should be consulted by anyone working with gender disorders. It should be emphasized that these guidelines are minimal standards. In fact, most established programs require longer periods of hormones, real-life experience, and therapy than the minimum periods defined by the Standards of Care.

The most essential step of the gender reassignment process is the "real-life experience." This involves the person living and working at all times in the desired gender role, as well as making legal name and gender changes. It requires that the gender dysphoric individual try on the gender role that he or she wishes to adopt and determine whether it fulfills his or her needs. This greatly reduces the chances that a person will regret irreversible gender surgery. For a few individuals, the real-life experience makes it clear that the desired gender role does not provide what they had hoped for and they abandon their pursuit of gender reassignment. Evidence of a successful real-life experience comes from examining the person's vocational, social, and psychological adjustment. Corroborating evidence is usually sought from significant others in the patient's life.

Psychotherapy for Gender Dysphoria

The Standards of Care outline the role of the clinician with regard to the gender reassignment process. They do not, however, elaborate on the complexities of therapy with these patients. Besides assessment and approval for medical treatment, the central task of the clinician is to provide psychological treatment before any medical interventions occur. Over the years, the Standards of Care have relied less and less on therapy. For example, the original Standards of Care required a period of 6 months of regular therapy for all patients who sought gender reassignment. In the most recent version, psychotherapy is not required at all, but is strongly recommended and it is left to the evaluating clinician to determine whether it is necessary.

Psychotherapy with gender dysphoric patients can be both challenging and rewarding. As noted above, many patients have great difficulty with the recommendation for therapy, although they may come to value it over time. Few patients are as appreciative as those who have been able to find a sense of psychological well-being, usually for the first time in their lives, through this process.

There are four main goals of psychotherapy:

1. Therapy should help persons to understand themselves and their life situation, including a broader understanding of their personality, sexuality, and relationships. A historical perspective is useful in this process and helps patients to understand the development of their gender identity, as well as other aspects of their personality. Though one cannot usually identify the "cause" of the person's gender dysphoria, it is beneficial to the patient to have a clear picture of his or her own life story.
2. Therapy should involve an exploration of the options available for the resolution of gender dysphoria. This will include consideration of options that the patient may have not seriously considered. For example, many patients have not thought about living part-time as the other gender and taking hormones, but living most of the time in their original gender and not pursuing surgery. The patient must evaluate the benefits and costs, advantages and disadvantages of the various options. For example, few male-to-female patients have considered the fact that, as a woman, they are likely to make less money or to be harassed by men. Likewise, few female-to-male patients realize that once they start taking hormones they are likely to develop male-pattern baldness.

A valuable aid in this process is guiding the patient to sources of information for transgender individuals. Valuable resources for this include the International Foundation for Gender Education (www.ifge.org), the Gender Identity Research and Education Society (www.gires.org.uk), the Renaissance Transgender Association (www.ren.org), Transsexual Women's

Resources (www.annelawrence.com/twr), the Society for the Second Self (www.tri-ess.org), and FTM (Female to Male) International (www.ftmi.org). The clinician working with transgender patients should become educated about local support groups. Patients typically find the opportunity to talk with other gender dysphoric people very helpful. The Internet and online group discussions serve this function as well. Patients should be cautioned, however, that these groups may have their own biases regarding the proper resolution to gender dysphoria.

3. It is critical that the assessment of gender dysphoric individuals includes a broader assessment of their psychological functioning. Given the incentive to appear well adjusted, psychological testing is useful in assessing underlying personality and psychopathology. Therapy should address psychological difficulties in the person's life other than the gender identity issue. Most individuals who seek treatment for gender dysphoria have experienced considerable distress in their lives, usually as a result of their gender conflict. This has manifested itself typically as depression, but it may also be expressed through acting out behavior or substance abuse. The gender problem also typically interferes with the development of peer, family, and intimate relationships. Confusion and conflicts regarding sexual orientation are also common. While the gender patient need not be a paragon of mental health, research indicates that patients with attendant mental health difficulties fare more poorly through the course of gender reassignment.

The literature regarding the associated psychopathology of persons with gender dysphoria has changed over time. Early on, most of the clinical literature suggested that they usually manifest severe personality disorders (Lothstein, 1984). More recent studies have indicated that most transgender individuals do not typically exhibit significant elevations in psychopathology (Brown, Wise, & Costa, 1995). The question remains whether this change in the literature reflects an improvement in research quality, an overcoming of clinical biases, or a change in the population of gender dysphorics presenting for treatment.

Another issue is whether a gender dysphoria patient with a significant mental health problem, such as schizophrenia, bipolar disorder, or severe personality disorder, should be allowed to pursue gender reassignment surgery. While none of these mental disorders necessarily rule out gender reassignment, it is the responsibility of the mental health professional to help the patient receive appropriate treatment for these other conditions before pursuing medical intervention. A severely depressed person is not in the appropriate state of mind to make major life decisions that may be irreversible. An actively psychotic person should not undergo surgery.

4. Therapy with gender patients should focus on the person's life goals through development of a carefully delineated plan. This plan should address the following issues:

a. When and how he or she will make a full transition to the other gender role.
b. How he or she will make the gender change at work (e.g., whether to stay on the same job or to quit and start a new job after the transition).
c. When and how to reveal his or her intentions to family and friends.
d. When and where to obtain hormonal and/or surgical treatment.
e. If not pursuing full-time transition, when he or she will present as one gender or the other.
f. The nature of his or her future sexual and/or romantic relationships.

When problems occur in gender transition, it is usually because the person and/or therapist did not anticipate the obstacles he or she would encounter. For example, some gender dysphoria patients will begin to present themselves in androgynous or gender-confused ways (e.g., a male wearing two earrings, makeup, and female shirts) at their work, which may then trigger negative reactions or dismissal. Another common mistake for transitioning gender patients is to come out too quickly or to be too confrontational in their approach with others.

Outcome Research on Gender Reassignment

Gender reassignment (sex change) has been the most carefully studied outcome for gender dysphoria. Over 80 empirical studies and several reviews of the outcome of gender reassignment surgery have been published (Abramowitz, 1986; Carroll, 1999; Green & Fleming, 1990; Pfäfflin & Junge, 1998). The quality of this research, however, is relatively weak. Fortunately, despite the methodological shortcomings, there is a great deal of consistency in the findings of the various studies. Gender reassignment results in improvement or a satisfactory outcome in two-thirds to 90% of patients. This is true with both male and female transsexuals, with a variety of surgical, hormonal, and psychological interventions, and when outcome is measured at widely varying points in time. Most studies define success as improvement in social, psychological, or vocational function and/or satisfaction with the outcome. The domains that have shown the greatest improvement are self-satisfaction, interpersonal interaction, and psychological health, while the area of economic success typically show less improvement. Satisfaction with cosmetic results was often inconsistent, due perhaps to significant changes in technique and/or expectations over the years. The impact on sexual functioning is often negative (Schroder & Carroll, 1999). However, the overall evidence of positive outcomes for the gender reassignment process is a striking conclusion.

The rate of poor outcomes appears to be 8% of patients (Abramowitz,

1986). Pfäfflin and Junge (1998) found that the incidence of regret about gender reassignment surgery is very low (less than 2%). Poor differential diagnosis, failure to go through a trial period of living as the desired gender, and poor surgical results were the primary reasons for postoperative regrets. Those who began to cross-dress later in life and those with serious psychological difficulties before gender reassignment are more likely to regret surgery (Kuiper & Cohen-Kettenis, 1998).

Female-to-male transsexuals consistently manifest a more favorable psychosocial outcome following gender reassignment than do male-to-female transsexuals (Bodlund & Kullgren, 1995; Pfäfflin and Junge, 1998). Kuiper and Cohen-Kettenis (1995) suggested that this might be due several factors, including better social acceptance of these individuals, greater ease for female-to-males in passing as their desired gender, and greater burdens for male-to-females, such as marriage and child rearing. Clinical observations frequently suggest that female-to-male transsexuals, as a group, present as mentally healthier and more stable than male-to-females. They also appear to be more cooperative with treatment.

Autogynephilic transsexuals are significantly more likely to regret reassignment surgery or experience poor outcomes than are androphilic transsexuals. The reasons for the differences between these two groups remain unknown.

Several studies have found that those individuals with character pathology, negative self-image, poor judgment, a history of serious depression, an "over-reactive temperament," or other serious psychological disorders show a significantly poorer response to gender reassignment, are more likely to regret reassignment surgery, and are more likely to attempt suicide following reassignment (Abramowitz, 1986; Bodlund & Kullgren, 1995; Botzer & Vehrs, 1995; Green & Fleming, 1990).

Botzer and Vehrs (1995) found that greater satisfaction with reassignment surgery was also associated with a better work history, and family and other social support. Schroder and Carroll (1999) found that the individuals who reported high levels of current stress reported less satisfaction with the psychosocial outcome of reassignment surgery.

Patients reported more satisfaction when they had undergone at least a 1-year period of living in the desired gender role before surgery and that the longer the period is, the better the outcome (Botzer & Vehrs, 1995; Carroll, 1999; Pfäfflin & Junge, 1998). A break in the real-life trial of living as female was associated with a poorer outcome. Not surprisingly, better psychosocial outcomes for gender reassignment have consistently been found to be related to good surgical outcomes. Consistent administration of hormones has also been associated with better postoperative satisfaction. Realistic expectations of surgery were also predictive of better outcome. Appropriate psychological treatment has also been associated with more positive outcomes. The standard process of psychotherapy, hormonal

treatment, real-life experiment, and surgical reassignment has been shown to benefit older adolescents as well (Cohen-Kettenis & van Goozen, 1995).

In sum, this large body of research finds strong empirical support for the effectiveness of the HBIGDA Standards of Care in the assessment and treatment of those with gender dysphoria.

CASES OF TREATMENT OF GENDER DYSPHORIA

The following cases are composites of several cases each in order to protect privacy and highlight common patterns.

A Case of Male-to-Female Transsexualism

Angela was a 45-year-old white male who presented with a desire to have genital gender reassignment surgery as quickly as possible. Her explanation was "All my life I have wanted to be a woman." She had been married for 15 years and had two daughters. She was working as a steelworker and had been steadily employed for 22 years.

Angela came from a working-class background. She was the third of three sons. Her parents were both immigrants from Italy. She denied that they had ever expressed either an overt or covert wish for her to be a girl. She reported that her father had been very masculine and a hard worker. She had a distant, but not conflictual relationship with him. She described her mother as negative and uncaring. She never felt close to her mother, although she had tried to improve the relationship over time.

In childhood, Angela was not at all effeminate; rather she was an active and rough boy. She was involved with sports and not interested in female games or girls her own age. At age 6 or 7, she began to occasionally dress in her mother's clothes. She reported that this felt pleasurable, but she denied any sexual arousal during this activity. She was ashamed of this behavior and kept it hidden from her family.

Beginning with adolescence, the cross-dressing became sexually stimulating. It was also emotionally satisfying to imagine herself as a woman. Her cross-dressing consisted of putting on her mother's clothes, applying makeup, and looking at herself in the mirror. She would usually sexually stimulate herself. Her cross-dressing had continued up to the present, usually once or twice per week. On four occasions, she purged herself of her collection of female clothes, makeup, and accessories (e.g., wigs), because she felt disgusted with the behavior. This was also prompted on two occasions by her girlfriend or wife finding her clothes, becoming upset, and threatening to leave. Over time, however, she would begin to cross-dress again and rebuild a female wardrobe.

Her sexual attraction during adolescence and young adulthood was

primarily toward women. She rarely dated girls in high school. She first had sex at the urging of her female partner. She did not have any serious relationships with women before meeting her wife. She also began to have fantasies during the cross-dressing that were of herself, as female, being with a man, but not sexually involved. They would, instead, be having a romantic dinner and kissing. Men's bodies were not sexually appealing to her, but rather the fantasy of being with a man made her feel more like a woman.

Beginning at the age of 15, Angela occasionally went out in public dressed as a woman. She was very anxious while doing this and tended to do it at night and remain in her car, so that others would not be able to perceive her as male. In her mid-20s, she became aware of transsexualism and the gender reassignment process. She then developed a desire to make the transition to female, but did not seek out treatment, due to conflicts about these urges.

Angela met her wife at the age of 18. She was attracted to her because she was pretty, feminine, and caring. The coupled dated for a year before marrying. Angela hoped that the marriage would eliminate her desire to become female and the urge to cross-dress. She enjoyed the sexual relationship and initially found that she was less interested in cross-dressing. However, she never completely relinquished her autogynephilic fantasies. After a year of marriage her desire to cross-dress grew stronger again and she began to go out occasionally as female. She admitted to her wife that she had a strong need to cross-dress. After some distress and conflict, her wife accepted this and allowed Angela to cross-dress at home. Eventually, her wife would also go shopping with Angela for female clothes. She refused, however, to have sex with Angela when she was dressed as a woman. During this period, Angela continued to work and live as a male. Shortly before the start of treatment, Angela revealed her cross-dressing and gender dysphoria to her adolescent daughters, because she felt that they should know her "real self."

Angela described the year prior to seeking treatment as extremely difficult. Her struggle with her desire to become female, while wanting to maintain her marriage and her family, became more intense. She became depressed and started to abuse alcohol.

Angela sought treatment due to her growing unhappiness. At the start of treatment, she was insistent on obtaining gender surgery but was naive about the process. As part of the initial evaluation, she was seen for several sessions alone and once with her wife. Her wife was supportive of Angela, including her desire to come out as female. The initial evaluation also revealed that Angela was chronically depressed and abused alcohol. In spite of these difficulties, Angela was functioning well in her work and social roles. She also had good relationships with her daughters.

Based on the HBIGDA Standards of Care and, given the presence of

depression and alcohol abuse, it was recommended that Angela engage in psychological treatment for a minimum of 1 year before any hormonal or surgical intervention. She was not pleased with this recommendation but accepted it. She resisted the view that she needed time to consider her pursuit of gender reassignment. Couple and family therapy were also recommended to Angela to address the inevitable issues that the gender dilemma created in the family.

Despite her early resistance, Angela began to use the therapy productively by thinking through her future options and by mapping out a plan for transition. She also was able to listen to the therapist's suggestions on how to address these issues with her daughters. Couple therapy sessions explored her wife's feelings about the future and helped them to come to a decision to divorce, but to both remain involved with their daughters. Their daughters responded well to the family sessions and agreed that Angela was happier when able to dress as a woman.

After 1 year of therapy, Angela started on female hormones and began the process of coming out as female. Coworkers accepted the change and she was even reelected president of her softball league, although she had to switch from the men's team to a mixed gender team. Her parents and siblings, however, remained adamantly opposed to the change and stopped socializing with her. Angela and her wife divorced, but lived in adjoining apartments so that they could remain close to each other and their daughters. Angela also began to date men sporadically. These relationships did not last very long and never extended beyond kissing. They were with men who knew of her gender transition. Angela remained frustrated with these romantic experiences. Over time, her depression lifted and she curtailed her drinking. She lost considerable weight and stopped smoking, because she felt she now had a reason to want to be healthy.

After 2 years of feminizing hormones, living full-time as a woman, and continued therapy, Angela felt ready for genital surgery. Following the HBIGDA standards of care, she received a second evaluation from another psychologist, who also approved surgery. Her surgery went well and despite some minor complications, Angela was pleased with the cosmetic results.

A follow-up 1 year after surgery found that Angela was doing well. She had remained in her job, although she had experienced some pressure from her employer to leave and had to threaten a lawsuit to protect her job. She continued to live next door to her ex-wife and daughters, who now called her Aunt Angela. She had lost some of her old friends, mostly male, and had gained some new ones, mostly female. Her biggest frustration was difficulty in developing a romantic relationship with a man. She had dated several, but they had backed away when she wanted the relationship to become more serious and/or sexual. She became depressed on several occasions when these relationships didn't work out. Overall, how-

ever, she felt strongly that the gender reassignment was the best thing that had ever happened to her.

Comments

This case is quite typical of the autogynephilic transsexual, in that there is a history of early cross-gender identification, but not effeminate behavior in childhood. Cross-dressing is associated with sexual arousal during adolescence and young adulthood. In addition to the autogynephilia, there is a sexual attraction to females. There is a pattern of attempting to stop the cross-dressing and purging the female wardrobe. Gender dysphoria and the wish for gender reassignment become more pronounced with age.

The course of treatment is also similar to most in that it began with initial resistance to therapy but then developed into a productive process. The outcome is characteristic in that she experienced a significant improvement in psychological well-being but had difficulties in finding and establishing satisfying romantic or sexual relationships.

What is atypical with Angela is the consistent support of her wife and daughters. Male-to-female transsexuals often lose their relationships with their wives and become estranged from their children. This case shows that with appropriate intervention the families of transsexuals need not be harmed by the gender transition. Angela's story also demonstrates that for many gender dysphoric patients, if carefully evaluated and treated appropriately, gender reassignment is a successful resolution to gender dysphoria.

A Case of Female-to-Male Transsexualism

Benito presented as a 21-year-old Hispanic female and a senior at a large state college. He reported that he was confused about his sexual identity, and felt he didn't fit into the role of being a woman. Initially, he was not pursuing a gender transition but rather wanted to alleviate thoughts identifying himself as a male. He had sought psychological treatment at school but felt angry that the counselor had told him he was just going through a stage and did not address his gender identity confusion. His parents, likewise, told him that he was just immature and that having sex with a man would cure him of his gender dysphoria.

Benito was born and raised in a middle-class section of a small city. He had one older sister. He described his mother as very loving, very feminine, but also stubborn, "square," and closed-minded. As a child he was close to his mother, but over time felt that his mother was unhappy that he was not her "little girl." He described his father as very masculine and smart. He was not very affectionate, but more easygoing than Benito's mother. In childhood Benito felt closer to his father and they would often do things together. He described his older sister as very in-

telligent and feminine. He felt that his sister was the parents' favorite child in the family.

Benito described childhood as very uncomfortable because he was often worried. He noted that he was a tomboy and always preferred to play sports with the boys. He hated being forced to be with girls in grade school. He became distraught at puberty when he developed breasts and started menstruation. He became more alienated from the family. Despite this unhappiness, he tried to date boys in order to fit into the social cliques at school. He was, however, never sexually or romantically attracted to boys and suppressed his sexual and emotional attraction to girls and women.

A separate interview with Benito's parents indicated that they thought the problem was his "attitude." They felt he was trying to cling to childhood by rejecting his given gender role. They described Benito as a delightful child, free-spirited and extroverted. They did admit that when asked at age 3 what he wanted to be when he grew up, he answered, "A boy." They noted that at puberty he became more withdrawn and hostile. They believed this was due to his problems with relationships.

In college, Benito went through a period of alcohol abuse and depression. His gender dysphoria and attraction to women intensified, but he still avoided initiating sexual relationships with women because he felt lesbian sex was disgusting. His excessive drinking became an escape from his gender conflicts. He did, however, give up his pretense of dating men and he began to adopt a more masculine appearance. His parents became more concerned about him but resisted taking him to a psychologist, for which he was resentful. He eventually sought therapy on his own but found that it didn't help, because his therapist had no experience with gender dysphoria. His school counselor then referred him to a gender dysphoria program.

The initial evaluation identified long-standing gender dysphoria, as well as dysthymia and alcohol abuse. Psychological testing indicated that, while attempting to maintain an outwardly pleasant demeanor, he was experiencing considerable anger and hopelessness. A period of 1 year of psychotherapy, with occasional family therapy sessions, was recommended. His parents reluctantly agreed to the plan. Benito was cooperative throughout therapy. Once he realized that he was not going to be pushed to give up his masculine identification, he became more trusting. He used psychotherapy to explore his gender conflicts, his low self-esteem, his confusion about relationships and sexuality, and his future goals. He stopped drinking and began to focus on his schoolwork. He established a romantic and sexual relationship with a bisexual woman who was attracted to his masculine demeanor. His appearance continued to evolve to a more androgynous look. He had not, however, gone out as male in public due to his fear of being caught as a woman dressed as a man.

The occasional family sessions were difficult because his parents were upset with his apparent movement toward gender transition. They insisted that he hide this from the extended family and their friends. Family therapy focused on educating them about gender dysphoria and helping them to cope with the changes in Benito.

After 1 year of therapy, Benito was functioning well in school, had a stable relationship with a woman, and was no longer depressed. He had decided to pursue a full gender transition to male and was ready to begin hormonal treatment. After taking hormones for several months, he became more comfortable going out publicly as man, but only at night and in distant towns. Therapy began to focus more on his plans for making a gender transition and his relationship with his girlfriend. It also addressed ways to help his family understand and accept his gender identity. After another year of treatment he moved to another state, where he started working as a man. He had had all his school records and identification papers changed to his male name and gender.

Several years later, Benito returned for a follow-up evaluation for breast surgery and hysterectomy. He was doing well at his job, where no one knew of his past. He was engaged to be married to his former girlfriend. He was seen for a second opinion by another psychologist, who also approved him for gender surgery, which involved bilateral mastectomy and a hysterectomy. He was very pleased with the cosmetic results. At the time he reiterated his desire to have genital surgery, but was unable to afford the cost. He was frustrated, but was determined to save the necessary funds.

Another 4 years later, Benito called again to say that he had saved enough money for the female-to-male genital surgery. He was again reevaluated and found ready for genital surgery. Despite some early complications, the surgical results were very good. At a 1-year follow-up, Benito was able to have intercourse with his neophallus, which had sexual sensation, although he was not able to achieve orgasm through intercourse. He had ended the relationship with his fiancée and had developed a new relationship with a heterosexual woman who knew of his previous gender. He felt as though he had accomplished all of the goals he had set for himself regarding his gender identity, except marriage and children. He hoped that in time he would have these as well. His main disappointment was his parents' inability to accept his new identity and their continued estrangement from him.

Comments

Benito's history is typical of female-to-male transsexuals in most respects, especially the early masculine identification, attraction to women, and rejection of a lesbian orientation. The presence of a period of depression and

alcohol abuse is also common. His story is somewhat different than most in that he pursued treatment at a relatively early age and was able to afford phalloplastic surgery. The outcome, however, was typical (i.e., great satisfaction with the gender transition).

A Case of Cross-Dressing with Gender Dysphoria

The third case is that of a 40-year-old, African American married man with four children. Charles was a colonel in the army. He presented with a request for help in controlling his cross-dressing activities. His wife had recently discovered that he was cross-dressing and was threatening to divorce him and take their children away. She had discovered his cross-dressing once before, and he had had a brief period of treatment and stopped the behavior for 6 months. He had then restarted cross-dressing and continued it for 4 years, without his wife's knowledge. At the time of the initial evaluation he was highly motivated to control the cross-dressing, due primarily to fear of losing his family. He was also concerned that he would be discovered by his superiors and dishonorably discharged. He reported being ashamed of the behavior, which made him feel less than a man.

At the age 6, Charles began to cross-dress in the clothes of his younger sister. Cross-dressing became sexually arousing at puberty at age 11. When he was 9, his younger sister died in a car accident. He reported that for several years after her death, he consciously wished to take her place and continued to cross-dress in her clothes. He fantasized that he could be his mother's little girl. During childhood and adolescence, he cross-dressed about once per month. He also developed a more typical sexual attraction toward females. From ages 12 to 14, he experienced infatuations with several male peers, although he had never had any sexual experience with males and had not had homosexual urges since that time. He stopped cross-dressing for 7 years when he first went into the army, but started again shortly after getting married at age 24. Since that time, he had gone through cycles of spending increasing time and effort in his cross-dressing, followed by purging himself of his feminine attire, stopping for several months, and then slowly beginning it again.

Charles's cross-dressing involved secretly taking his female clothing and accessories, such as a wig and makeup, on out-of-town trips. While away, he would spend 2 to 3 hours preparing himself in order to achieve an illusion of himself as a female. He would go out in public with the hope of receiving attention as a woman. The whole process was sexually arousing and would culminate with masturbation after returning to his room, using the image of himself as a woman out in public. He would also engage in frequent masturbation to these fantasies when he was not able to cross-dress. He described the cross-dressing, and passing as a female, as intensely

exciting. Charles also reported that, beginning about 1 year before the evaluation, he had begun to think more frequently about gender reassignment.

The patient was the middle of seven children. He described his father as very violent, alcoholic, and extremely strict. He routinely physically abused the patient and his siblings, with the exception of the sister who died. He described his mother as timid, insecure, and unaffectionate. She was seriously depressed and completely unavailable to the patient for several years before and after his sister's death.

Treatment first focused on helping Charles and his wife through the crisis, brought on by rediscovery of the cross-dressing behavior. Charles's wife was also significantly depressed at this point and she was referred for individual treatment. Once the couple was more stable, the options for the resolution of the problem were explored with Charles. It was discussed that he could try to stop the behavior or his wife could try to accept the behavior with limits. Both insisted that they wanted him to completely stop the cross-dressing. The treatment then consisted of a combination of behavioral interventions to inhibit the behavior, psychotherapy to explore psychological issues, and intermittent couple therapy sessions to deal with marital issues. Covert sensitization was used to give Charles a way to inhibit the urge to cross-dress by imagining aversive consequences to his behavior. For example, he was asked to write out a scenario in which he was caught while cross-dressing and was thrown in jail, humiliated in front of his neighbors, divorced by his wife, denied contact with his children, and dishonorably discharged from the army.

The behavioral treatment quickly succeeded in eliminating the behavior, although the impulse continued at a reduced frequency and intensity. Psychotherapy focused on exploring the possible origins of his cross-dressing as a form of emotional self-soothing, as an escape from his father's abusiveness and his mother's emotional absence. The couple therapy sessions provided reassurance to his wife that he was able to control the behavior and focused on strengthening their sexual and emotional intimacy.

He remained in regular treatment for 6 months and continued through intermittent follow-up visits. Several years later, he reported an absence of cross-dressing behavior. He had, however, occasional periods, usually times of stress, when the urge to cross-dress and the autogynephilic fantasies were more intrusive and difficult to inhibit. He also reported a complete absence of desires to become a woman.

Comment

This case is similar to that of other paraphilias, except that the sexual impulse is for cross-dressing and the sexual fantasy is the image of being a woman. What is interesting about this case is the patient's increasing gen-

der dysphoria and desire to become a female. In spite of this, treating the autogynephilia as a paraphilia resulted in suppression of both the cross-dressing behavior and the autogynephilic fantasy. What remains striking is how similar Angela and Charles were, yet how they pursued different goals and ended up with different outcomes. It remains unclear as to why some individuals with autogynephilia choose to make a gender transition (Angela), while others attempt to eradicate their cross-dressing and impulse to become female (Charles), and still others are content with part-time cross-dressing.

SUMMARY AND CONCLUSIONS

As can be seen from the preceding overview, transgender experiences may take many forms. However, we still do not understand the etiologies of these various experiences. The clinician will be challenged to understand the unique presentation, history, and needs of each patient. It is important to remember that the transgender experience itself may not be a disorder, but that it may lead to difficulties in a person's life and that these may be the focus of treatment.

While the clinician may have the role of gatekeeper to medical treatment (e.g., hormones or surgery), he or she must respect the fact that the choice of resolution to the gender dilemma lies with the patient. Fortunately, there are clear guidelines for work with individuals presenting with gender identity difficulties. The HBIGDA Standards of Care (HBIGDA, 2001) can direct the process of assessment and treatment and have been shown empirically to result in the best outcomes for those who desire gender reassignment. It should also be reassuring to the clinician to know that, following work with the patient to explore and identify the most workable resolution, the outcome of treatment is generally positive.

Clinicians who work with transgender individuals need to work closely with the physicians who will provide the necessary hormonal, surgical, and other medical treatments. They should also be comfortable in connecting their patients with appropriate educational resources and support groups. While the goals or philosophy of these groups may be biased, they can be of help to individuals in the process of exploring options to resolve their gender issues.

What remains to be done is to continue the work of understanding the possible biological and psychological factors that may create the various transgender experiences, keeping in mind that there is no single origin to the multiplicity of these phenomena. As we continue to make progress in understanding the origins of typical sexual development, we will also better understand these variations.

Much work also remains in educating not only professionals, but also

society at large about these conditions, in order to overcome the discrimination and stigma that still exist for transgender people.

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CHAPTER 17

The New Sexual Pharmacology

A Guide for the Clinician

ADAM KELLER ASHTON

The use of pharmacological interventions for treating sexual problems has become increasingly widespread. The advent of successful treatment of erectile failure with oral agents stimulated a change in the way sexual problems were viewed. Many physicians came to believe that most, if not all, sexual dysfunctions were organic and could be remedied by medical interventions. Regrettably, the initial optimism about finding the "right drug" for each dysfunction has been a disappointing undertaking and the need for concomitant sexual, interpersonal, and psychotherapeutic interventions is common.

Nevertheless, pharmacotherapy can be quite helpful with a variety of sexual disorders and, in fact, many patients prefer pharmacological treatment—at least as an initial treatment option. It is for this reason that it behooves clinicians to be aware of the cornucopia of pharmacotherapy alternatives and to have some understanding of which ones work best for particular problems. Equally important is to assess whether drug therapy is acceptable to the patient's partner.

In this chapter, Ashton differentiates between those (few) medications that are prosexual and on-label (intended for use with sexual problems) and those that are off-label (unintended for such use but nevertheless sometimes helpful). An example of the latter is the use of SSRIs to treat premature ejaculation; oral PDE5 inhibitors (sildenafil, vardenafil, and tadalafil) are an example of the former. As Ashton points out, the cost of doing business with any drug intervention is managing (or eliminating) unwanted side effects. Ashton summarizes the five major strategies that are typically employed: waiting for spontaneous remission, selecting a medication with a lower risk

of sexual dysfunction, dosage reduction, drug holidays, and finally, augmenting the "offending drug" with antidotes. As he suggests, the results are often less than totally satisfactory, and often, a trial and error process is entailed in finding the right approach, the correct dosage, or the most effective dosing schedule.

It is evident that the search for drugs to enhance or ameliorate female sexual response has been, by and large, unsuccessful. At this time, there are no FDA-approved drugs for female sexual dysfunction and it appears unlikely that any are forthcoming in the near future. The reasons for this are complex and beyond the scope of this book, but probably include the fact that satisfactory female sexual response is less a question of physical response and more associated with motivational and interpersonal variables. The search for a female (as well as a male) aphrodisiac is likely to continue—as it has for millennia—but to date, this goal appears elusive.

Finally, Ashton emphasizes that dialogue between patient and physician is essential if successful treatment is to occur. Therapeutic outcome is most successful when patients know and understand their treatment options, when physicians talk to both the identified patient and his or her partner, and when there is a commitment to work together to find the most satisfying interventions with the fewest side effects.

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Sexual dysfunction is a commonly encountered problem in clinical practice. According to the *Sex in America* survey, it is estimated that among 18- to 59-year-olds, 43% of women and 31% of men may suffer from impaired sexual functioning (Laumann, Paik, & Rosen, 1999; Michael, Gagnon, Laumann, & Kolata, 1994). This makes sexual dysfunction more prevalent than the most common medical disorder, cardiovascular disease, at 34% (American Heart Association, 2005). Furthermore, this estimate also suggests that sexual dysfunction is more common than the most common psychiatric disease—anxiety and depressive disorders (Kessler, Berglund, Demler, Jin, & Walters, 2005). In addition, the very medications most commonly used to treat mood and anxiety disorders can iatrogenically cause sexual dysfunction in our patients. It is common to see patients who present both with emotional complaints and sexual concerns. Then, once treated, they are subjected to greater sexual problems than they had prior to contact with those of us who prescribe psychotropic agents. Unfortunately, there is little research to guide us in ways to treat primary sexual problems and minimize the impact of medication-induced sexual dysfunction when it occurs.

This chapter addresses the extent of this problem and provides behavioral and pharmacological guidance for helping our patients who suffer in this fashion. When pharmacological options are available, it is preferable

to combine them with psychotherapeutic strategies, since it is common for dynamic issues to arise out of medicating someone's sexuality. All too often, the interpersonal impact of treating the identified patient has relationship consequences on the partner of the individual getting treated. The partner may not want the patient treated. The partner may not want the patient to be more sexual. The partner may feel heightened tension around the need to perform once the patient is treated. These issues and others may affect patient compliance and relationship homeostasis, which medication alone will not address. The patient must then learn to identify and manage these subtle but important issues.

The decision to utilize medication rather than counseling is dictated by the individual situation. Some patients may refuse a pharmacological approach, finding it "unnatural," costly, or cumbersome. Likewise, some patients may oppose a psychotherapeutic approach for some of the same reasons. Nevertheless, medication is probably preferable for a patient with a stable relationship who develops a new sexual dysfunction after recently changing a medication or discovering a medical problem. On the other hand, jumping in with medication for sexual problems may cause the clinician and patient to miss the opportunity to address dynamic relationship issues that may need to be resolved if fundamentally flawed relationships are to be improved or sustained. For example, a man who takes sildenafil to promote erectile functioning may find an unwilling partner if that person is now expected to perform sexually after a protracted period of abstinence, especially if that period was felt to be "a good thing" by the partner. Bringing the partner in to be a consultant and participant in the treatment may improve outcome in several ways. It can reduce anxiety and apprehension in the identified patient and make the partner aware of the extent of the problem, along with the likelihood of success of treatment. The partner would also know the expectations for the couple to perform "homework assignments," improve communication, and take medication if indicated. I believe a partner who is a willing participant in treatment is a major ally who greatly increases the chance for success.

The medication discussion that follows is largely "off-label," meaning that many of the medications mentioned in this chapter are not definitively proven in randomized, placebo-controlled studies of sexual dysfunction for use by the Food and Drug Administration (FDA). Instead, I will be relying on clinical experience and open-label research that, for better or worse, is often what practitioners use to make their recommendations. Certainly this is not ideal, and further research, preferably controlled and blinded, is needed. This chapter is not intended to be the end of this discussion but instead a place to begin outlining what we know, what we think we know, and ways to maximize success until we know more. For those unfamiliar with the names of medications, Table 17.1 (on p. 517) provides a list of brand and chemical names along with dosages usually prescribed.

ON-LABEL USES OF MEDICATION

Several medications are now approved through the FDA for use in treating sexual dysfunctions. Outside of hormones used to treat hypogonadal disorders and other agents used to treat primary medical conditions with sexual symptomatology such as thyroid or cardiovascular disease, the first approved agent was yohimbine. Yohimbine has a mechanism of action whereby it antagonizes alpha$_2$ receptors centrally (Tam, Worcel, & Wyllie, 2001). The most commonly experienced side effect of yohimbine is agitation, which can sometimes be thought to exacerbate a baseline anxiety disorder. Typically it is used for the treatment of male erectile disorder in a dose of 5.4 mg three times a day. Higher dosing has also been reported. In one small noncontrolled study, 10.8 mg three times a day was effective and generally well tolerated in five out of eight (62.5%) men for whom standard lower dosing had already failed (Ashton, 1994). A common theme that reoccurs throughout this chapter is the importance of dosing. A dose that may work for most patients may be suboptimal for a select few. Nonresponders can frequently be turned into responders simply by increasing the dose. Occasionally, physicians may even prescribe medications outside of FDA guidelines—both higher and lower. While the safety and efficacy of this strategy are outside the scope of this update, unusual dosing is a reality in many clinical practices and may be appropriate for some selected individuals.

The other class of medications currently approved for treatment of a sexual dysfunction, specifically male erectile disorder, is that characterized by the inhibition of phosphodiesterase type 5 (PDE5). These are used on-label to treat male erectile disorder. Currently there are three medications available in this class in the United States, sildenafil, vardenafil, and tadalafil. They all are potent selective blockers of PDE5, which is found primarily in the corpora cavernosal tissues in males. When PDE5 is antagonized, this inhibition can cause accumulation of cyclic GMP (guanosine monophosphate) in response to nitric oxide by preventing its conversion to GMP (Padma-Nathan & Shabsigh, 1999). This chemical acts as a local peripheral vasodilator, which increases blood flow into the corpora cavernosa. This action is what causes enhanced erectile ability. The mechanism of action is further delineated in Figure 17.1.

The following is a typical clinical case.

> Mr. K is a 61-year-old, Caucasian male married 15 years with a past medical history significant for benign prostatic hypertrophy, hyperlipidemia, and hypertension taking terazosin for his prostate, pravastatin for his lipids, and two medications for his blood pressure, hydrochlorothiazide and diltiazem. He presented with long-standing male erectile disorder along with a new-onset delayed ejaculation caused by

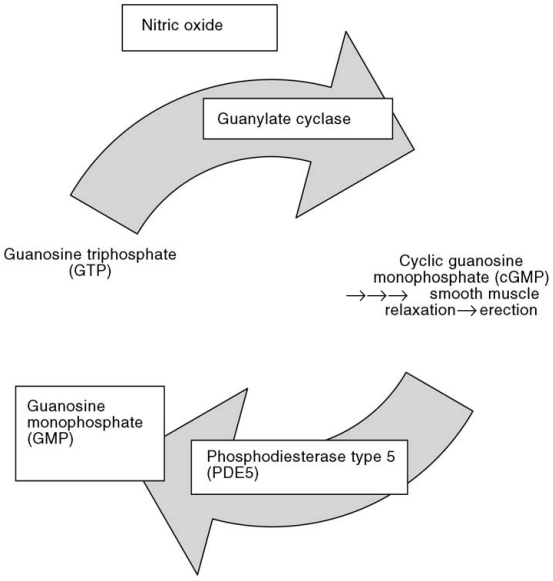

FIGURE 17.1. Physiological effect of phosphodiesterase type 5 on erectile function.

sertraline, which was successfully treating his major depressive disorder and panic disorder with agoraphobia. Lowering the dose of sertraline led to relapse so this was not useful. Sildenafil augmentation was ineffective at 50 mg 1 hour prior to anticipated sexual activity but was very effective at reversing both his erectile dysfunction and delayed ejaculation at 100 mg. He has continued using sildenafil successfully for more than 2 years without side effects.

TREATMENT MODALITIES FOR PREMATURE EJACULATION

A universally accepted definition of premature ejaculation (PE) has yet to be established. PE is also known as rapid or early ejaculation. Kaplan (1974) first defined PE as a problem of voluntary control over timing of ejaculation. DSM-IV-TR (American Psychiatric Association, 2000) defines PE as "persistent or recurrent ejaculation with minimal sexual stimulation before, upon, or shortly after penetration and before the person wishes it." Personal and interpersonal relationship difficulties may occur as a result of this disorder and are required for the diagnosis.

Epidemiological studies suggest that PE may be the most common male sexual disorder. Data from the National Health and Social Life Survey have revealed a prevalence of 31% in men ages 18 to 59 in the United

States (Laumann et al., 1999). Using various definitions, other studies have reported prevalence rates from 5% (Simons & Carey, 2001) to greater than 30% (Aschka, Himmel, Ittnes, & Kohen, 2001; Frank, Anderson, & Rubenstein, 1978; Metz, Pryor, Nesvacil, Abuzzahab, & Koznar, 1997). PE has traditionally been considered a psychological defect, but more recently, organic causes have been found, both locally within the penis and in the central or peripheral nervous system (Strassberg, Kelly, Carroll, & Kircher, 1987). Using an evidence-based approach, Waldinger (Waldinger, 2002; Waldinger & Olivier, 2000; Waldinger, Berendsen, Blok, Olivier, & Holstege, 1998) postulated that PE is related to 5-hydroxytryptamine (HT) 2C receptor hyposensitivity. It may also be related to 5-HT_{1A} receptor hypersensitivity. Treatment should then be based on 5-HT_{2C} receptor stimulation or 5-HT_{1A} receptor inhibition (Waldinger & Olivier, 1998).

Many options for treating premature ejaculation are available. These include behavior therapy, oral pharmacotherapy, the use of topical agents and intracavernosal vasoactive injections (Semans, 1956; Masters & Johnson, 1970; Choi et al., 1999; Haensel, Rowland, & Kallan, 1996; Kim & Seo, 1998, Balon, 1996 Fein, 1990, Seftel & Althof, 2000). (A more thorough discussion of phenomenology and treatment strategies is found in Chapter 8, which focuses solely on this dysfunction.)

Waldinger, Zwinderman, Schweitzer, and Olivier (2004) conducted a systematic review and meta-analysis of all drug treatment studies published from 1943 to the present. Three drug treatment strategies emerged from the study: daily treatment with serotonergic antidepressants; "as needed" treatment with specific antidepressants; and anesthetic topical ointments. None of these medical or any other medical therapies are approved by the FDA for the treatment of PE. Nevertheless, physicians often select pharmacotherapy as an intervention for this purpose. The following is a brief summary of treatment approaches when using medication to treat PE.

Oral medications in the antidepressant class, specifically serotonergic antidepressants, are the ones most commonly chosen when treating PE. Clomipramine and selective serotonin reuptake inhibitors (SSRIs) activate the 5-HT_{2C} receptor leading to a delay in ejaculation (Waldinger, 2004). Daily treatment can be with any of the SSRIs at customary doses used to treat depressive and anxiety disorders, although for treatment of PE, the doses are generally lower than those used for the treatment of depression. A meta-analysis of serotonergic drug treatment showed that paroxetine caused the greatest ejaculation delay (Waldinger et al., 2004; Balachandra, 2001). Some studies suggest that nefazodone, citalopram, and fluvoxamine are ineffective for the treatment of PE, although doses used in these studies may have been too low (Montague et al., 2004). Underdosing may cause a certain agent to appear less likely to delay ejaculation, since this effect is often dose related. Higher doses tend to lead to more delay. Of course, patients using these medications for this purpose may experience the usual

side effects commonly associated with SSRIs, including nausea, GI-related problems, insomnia, anxiety, and reduced libido. Side effects generally begin during the first week and gradually resolve within 2–3 weeks if they are going to diminish over time. Ejaculation delay usually occurs by the end of the second week with a daily dosing (Waldinger, 2004).

Whether continuous or as-needed dosing of antidepressants in the treatment of PE is more effective remains unclear. There have been limited studies published evaluating the as-needed treatment strategy for PE. Sertraline taken in 50 mg doses 4–8 hours prior to intercourse (Mendels, Camera, & Sikes, 1995) and clomipramine 25 mg 4 hours prior to intercourse have been shown to increase ejaculatory latency (Althof et al., 1995). The following is a case of using a serotonin enhancing medication to treat premature ejaculation in this fashion.

> Mr. N is a 50-year-old Caucasian married male with a lifelong history of premature ejaculation, even with masturbation. When attempting intercourse, he would often ejaculate upon entry, which frustrated his wife of 27 years. Occasionally, she would make "hurtful remarks" when this occurred. Sexual intimacy lessened and marital discord increased. Couple counseling helped decrease some of their frustration but sex therapy was only of limited help. The patient had seen many psychiatrists and therapists over many years. Clomipramine was started at 25 mg and then 50 mg at 6 P.M.. Time to ejaculation increased to 10 minutes following penetration. Dose was increased to 100 mg, which the patient felt made him last "almost too long" and was sedating. The drug dose was then reduced to 75 mg, which helped the husband last 10–20 minutes but was still oversedating. Modafinil augmentation helped with tiredness so that he could continue with clomipramine at his optimally effective dose. He has continued using this regimen for over 6 months and reports that both he and his wife find it satisfactory.

Another class of oral drugs gaining rapid acceptance in as-needed dosing is the PDE5 inhibitor. In one study, sildenafil at a dose of 50 mg taken 3–5 hours prior to coitus was superior to clomipramine, paroxetine, and sertraline, as well as the pause-squeeze technique, in delaying ejaculation. There were limited side effects, including headache and flushing (Abdel-Hamid, El Naggar, & El Gilany, 2001).

A single case report on the successful use of gabapentin in the treatment of PE has been released (Chue, 2004). It is postulated that its effect on ejaculation be may be via GABA receptor agonism. An Italian team has reported limited success with levosulpride, an antidopaminergic drug used for dyspeptic syndromes in anxious patients (Greco, Polonio-Balbi, & Spernza, 2002).

The use of topical anesthetic agents is probably the oldest treatment

for PE. Few studies have been reported. Lidocaine/prilocaine cream applied to the penis topically 20–30 minutes prior to intercourse has been shown to be beneficial (Berkovitch, Keretesci, & Koven, 1995). Prolonged application can cause penile numbness. Another treatment involves intracorporal injection of a vasoactive agent such as alprostadil (Fein, 1990). Limited efficacy was reported with medications, which block adrenergic receptors such as alfuzosin and terazosin (Cavallini, 1995). These interventions should be reserved for particularly refractory cases given the relative safety and efficacy of alternative approaches mentioned earlier and psychotherapy.

ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

The most commonly encountered medication-induced sexual dysfunction in clinical practice is that caused by antidepressants. Although this problem has plagued patients since the advent of this medication class, attention to these difficulties was magnified upon the release of the serotonin reuptake-inhibiting antidepressants (SRIs) in the United States. This class can be further subdivided into the selective serotonin reuptake-inhibitors (SSRIs) and the serotonin and norepinephrine reuptake-inhibitors (SNRIs). Currently there are six SSRIs available in the United States. These are fluoxetine, sertraline, paroxetine, fluvoxamine, citalopram and escitalopram. There are only two SNRIs available currently. They are venlafaxine and duloxetine. A list of medications discussed in this section and commonly prescribed dosages are listed in Table 17.1.

We had been aware of the sexual consequences with the other two major classes of antidepressants, namely tricyclics (TCAs) and monoamine oxidase inhibitors (MAOIs), but other side effects such as sedation, weight gain, blood pressure suppression, and dangerous drug interactions superseded concern over sexual dysfunction. It almost became the "cost of doing business" to expect side effects from the use of pharmacological agents. So clinicians often decided that since sexual impairment was not potentially life threatening and perhaps relatively less important than effective treatment of the major complaint, less attention was paid to sexual complaints. Also, for decades, many doctors felt that treatment with antidepressants would only be for a matter of months. Hence, sexual side effects could be dealt with simply by telling the patient that the side effect would disappear when the medicine was stopped and that the medicine could be stopped not too long after clinical improvement occurred. Consequently, patients might only need to accept the inconvenience of sexual dysfunction for a limited amount of time. Within the past 10 to 15 years, however, it became clearer that longer term treatment of depression with antidepressants may be necessary in many if not most depressed individuals (Frank et al., 1990;

TABLE 17.1. Names of Medicines Mentioned in This Chapter and Their Customary Dosages

Selective serotonin reuptake inhibitors (SSRIs)
- Fluoxetine (Prozac) 20–80 mg
- Sertraline (Zoloft) 50–200 mg
- Paroxetine (Paxil) 20–60 mg
- Fluvoxamine (Luvox) 150–300 mg
- Citalopram (Celexa) 20–60 mg
- Escitalopram (Lexapro) 10–20 mg

Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Venlafaxine (Effexor) 75–375 mg
- Duloxetine (Cymbalta) 30–120 mg

Tricyclic antidepressants (TCAs)
- Clomipramine (Anafranil) 75–225 mg

Other antidepressants
- Bupropion (Wellbutrin) 225–450 mg
- Nefazodone (Serzone) 300–600 mg
- Mirtazapine (Remeron) 15–45 mg

Antidotes
- Amantadine (Symmetrel) 100–200 mg
- Buspirone (Buspar) 20–60 mg
- Cyproheptadine (Periactin) 4–16 mg
- Ginkgo biloba 120–240 mg
- Granisetron (Kytril) 2 mg
- Yohimbine (Yocon, Aphrodyne, Afrodex) 5.4–32.4 mg

Phosphodiesterase type 5 inhibitors
- Sildenafil (Viagra) 50–100 mg
- Tadalafil (Cialis) 10–20 mg
- Vardenafil (Levitra) 10–20 mg

Stimulants
- Methylphenidate (Ritalin, Concerta, Focalin and others) 15–60 mg
- Mixed amphetamine salts (Adderall) 15–60 mg
- Dextroamphetamine (Dexedrine) 10–60 mg

American Psychiatric Association Practice Guidelines, 2000; Mueller et al., 1999). This shift in treatment duration made living with side effects, including sexual dysfunction, for extended periods of time more commonplace. Then, upon the widespread use of SRIs, patients had to endure fewer serious side effects. Greater tolerability led some practitioners to feel that SRIs were practically devoid of chronic side effects. After SRIs were available for a few years, though, the first reports of SRI-induced sexual dysfunction were published. It was only then that clinicians were forced to

face the reality that their patients were increasingly unwilling to tolerate sexual side effects. It was against this backdrop that researchers and clinicians began to develop treatment paradigms for managing SRI-induced sexual dysfunction. Several strategies had been developed by the mid-1990s. Balon (1995) described five ways of dealing with SRI-induced sexual dysfunction: waiting for spontaneous remission; choosing/switching to an antidepressant with less risk of sexual dysfunction; dose reduction; drug holiday; and augmentation with a pharmacological antidote. These are listed in Table 17.2. The data supporting the efficacy of these approaches will be reviewed. Physicians who do not encounter these problems are probably not asking about them or are unwilling to see them, as these side effects are quite common and often of long duration.

Incidence

The incidence of antidepressant-induced sexual dysfunction has been the subject of some controversy over the last decade. The definitions of dysfunction, proximity to treatment, patient selection, and tools used to evaluate the extent of the problem all have affected our ability to determine its extent. As more studies were published, a higher incidence of dysfunction was reported. As patients became more aware of the potential for difficulty and as clinicians became more adept at questioning patients about changes in sexual functioning, more problems emerged (Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001).

Ashton, Hamer, and Rosen (1997) published one of the earliest studies asking not about current degree of sexual impairment, but instead about changes in sexual functioning associated with taking a specific antidepressant. Unfortunately, a formal rating tool was not used. Also, after the close of the study, which included ongoing assessment of individuals for up to 38 months, many patients indicated that although they had been repeatedly asked about sexual functioning and sexual changes they may have experienced, they had initially denied that problems existed, and only admitted them after years on the medicine. This reinforces one fundamental diffi-

TABLE 17.2. Treatment Strategies for Antidepressant-Induced Sexual Dysfunction

- Wait for spontaneous remission.
- Choose an antidepressant with minimal sexual dysfunction associated with it.
- Reduce dosage.
- Take a drug holiday.
- Add secondary pharmacological agent.

Note. Based on Balon (1995).

culty in assessing sexual dysfunction–patient lack of awareness of or unwillingness to identify changes in their sex lives. Unfortunately, there is no definitive objective assessment (i.e., laboratory test), and thus we are forced to rely on patient self-report, which may be subject to outside influence, prejudice, and perceived expectation.

One of the most comprehensive, if not largest, research studies undertaken to minimize some of the interstudy variability was published by Clayton et al. (2002). These researchers found that all available SRIs had a similar incidence of about 30% of new-onset sexual dysfunction in both men and women. There is somewhat lower likelihood of sexual dysfunction caused by nefazodone and least with bupropion, a norepinephrine and dopamine reuptake-inhibiting antidepressant (NDRI) that does not act on serotonin. In fact, the lower incidence with bupropion appeared to approach the placebo likelihood of iatrogenic sexual dysfunction. As these studies were published, clinicians began to use this data to apply the strategies of Balon. Below I describe how to begin to utilize these principles when treating actual patients.

Waiting for Spontaneous Remission

This approach is the one most clinicians wish would work, yet, unfortunately, it rarely does. In fact, physicians often want to deal with problematic, difficult to treat, or uncomfortable to talk about side effects by "watchful waiting." In other words, they wish the side effect or the patient would just go away. A Spanish study looked at this in the short term, to find only 5.8% of patients experienced resolution of this side effect within 6 months of waiting (Montejo-Gonzalez et al., 1997). The longest study to date looked at patients who continued to take the offending antidepressant for up to 38 months. It found that 9.8% of patients accommodated to sexual side effects or had them lessen over time (Ashton & Rosen, 1998a). Hence, most patients who have SRI-induced sexual dysfunction will not be helped by continuing their medicine without further intervention. Therefore, the clinician must take a proactive approach to the management of sexual side effects, as procrastination is not effective in most individuals and could potentially lead to noncompliance. In fact, surveys suggest that sexual side effects are among those most patients want to avoid, along with weight gain and sedation (Ashton, Jamerson, Weinstein, & Wagoner, 2005).

Not addressing the sexual dysfunction could lead some patients to skip pills, reduce dose, or stop taking medication entirely in an attempt to lessen their sexual impairment. This perhaps is especially true for those individuals whose self-esteem or relationship might be in jeopardy as a consequence of persistently impaired sexual functioning. It is for these reasons that alternative strategies to manage sexual side effects are pursued.

Selecting an Antidepressant with Less Risk of Sexual Dysfunction

A common approach for dealing with unwanted sexual side effects from antidepressants is to switch medications to an antidepressant that might give less sexual difficulty than the one the patient currently is taking. This approach leaves physicians with very few choices. Data regarding bupropion are strongest in terms of not causing sexual dysfunction beyond a placebo rate (Croft et al., 1999; Coleman et al., 1999, 2001; Clayton et al., 2002). Unfortunately, this agent has not been proven clinically effective in treating anxiety disorders, which are so commonly managed with serotonin agents. This is of particular relevance since many patients with major depressive disorder have a comorbid anxiety disorder (Sartorius, Ustun, Lecrubier, & Wittchen, 1996). Even for those individuals without a primary or coexisting anxiety disorder, there is no guarantee that bupropion will treat the depressive disorder as successfully as the antidepressant the patient is currently taking. Nevertheless, there is some evidence that bupropion may help the majority of depressed patients who are switched in this fashion (Walker et al., 1993).

Nefazodone is the next antidepressant that appears somewhat less likely to cause sexual dysfunction (Feiger, Kiev, Shrivastava, Wisselink, & Wilcox, 1996; Ferguson et al., 2001; Clayton et al., 2002). However, this agent has limited data for treating comorbid anxiety and is not indicated for the treatment of any anxiety disorder, unlike the serotonin reuptake inhibiting agents. It also possesses a small risk of hepatotoxicity, which may make it undesirable in some individuals.

All SRIs are thought to cause comparable degrees of sexual dysfunction (Clayton et al., 2002). There is limited evidence suggesting less impairment with the newest SSRI, escitalopram (Ashton & Mahmood, 2005). Although this is frequently claimed when a medicine is released, it is often found to be less true when experience builds or when larger studies are completed.

Switching antidepressants may cause patients to clinically decompensate and have their mood worsen by withdrawing a medication that had been effective. Also, it is presumptuous to think that patients will want to stop their medicine simply because of the sexual side effects. The degree of impairment may be mild or of little concern to a particular patient. Sex may not be that important. A delay in orgasm in a male patient may not be considered a problem at all, particularly if the patient feels he had difficulty with rapid ejaculation. In this case, the SRI is actually treating a preexisting or perceived problem. Finally, many patients have suffered from their mood disorder for such a protracted period of time that they simply do not want to risk relapse, especially over non-life-threatening side effects such as sexual dysfunction. Patients may have waited years to experience

the degree of relief they have found from their antidepressant and therefore may wish to endure the sexual dysfunction rather than face the possibility that their long-sought-after euthymia might be lost while searching for greater sexual satisfaction.

Thus, there are many good rationales for not changing a medication regimen that is working. However, many patients feel they would stop their medicine immediately if there was an alternative drug that could treat their mood disorder without causing sexual impairment, even if it meant risking relapse. The following sections will describe medication adjustments that can be tried.

Dosage Reduction

One of the most logical strategies for limiting medication side effects is to decrease the amount of drug used. Sexual side effects appear to be dose dependent. This means that as the dose increases, the risk of developing sexual side effects also increases. Inherent in this is the fact that the severity of sexual side effects also may increase with increasing dose. There is a great deal of individual variation, however. Some patients on a high dose of medication may have no change in sexual functioning while others on seemingly minimal, subtherapeutic amounts may experience profound impairment.

The primary limitation of dosage reduction as a strategy to manage medication-induced sexual dysfunction is that of potential risk of relapse. If a patient has his or her dose of medicine lowered to an amount that previously was suboptimal or ineffective, it is likely to not work again. However, if a dose is increased too aggressively, to a point at which it is effective but causing sexual dysfunction, one approach would be to cut back to a dose between a prior ineffective dose and the current "toxic" dose. For example, if a patient did not benefit from 20 mg of paroxetine and obtained benefit at 30 mg, but also developed a new-onset sexual dysfunction, perhaps cutting the dose to 25 mg would be successful. This dose is more than the initial, subtherapeutic amount but less than the side effect–causing amount. The following case describes a patient who had this very same problem.

> Mrs. H is a 44-year-old Caucasian female with a past psychiatric history significant for obsessive–compulsive disorder (OCD) responsive to low-dose clomipramine 25 mg at bedtime over many years. She had been anorgasmic with it for over 10 years except for times when she would stop taking it. When off it for 3 weeks, she could orgasm but her OCD would return. She had failed to respond to, or could not tolerate, all available SSRIs. After the launch of the newest SSRI, escitalopram, she discontinued clomipramine and started taking 10

mg daily of escitalopram. OCD was controlled but she remained anorgasmic. Since she did well with low-dose clomipramine, it was decided to try to lower the dose of escitalopram. Dosage was reduced to 5 mg daily and OCD remained controlled but she was now able to orgasm, although only with great difficulty. Dose was then lowered to 2.5 mg daily and orgasm returned to her baseline but so did her OCD. She was then increased to 2.5 mg one day and 5 mg the next. On this dose, OCD was improved and satisfactory sexual functioning was preserved.

Drug Holiday

Patients occasionally discover that skipping pills, even over our objection, improves sexual functioning, even though we know this poses the risk of mood or anxiety destabilization. This temporary disruption of a medication schedule, typically called a "drug holiday," is another strategy occasionally employed to negate sexual side effects caused by medications (Rothschild, 1995). The premise is that if a patient waits until the drug washes out of his or her system the sexual side effect will rapidly dissipate. Although this approach is helpful for some, there are many problems to be considered.

One concern is that of relapse. Skipping medicine can lead to relapse. If a person skips pills frequently to have sexual activity, they essentially are cutting their dose. Sometimes relapse may take time to materialize, and patients may initially think they are succeeding. But over the course of weeks, months, or longer, they in fact are taking less and less medicine and thus may be vulnerable to relapse of their primary psychiatric disorder.

Another risk with drug holiday is that of patients not understanding the need to still take medication as regularly as possible. They may have an easy time remembering to take their pills daily, but not if they skip intermittently for sex. We tell our patients, "Take your medicine every day on a regular basis," just as they might take cholesterol or blood pressure medicine. It then sends a mixed message when we say, "Oh, unless you want to have sex. Then you can skip it here and there." Who is to say how many days can be missed? How long before sex should medicine be stopped? Should some patients never stop their medicine? Are some medicines easier to use with this strategy than others?

This last point is of particular relevance. SRIs with short half-lives (i.e., venlafaxine, paroxetine) wash out of the system faster than those with long half-lives (fluoxetine). This can be a double-edged sword. A drug that washes out faster should allow side effects to diminish faster as well, which is good for drug holiday. Unfortunately, drugs that wash out faster also can cause more frequent and sudden serotonin discontinuation symptoms upon their rapid removal from circulation. Symptoms of this syndrome in-

clude lightheadedness, nausea, vomiting, irritability, electric shock paresthesias, and sudden depression, among others. These can be so severe as to lead a patient to go to the emergency room. One could imagine how patients may not be thinking of improving their sex functioning while they are also throwing up. Medicines with long half-lives may buy patients some time before they experience these difficulties. But this also then means that patients will probably still have substantial amounts of the drug in their system, causing ongoing sexual dysfunction, which could last weeks after stopping their medicine. Therefore, drug holiday may not work as well in someone who is on a long half-life antidepressant who does not plan well in advance.

It is because of these issues that it takes an unusually informed and disciplined patient to use drug holiday successfully. The following is a case of one such individual.

> Mr. M is a 59-year-old Caucasian male with a past psychiatric history significant for generalized anxiety disorder who has done well on venlafaxine 25 mg twice a day over many years. Unfortunately, he has marked delayed orgasm with it. Changing anxiolytics many times has led to relapse, as has lowering the dose. Augmenting strategies have failed as well. He found that holding his morning dose until after he and his wife were intimate in the evening worked well for him. Their good communication allowed him to know in advance when they were likely to be sexually active. The short half-life of venlafaxine, approximately 5 hours, allowed it to mostly wash out of his system within 24 hours of his last dose. However, if he waited an extra day off medicine, he would develop nausea, weepiness, and lightheadedness as signs of serotonin discontinuation syndrome. He has successfully used this approach for 2 years.

Augmentation with Pharmacological Antidotes

Despite our best efforts to minimize medication and maximize tolerability, we are often faced with the realization that our patients require a dose of medication that produces sexual side effects that we are not able to eliminate. The aforementioned strategies have been tried or considered and either have failed or are inappropriate or unacceptable. It is then that pharmacologic augmentation, or the use of medication antidotes, is used in an effort to improve sexual functioning. Although this is thought of as an intervention of last resort, it is a strategy that is, perhaps, the most common. Certainly it is the intervention most asked about when clinicians gather to discuss therapeutic options in managing iatrogenic sexual dysfunction.

Once patients derive clinical benefit from a medication to reverse antidepressant-induced sexual dysfunction, they often remain on the agent indefinitely, given that spontaneous remission is unlikely (Ashton & Rosen,

1998a). My experience is that for a patient who uses an antidote on an "as needed" basis, relapse is usually immediate. In other words, a patient notices difficulty the very first time or two after not taking the antidote. For the patient who takes the antidote on a scheduled or maintenance basis, sometimes it may take several days or weeks to notice problems returning. This delay in relapse may reflect the time it takes to wash the antidote out of the patient's system, the patient's belief that he or she will not be impaired, or another psychological factor.

There are very few placebo-controlled studies of pharmacological antidotes used to manage antidepressant-induced sexual dysfunction. These are all listed in Table 17.3. They all involve reversal of sexual dysfunction caused by SRIs. That should not be interpreted as suggesting that other antidepressants (i.e., tricyclics or monoamine oxidase inhibitors) don't cause sexual problems. Treatment has simply not been reported.

The antidotes are reviewed below in alphabetical order, along with whatever placebo-controlled studies exist. However, the results of the majority of the placebo-controlled studies do not show active drug separation from placebo, and hence do not give us clear direction. All of the following agents are used to treat medication-induced sexual dysfunction by adding

TABLE 17.3. Placebo-Controlled Studies of Pharmacological Antidotes for SSRI-Induced Sexual Dysfunction

Lead author	Drug (mg)	Dose	Superior to placebo
Clayton (2004) (*N* = 42)	Bupropion SR	150 mg twice a day	Yes
DeBattista (2001) (*N* = 42)	Bupropion SR	150 mg	Yes
Jespersen (2004) (*N* = 12)	Granisetron	2 mg	No (female study)
Kang (2002) (*N* = 37)	Ginkgo biloba	120–240 mg	No
Masand (2001) (*N* = 30)	Bupropion SR	150 mg at 6 P.M.	No
Meston (2004) (*N* = 19)	Ephedrine	50 mg 1 hr prior to sex	No
Michelson (2000) (*N* = 19/18)	Buspirone/ amantadine	20–30 mg 50–1000 mg	No (female study)
Michelson (2002) (*N* = 36/35/38)	Mirtazapine/ yohimbine/olanzapine	15–30 mg/5.4–10.8 mg 2.5–5 mg	No (female study)
Nelson (2001) (*N* = 20)	Granisetron	1–2 mg	No
Nurnberg (2003) (*N* = 90)	Sildenafil	50 mg or 100 mg	Yes (male study)

them to a current antidepressant regimen. Hence, these agents are used to supplement the offending drug.

Amantadine

Amantadine is a dopamine agonist used to treat symptoms associated with Parkinson's disease and also to minimize the effects of viral illness. It has been reported as helpful in doses of 100 mg daily to thrice daily (Ashton et al., 1997; Michelson, Kociban, Tamura, & Morrison, 2002; Masand, Reddy, & Gregory, 1994/1995; Balogh, Hendricks, & Kang, 1992; Shrivastava, Shrivastava, Overweg, & Schmitt, 1995). In one of the larger studies done, 42% of the individuals appeared to benefit from this strategy (Ashton et al., 1997). The lone placebo-controlled study was conducted in 18 women and found no difference from placebo at a dose of 50 mg twice daily (Michelson, Bancroft, Targum, Kim, & Tepner, 2000). However, this dose is lower than that customarily used. Certainly amantadine appears well tolerated and few, if any, side effects are described at greater than placebo levels.

Bupropion

The most studied augmentation strategy to reverse antidepressant- and more specifically SSRI-induced sexual dysfunction is bupropion. It is an aminoketone, dopamine and norepinephrine reuptake-inhibiting antidepressant itself (Gardner & Johnston, 1985; Horst & Preskorn, 1998). It appears to improve sexual dysfunction apart from its antidepressant effect. A study by Walker et al. (1993) found 84% of patients switched from fluoxetine to bupropion experienced improved sexual functioning while maintaining antidepressant effect.

An initial case report found improvement with bupropion augmentation to reverse antidepressant-induced sexual dysfunction (Labbate, Grimes, Hines, & Pollack, 1997). This led to a subsequent study using immediate-release bupropion 75–150 mg 1 hour prior to anticipated sexual activity on an as-needed basis. This produced sexual improvement in 38% of patients. If as-needed use failed, they were then titrated to 75 mg three times daily over the course of 1 week and continued treatment for an additional 3 weeks. This improved sexual response in an additional 57% of those patients for whom as-needed treatment already had failed. Therefore, a total of 66% of patients showed improvement with this approach (Ashton & Rosen, 1998b).

These early promising data led to the first double-blind, placebo-controlled study of any pharmacologic antidote to reverse antidepressant-induced sexual dysfunction. It utilized 150 mg daily of bupropion slow release (SR) at 6 P.M. for 3 weeks. Unfortunately, it did not separate from

placebo (Masand, Ashton, Gupta, & Frank, 2001). Reasons for this are not clear but may have been due to small sample size or short duration of trial. One placebo-controlled study did show benefit at this dose, although it was a longer study with a larger sample (DeBattista, Solvason, Fleming, Kendrick, & Schatzberg, 2001). Subsequently, another double-blind, placebo-controlled study of bupropion SR with a duration of 4 weeks, utilizing a dose of 150 mg of bupropion SR twice daily, was undertaken. Using this protocol, a statistically significant improvement in sexual desire and frequency was seen, although not in arousal or orgasmic ability (Clayton et al., 2004). This study also suffered from small sample size with only 42 patients enrolled. The problem from small sample size is that it makes separation from placebo more difficult to demonstrate, because it produces wider confidence intervals.

Bupropion is sometimes used to treat primary female sexual dysfunction. Although there is little research, Modell, May, and Katholi (2000) did report significant improvements in orgasmic ability beyond placebo with 150 and 300 mg per day of bupropion in a sample of nondepressed women. Another interesting prosexual study of bupropion was done in women with hypoactive sexual desire by Segraves et al. (2001). They found 29% of patients had improved desire using 300 mg per day. One open-label study and one prospective study also suggested clinical benefit by using bupropion SR (Gitlin, Suri, Altshuler, Zuckerbrow-Miller, & Fairbanks, 2002; Clayton, McGarvey, Abouesh, & Pinkerton, 2001). These studies are far from definitive, but they suggest benefit from using bupropion in patients with SSRI-induced sexual dysfunction. Although no study has been shown to measure prescribing patterns, bupropion augmentation has been the preferred and most commonly chosen intervention by physicians to treat sexual side effects in their patients taking serotonin-enhancing medications. The following is an example.

> Ms. A is a 44-year-old Caucasian female with a past psychiatric history significant for major depression (recurrent) who had decreased libido on SSRIs. After the patient had discontinued citalopram and paroxetine because of sexual side effects, she had remission of her depression from 450 mg of bupropion XL in combination with 50 mg of sertraline. Perhaps more importantly, she had no sexual side effects, as it appeared that the bupropion negated any sexual dysfunction from the SSRI.

Buspirone

The 5-HT_{1A} agonist buspirone has been reported to improve sexual functioning in patients treated for generalized anxiety disorder (Othmer & Othmer, 1987). There also is a report of buspirone augmentation assisting

in reversing SSRI-induced sexual dysfunction (Norden, 1994). It was hoped that this enhancer of the serotonin auto receptor might be able to negate sexual side effects on a larger scale. It was with this in mind that a double-blind, placebo-controlled study of buspirone augmentation was undertaken. Buspirone in flexible doses of 20 to 60 mg per day was given for 4 weeks to men and women with sexual dysfunction on various SSRIs. Unfortunately, in a study with male patients, buspirone did not separate from placebo. It worked better in women during weeks 1 and 3 but not 2 or 4. Data pooled by gender showed improvement only during weeks 2 and 3 (Landen, Eriksson, Agren, & Fahlen, 1999). Another small placebo-controlled study using buspirone also did not separate from placebo (Michelson, Bancroft, Targum, Kim, & Tepner, 2000). This suggests that benefit of this agent may not be particularly robust and perhaps little, if any, better than placebo.

Ginkgo Biloba

Many patients prefer to take "natural" or herbal remedies to manage physical ailments. Often, individuals feel nonsynthetic, nonmanufactured products may be safer or have fewer side effects than traditional pharmaceuticals. A preliminary study using ginkgo biloba reported extremely high success rates using 120 mg twice daily to reduce antidepressant-induced sexual dysfunction (Cohen & Bartlik, 1998). However, reports critical of this study raised concern that faulty study design and statistical analysis dramatically overestimated the success rate of this strategy (Levine, 1999). Replication of this protocol failed to show much benefit. In fact, only 3 of 32 (14%) consecutively treated patients for SSRI-induced sexual dysfunction found improvement in functioning by augmenting with ginkgo biloba (Ashton, Ahrens, Gupta, & Masand, 2000). Two subsequent reports have demonstrated conflicting results (James & Patricia, 1998; Kang, Lee, Kim, & Cho, 2002). Therefore, with the few reports thus far published, clear advantage to using this agent to manage sexual complaints from patients taking various antidepressants has not been demonstrated. Therefore, this approach has tended to be a secondary one, used when several other medicines have failed.

Cyproheptadine

Small case series reports have suggested benefit from cyproheptadine in reversing SSRI-induced sexual dysfunction (McCormick, Olin, & Brotman, 1990; Feder, 1991; Lauerma, 1996; Ashton et al., 1997). The reason for potential benefit lies with the pharmacological action of cyproheptadine, which among other chemical effects acts as a serotonin receptor antagonist. Since sexual dysfunction caused by serotonin enhancing antidepres-

sants is thought to be caused by excess serotonin centrally, it is no surprise that a medicine which opposes this action might be beneficial in reversing this side effect. Research is sparse and sample sizes are small. As is seen in reports with other proposed antidotes, cyproheptadine benefit has been questioned, despite early hope. Concern has been raised about reversal of antidepressant effect by adding an agent that antagonizes serotonin (Feder, 1991; Kapur et al., 1997). Side effects also have proven to be problematic, with sedation and increased appetite particularly troublesome. These side effects appear to be dose related, with increasing severity as dose increases. Therefore, use of the lowest dose required to provide clinical benefit is of particular relevance with this agent. Dosage varies on individual response, but generally speaking, start treatment at 2 to 4 mg before bedtime and increase the dose over days to weeks depending on benefit and tolerability. Doses higher than 16 mg have not been systematically reported and it is my experience that tolerability limits dose escalation beyond this in most individuals.

PDE5 Inhibitors

The most exciting advance in the pharmacological management of sexual dysfunction was the release of the PDE5 inhibitors. Blockade of PDE5, which is found in abundance primarily in smooth muscle, especially that of the corpus cavernosum, allows for vasodilatation, by restricting the breakdown of cyclic guanine monophosphate (cGMP). This leads to increased blood flow and ultimately stronger erections. The three agents in this class, sildenafil, vardenafil, and tadalafil, all work through the same mechanism, although some patients prefer one agent to another. Side effects typically include headache, flushing, or warmth. Occasionally a blue-green visual color tint has been described. This is thought to occur by a small degree of vasodilatation in the retina brought about by slight inhibition of phosphodiesterase type 6 found in the retina. It is not clear that this is indicative of any particular medical danger. These agents primarily differ in duration of action and interaction with food. Sildenafil has the greatest interaction with food such that absorption is limited after a high-fat meal. It also has the shortest duration of action at 4 to 6 hours while tadalafil has the longest at up to 36 hours (*Physicians' Desk Reference*, 2005). All members of this class are contraindicated with nitrates due to the potential for profound hypotension. These agents are FDA approved to treat erectile dysfunction. Use outside of this diagnosis has not proven to be superior to placebo, except possibly in some men (Ashton & Bennett, 1999; Nurnberg et al., 2001; Nurnberg et al., 2003). Regardless of this drawback, attempts to use these agents in a nonapproved fashion have been widely popular even without a large amount of scientifically proven benefit.

Use of phosphodiesterase inhibitors in women is even less studied, al-

though case reports with all three agents have described individuals who have benefited (Fava, Rankin, Albert, Nierenberg, & Worthington, 1998; Ashton, 1999; Nurnberg, Lauriello, Hensley, Parker, & Keith, 1999; Salerian et al., 2000; Ashton, 2004; Ashton & Weinstein, 2006). Generally speaking, the patient would take the pill 1 hour before anticipated sexual activity. It is unknown how these agents could help with anorgasmia, the most commonly encountered SSRI-induced sexual dysfunction (Ashton et al., 1997). One thought is that since these agents increase blood flow to the genitals, vasocongestion occurs and tissues are subsequently stretched. This may lead to increased stimulation of neurons and, consequently, increased sensation and subsequent orgasm. Also, increased sensation and greater chance of orgasm could lead to increased desire by enhancing pleasure. This may explain the clinical benefit seen in women apart from the proven benefit in erectile dysfunction. Use of an agent in this class may be preferred in a patient who may be infrequently sexually active or for a patient who is not inclined to take a medication on a daily basis. The following are cases in both sexes where this class of drug has been useful.

> Mr. E is a 55-year-old Caucasian male with a past psychiatric history significant for dysthymia, generalized anxiety disorder, and alcohol abuse in remission who had sexual side effects and apathy from fluoxetine, sedation from sertraline, and sexual dysfunction from citalopram. He was switched to escitalopram, which was effective but led to markedly delayed orgasm without decreased libido or erectile dysfunction. He was given 20 mg of vardenafil, which he took 30 minutes before anticipated sexual activity. This completely eliminated his orgasmic dysfunction without causing any adverse effect. He has used this approach for several months successfully.

> Ms. J is a 69-year-old Caucasian female with a past psychiatric history significant for panic disorder and OCD who has been in remission for many years on paroxetine monotherapy taking 50 mg daily. She developed anorgasmia from the paroxetine without decreased libido or arousal difficulty. She began taking 50 mg of sildenafil on an empty stomach on an as-needed basis before sexual activity, which restored orgasmic ability and has been successful now for 1 year without any adverse events.

Stimulants

Psychostimulants are dopamine releasing agents along with enhancing noradrenergic systems (Solanto, 1998). A feedback loop exists between serotonin and dopamine such that as serotonin increases, dopamine decreases and prolactin increases. This effect may be responsible for the occasional menstrual irregularity and breast discharge seen with SRIs. Negating

and possibly reversing this feedback loop underlies the theoretical reason why dopamine-enhancing drugs can reverse SSRI-induced sexual dysfunction. Although no placebo-controlled studies have been done, case series have been published (Bartlik, Kaplan, & Kaplan, 1995). It is unknown whether one stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) is more effective than another. When used to reverse sexual problems, dosage typically starts at 5–15 mg daily and increases up to a maximum of 60 mg daily, often in divided doses. Occasionally these medicines are taken on an as-needed basis, up to several hours before anticipated sexual activity. It may be best to initiate treatment on a scheduled, daily basis, so that if it works, the dose can be reduced at a later date to see if less is adequate. Alternatively, if one starts medicine on an as-needed basis and it fails, the dosing schedule will need to be increased and the patient would have gone additional weeks experiencing sexual dysfunction. In other words, by starting the regimen on a scheduled basis if a medicine is effective, the patient benefits and the dose can be lowered at a later date. If the medicine is ineffective but is dosed adequately, it can be discontinued and a new one can be utilized. However, if a medicine is underdosed, then the dose has to be adjusted upward and the patient needs to wait a longer period of time for satisfactory impact.

Yohimbine

Yohimbine is a centrally acting presynaptic alpha-$_2$ antagonist that is approved to treat male erectile disorder (*Physicians' Desk Reference*, 2005). Efficacy has been described in studies dating back over 20 years (Morales, 2000; Margolis, Prieto, Stein, & Chinn, 1971; Susset et al., 1989). More recently, in the 1990s, a few reports surfaced regarding the successful use of yohimbine in high doses (Ashton, 1994). Although yohimbine is often thought of as an established antidote, in fact, very few studies have been performed and none are large scale. There are conflicting results using yohimbine to reverse SSRI-induced sexual dysfunction (Jacobsen, 1992; Hollander & McCarley, 1992; Ashton et al., 1997; Michelson et al., 2002). The lone placebo-controlled study failed to demonstrate efficacy, possibly as a result of a higher than expected placebo response, gender bias (it was an all-female study), or lower than usual yohimbine dose used of 5.4–10.8 mg daily (Michelson et al., 2002). The customary dose is 5.4 mg taken three times daily. Nevertheless, the three other initial yohimbine antidote studies were promising, all having success rates above 80%. Generally, as is the case with other antidotes, the effect is seen by 3 to 4 weeks or not at all. Scheduled daily use can reveal whether this benefit will be experienced. Should the treatment prove efficacious, the dose may be reduced to one or two daily. In some cases, as needed dosing might also be successful.

Other Medications

A variety of other medications have been suggested as having potential benefit in reversing or managing antidepressant-induced sexual dysfunction, although there are limited data to justify these approaches. Nefazodone has been thought to have fewer sexual side effects as an antidepressant than most alternatives (Clayton et al., 2002; Ferguson et al., 2001). Unfortunately, there has been little research into the ability of nefazodone to treat iatrogenic sexual dysfunction. A single case report of successful use of nefazodone in reversing sertraline-induced sexual dysfunction has been published (Reynolds, 1997).

Granisetron had been thought to be helpful in reversing SSRI-induced sexual dysfunction because of its clinical action as a 5-HT_3 receptor antagonist (Nelson, Keck, & McElroy, 1997). Studies of its use have failed to show much utility. In fact, the two placebo-controlled studies failed to show any statistical separation from placebo, although the studies were likely underpowered for this purpose (Nelson, Shah, Welge, & Keck, 2001; Jespersen et al., 2004). Meston (2004) recently published a study regarding the use of as-needed ephedrine in the treatment of SSRI-induced sexual dysfunction. Unfortunately, she found no statistical separation from placebo.

Bethanechol has been reported to be helpful in treating antidepressant-induced sexual dysfunction. It is not known how useful it is with serotonin-enhancing agents, since it is a cholinergic drug acting as an agonist at this receptor (Gross, 1982; Segraves, 1987).

Testosterone

Although testosterone has not been systematically studied for antidepressant-induced sexual dysfunction, some mention of its use is warranted. Testosterone has a number of physiological roles. It is required for normal differentiation of male internal and external genitalia in the fetus, for the development and maintenance of male secondary sexual characteristics, and to promote sexual function in both sexes (Dorfman & Shipley, 1956; Breuer, 1980).

A significant number (2.1% to 23%) of the 20 million to 30 million men in the United States men with erectile dysfunction have below normal serum testosterone levels (Nehra, 2000). Testosterone declines with age in men. However, the pathophysiological and clinical consequences of this decline are unknown, especially given the wide range of normal testosterone levels. A man with borderline low testosterone may have functioned perfectly well his entire life, whereas another man with a higher amount could have had a clinically significant drop of a few hundred units and experienced significant alteration in his sexual response. With over a decade of

research, it appears that the classic candidate for androgen replacement therapy may be a male who presents with signs and symptoms of hypogonadism, including the inability to obtain and/or maintain an erection (Burris, Banks, Carter, Davidson, & Sherins, 1992; Arver et al., 1996).

Clinicians have long thought that female sexual dysfunction is tied to hormone status, especially that of testosterone (Kaplan, 1992; Kaplan, 1993). Low testosterone has been linked to diminished sex drive (Appelt & Strauss, 1984). However, many women with hypoactive sexual desire have normal testosterone levels. Some women with low testosterone levels have normal sexual drive, and high testosterone levels are not always associated with high libido (Meston & Frohlich, 2000). There are no medications currently approved for the treatment of female sexual dysfunction. This may be a consequence of less research in female sexual disorders, along with the lack of clear physiological origin for the majority of female sexual dysfunctions. Much of female sexual function depends on motivational factors, which may be largely affected by circumstance and the status of an interpersonal relationship. No medication is indicated to treat hypoactive sexual desire in either gender.

Whereas exogenous testosterone treatment can be effective when treating a subset of women with lowered sex drive, most of this research to date has focused on surgically menopausal women (Sherwin, Gelfand & Brender, 1985; Shifren et al., 2000). Although the mechanism by which testosterone exerts a prosexual effect in women is unclear, Tuiten et al. (2000) reported a significant increase in vaginal measures of blood flow and also subjective reports of arousal 4 hours after testosterone administration. Currently, testosterone is not FDA approved for any female sexual dysfunction. However, it is occasionally used in clinical practice, and early clinical trials suggest that it may be effective and safe in the treatment of low libido (Sherwin et al., 1985; Davis, McCloud, Strauss, & Burger, 1996; Shifren et al., 2000).

CONCLUSION

It is unfortunate that many commonly used medications are associated with sexual side effects. This is particularly problematic with almost all antidepressants, given that most individuals require continuation of treatment for mood and anxiety disorders for protracted periods of time. Patients often consider drug discontinuation solely as a result of their unwillingness to tolerate this side effect (Ashton et al., 2005). Patients may be willing to tolerate unpleasant side effects for short durations, but chronic adverse events that affect the quality and enjoyment of life challenge the patient and the physician to find an acceptable solution. Occasionally,

patients will simply choose noncompliance or drug discontinuation, especially when in their minds the side effects are worse than the illness being treated.

If physicians and patients are to strike a balance, a dialogue must occur. Options must be offered. Expectations must be disclosed. Patients want to stay well and hope that their side effects can be minimized. They want their doctors to understand their dissatisfaction and work with them to find resolution. Not every patient finds success after struggling against sexual dysfunction caused by medicine. Some patients must learn to live with their side effects, which is, of course, easier for patients who are not or choose not to be sexually active. As patients struggle with side effects, they expect their doctors to struggle along with them in the search for a remedy, despite the effort and exasperation this may entail. Patients do not know their options. They always hope something more can be done. Many, if not most, patients will benefit from one of the diverse options offered in this chapter. Some patients will need medication adjustment. Some will need augmentation with another medicine. Some will not have their problem resolved. However, patients may derive satisfaction either from clinical improvement, or in the journey to achieve it.

More research is required to more clearly define if a single approach is best. There is woefully little research in women. This may be due to a number of factors including the complexity of female sexual dysfunction and the difficulty of measuring success, the possibility of a greater role of emotion and attachment in female sexual functioning compared with males, and the lack of a blockbuster medication to compel the pharmaceutical industry to capitalize on new information and fund research. Perhaps the best medicine for both men and women has yet to be found. Until more is known, the strategies outlined here can be currently used to assist our patients experiencing sexual dysfunction, particularly when caused by serotonin-enhancing antidepressants. Sometimes, these very antidepressants assist us in treating sexual dysfunction, as is the case with premature ejaculation. In some cases, treatments for sexual dysfunction are clearly successful in most patients, as is the case with the PDE5 inhibitors when treating male erectile disorder.

We have come far in our search for medicines to improve sexual functioning. Hopefully, progress will continue, so that we may further enhance quality of life for our patients and allow them to experience their full sexual and relationship potentials, without forcing them to decide between illness and side effects. Until we have a superior choice, a particular patient may find success with any one of the many approaches discussed. Better sex through pharmacological adjustment is now obtainable for many. If our patients are willing to embark on this journey, they need us to escort them.

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Index

"f" following a page number indicates a figure; "n" following a page number indicates a note; "t" following a page number indicates a table.

B

C

G

H

N

O

P

Q

R

S

T