9 Poglavje:

SEXUAL THERAPY IN ERECTILE DYSFUNCTION

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Prispevek je napisan v angleškem jeziku, ker avtor ni slovenski državljan.

9.1 Introduction

Sexual therapy is a relatively new development in the treatment of erectile dysfunction and other sexual dysfunctions. During the 19th and 20th century different methods of treatment were used for management of impotence[1]. In cases of psychological („psychogenic“) impotence, the most used treatment during the first half of the 20th century was psychodynamic (analytic) individual therapy, but with very poor results[2]. During the 1960s Masters and Johnson did their seminal work on human sexual response cycle (and published it in a book Human sexual Response, 1965). Next, they developed a programme of treatment for people with different sexual dysfunctions (but primarily for patients with erectile dysfunction) (it was described in another book, Human sexual inadequacy, 1970). This therapy is called (psycho)sex(ual) therapy. Helen Singer Kaplan further developed sex therapy, as explained in her book The new sex therapy (1974) (Lew-Starowich et al, 2021). Her approach was a combination of psychodynamic, systemic and behavioural approaches, including pharmacotherapy (Kirana, 2015). Many other therapists (such as Heiman, LoPiccolo, Annon, Leiblum, Tiefer and others) further enriched sex therapy (Masters et al, 2006; Weiner & Avery-Clark, 2014).

Although sexual therapy is a relatively new development, sexology is much older and treatment attempts (including „talk therapy“) were introduced before sexual therapy was established. Sexology as a scientific filed was developed during the second half of the 19th century and one of the most important founders of sexology was Hirschfeld. He introduced a lot of things that are important for launching some filed into the arena of science and

[1] Impotence was the name for what we today call erectile dysfunction (ED) or erectile disorder (this is the name of the disorder in DSM-5). Due to the negative meaning of the term impotence and due to somewhat vague definitions of what impotence is, during 1980s this term was changed to ED.

[2] It should be noted that newer forms of dynamic interventions, introduced by Kaplan and developed by other researchers and therapists, have much better results. Sometimes, today, both behavioural and dynamic interventions are used together, for the treatment of sexual dysfunctions.

profession (such as founding societies, organizing congresses, writing textbooks, establishing professional journals).

Sexual therapy is important for both people who predominantly have physical reasons for their erectile problems (such as people with diabetes) and for those with primarily psychological causes of the problem (Lynn et al, 2023). Sexual therapy has proved beneficial even in cases of infertile couples (Starc et al, 2019). Research and clinical work show that even patients with defined physical etiological causes of ED still perform worse when they are under stress (such as with a new partner or when the relationship with the partner is under the pressure). It seems that additional psychological factors (primarily anxiety and stress) can lead to even worse erection and performance. Furthermore, in these patients, techniques used in sexual therapy can provide better satisfaction with their sex lives even though the firmness of erection in some cases will not be improved. The aim of any therapy in patients with ED is not to achieve firm erections but to achieve satisfying sexual relationships. Sexuality is much more than „just“ peno-vaginal or peno-anal intercourse. Sexuality and satisfying sexual life are more about understanding, intimacy, mutual caressing, enjoyment and fulfilment. Sometimes, men with ED might take PDE5 inhibitors and want to „use“ their ability to have erections despite the fact that the partner is not interested and because of their pressure relationship problems might arise (Westhemier, 2007). Finally, and in accordance with the previous discussion, many studies show that treatment modalities that are exclusively focused on erection per se (such as PDE5 inhibitors) will have low patient adherence and many patients will cease to use medication because there were no changes in other aspects of their sexual relationships (up to 50% of patients dropout from taking pharmacotherapy) (Carvalheira et al, 2012; Melnik et al, 2008; Park et al, 2013). PDE5 inhibitors do improve erectile function, but do not improve sexual intercourse satisfaction (Wiggins et al, 2018). Focusing exclusively on erection and performance actually increases performance anxiety.

Psychological factors can have a predisposing, triggering or maintaining role in cases of ED. Men with ED significantly more often have neurotic personality traits, and more often hold stereotypic beliefs about sexuality (such as: “a man always wants and is ready for sex”) (Lew-Starowich et al., 2021; Quinta-Gomes & Nobre, 2011; Nobre & Pinto-Gouveia, 2006). In regard to maintaining factors, men with ED tend to interpret negative sexual events as a sign of failure and personal incompetence (Lew-Starowicz et al, 2021; Nobre, 2010). Other

psychosocial factors influencing erectile function are: depression, lack of sexuality education, psychosexual trauma, disrupted childhood attachment, relationship difficulties, previous unsuccessful sexual encounters (Bilal & Abbasi, 2022; Arbanas, 2010).

In cases of psychological („psychogenic“) ED sexual therapy was devised as a specific technique for etiological treatment of the disorder. Yet, other treatment modalities (e.g. PDE5 inhibitors) are useful in its treatment.

Combination of psychosexual treatment and medication shows superiority compared to either technique alone (Boddi et al, 2015; Bossio et al, 2018; McCabe et al, 2010). Furthermore, men in the medication alone group showed decreased sexual function over time, whereas in the combination of sex therapy plus medication group, gains in sexual function remained and additionally, depressive and anxiety symptoms also diminished (Frühauf et al, 2013; Aubin et al, 2009; Bilal & Abbasi, 2022). The longer the follow up the better are results for the combined treatment, and the worse for monotherapy-pharmacotherapy group alone (Khan et al, 2019). This is probably the consequence of the fact that combination therapy addresses sexuality related beliefs and sexual activity related behaviours, and not just erection or ED symptoms. Also, combination therapy shows even better results at follow up 15 months later, compared to immediate results (and contrary to pharmacotherapy) (Bilal & Abbasi, 2022).

Sexual therapy can be individual or couple therapy. Couple therapy is superior to individual therapy because the couple can use techniques taught at the therapy session in real life situations (i.e. at home) whereas in individual therapy the patient and the therapist discuss about certain aspects that cannot be checked in real life. Furthermore, if a person with a sexual dysfunction is in a partnership, both partners are involved in a sexually distressing situation and therefore, both should participate in the therapy programme (Sadock J & Sadock J, 2007). Sexual problem usually reflects other problematic areas of a relationship and during sexual therapy the entire relationship is treated. Relationship quality was recognized as an important factor that influences the onset and maintenance of ED. Finaly, ED can lead to relationship distress because of loss of trust and closeness (Lew-Starowich et al, 2021). Whatever the sexual dysfunction, the other partner is always emotionally involved. In cases of ED, women may feel that absence of a firm erection is an attack on their own sexual attractiveness, believing either that the partner is not sexually attracted and

sexually aroused by them anymore or believing that the partner has another woman and is not interested in them anymore. Also, we should keep in mind that many female partners of men with ED also have a sexual dysfunction (Porst, 2015). In a joined couple session, more information and aspects can be discussed and evaluated (Master set al, 2006). For all these reasons, couple therapy is always advised, if possible. In some cases, couple therapy will not be possible (e.g. the person does not have a partner, the partner is not interested in participating in therapy sessions) and in such cases individual therapy is indicated. Nevertheless, patients should be informed that couple therapy has better results. This is especially true for ED, since studies have shown that participation of the partner supports the adherence to therapy, and partner involvement facilitates successful long-term ED-therapy (Dean et al, 2008; Silvaggi & Tripodi, 2013).

Teaching better communication (both communication about sexual issues, but also communication between the partners irrespective of sexual problems) is an essential part of any sexual therapy. The therapist will observe, during the session, how the couple is communicating, what mistakes they make during verbal and nonverbal exchanges and will suggest more effective ways of communication. Usually, these skills are trained during the session.

There are some general rules for sexual therapy that are used irrespective of the specific sexual dysfunction and there are some specific techniques used for particular sexual disorders (and in this chapter we will focus on those related to ED) (Kaličanin, 1997).

One of the general suggestions is to stop having mutual sexual intercourses (sexual intercourse is not just peno-vaginal, peno-anal or peno-oral penetration, but also different other forms of being sexually active and intimate such as mutual masturbation, kissing, caressing etc.). This ban of sexual interactions is introduced because partners who have sexual problems (including ED) are dissatisfied with their sexual interaction, usually they tried to fix the problem by themselves but failed and there is tension between them when talking or negotiating sex. Sex for couples with sexual problems is the sauce of anxiety, dissatisfaction, uneasiness and possible conflicts. We, as therapists, want to stop this and we want to introduce intimate contact that is comfortable, satisfying, pleasurable and enjoyable for both partners. Therefore, we ban sexual contacts and introduce other forms of intimacy and physical closeness (such as touching each other, spending time together, planning

activities etc.). Patients are usually puzzled by this ban and do not understand why this is introduced because they want to fix their sexual problem fast. For that reason, it is important to explain the rationale for this ban and when explained properly, patients usually understand it and keep to it.

Another reason for banning mutual sexual intercourses in cases of ED is the performance anxiety. Men with ED try to keep erection as firm as possible and as long as possible. For that reason, they stop enjoying the moment, they do not focus on intimacy, pleasure and satisfaction, but instead focus on the firmness of their erection. They keep record on the erection, check it, try to feel it and keep an eye on the penis to see if erection is still there. So, they shift their focus from the experiencing role (being the one who experiences joy, sexual arousal and sexual satisfaction) to the spectator role (being the one who watches and checks the erection). This inevitably leads to the loss of erection. So, even in cases when the person would normally have firm erection, because of this role shift erection ceases because the person is not focus on their own enjoyment but on checking the erection. Therefore, all forms of mutual sexual interactions are banned. Yet, solitary activities (such as masturbation) are encouraged because this is now the only form of ejaculation and it proves the man that he is still sexually functional (if there are no erectile problems in masturbation).

Psychoeducation is part of almost any sex therapy. Psychoeducation means sharing some important information about epidemiology, definitions, risk and maintaining factors of ED as well as sexual response cycle, basic anatomy and physiology. Normalisation, in cases when people have erectile issues that do not meet criteria for ED are the most important part of counselling. Some changes due to age (e.g. need for stronger stimulation) can lead inexperienced therapists to diagnose ED, when there is no true ED and people just need adaptation to their changing body (Westheimer, 2007; Arbanas, 2013). Appropriate psychoeducation will make the patient more able to reach informed decisions about treatment options. Addressing issues of smoking, substance abuse, obesity and exercise is important for managing erectile problems. In cases when men are using psychotropic, antihypertensive or any other kind of medications that can cause erectile problems, possible solutions should be discussed.

9.2 Sexual therapy for couples and individuals with erectile problems

9.3 Sensate focus exercises

Specific technique that was suggested primarily for ED patients is sensate focus exercises (SFE). This set of exercises can be modified for other sexual problems (such as anorgasmia, delayed ejaculation, painful intercours). They were first introduced by Masters and Johnson and further developed by other clinicians (Masters & Johnson, 1970; Jaderek & Lew-Starowicz, 2019; Arbanas, 2021).

The couple is first introduced to non-genital stimulation (known as the first phase or the first exercise of SFE). In this first step the partners are encouraged to touch each other (first one partner touches the other one, who is passively lying on their stomach, than turns on the back, and after that they change positions). Therefore, in this first exercise one partner is active and another partner is passive, and after a few minutes they change their roles. The active partner is instructed to touch the partner's body with different styles and pressures (e.g. they can touch the partner gently with fingertips, or more strongly with the palm, or with their lips or with the forearm or any other way). The toucher (and the person being touched) should focus on temperature, pressure and texture. The instruction is to explore the partner's body, to find out how the body of the partner is different in different parts, and how the body reacts differently if we touch different skin regions. Touching is done for one's own interest, for one's self, with focusing on sensations (rather than on trying to make themselves or their partners feel a certain way) – in other words - it is intended to cultivate an attitude of non-demand touching for one's own interest (Weiner & Avery-Clark, 2014). Genital touching and breasts should be avoided because they usually produce sexual feelings and people are tempted to proceed with sexual activities. The passive partner should be focused, during the touching exercise, on different sensations these touches produce. If any touch is uncomfortable or painful, the passive partner should inform the other partner because we want to set comfortable and enjoyable environment.

In some cases, one or both of the partners say they do not feel comfortable with exposing their bodies to their partner because they do not believe their body is sexually appealing. In such cases, especially at the beginning, these exercises may be done with clothes on or covered by sheets. The most important instruction is to make the exercise comfortable, painless and enjoyable as well as consensual.

This kind of touching is not aimed at relaxation, at being a massage or an erotic encounter, not a prelude to sex or a form of a foreplay (De Villers & Turgeon, 2005).

It is valuable to tell the partners that this exercise should be done regularly, at least twice a week. One partner is encouraged to initiate the exercise first time, then the other one should initiate the next exercise and they should exchange in the initiating role. That way the balance of power is equal since once a person is doing the exercise when really wants it and the next time the same person complies with the partner's wish to do the exercise. It is only fair to do it this way.

On the next meeting (session) the therapist will talk about the experience of the sensate focus exercise and what was enjoyable and if something was interfering with focusing on the sensation of touch. Also, any possible negative feelings associated with the sensate focus should be discussed. When the therapist decides (in partnership with the clients) that they are ready to go to the next step, the couple continues with the SFE series. The next step is introducing different types of touch: touching the partner's body with a bare hand and with a coved hand (with a sheet or some other textile), with a bare, naked hand and with a hand with a little bit of cream or oil, with the cold and the warm hand (put your hands under the cold and warm running water, wipe the hands and touch the partner) and many other varieties of touch. Partners can introduce forms of touching that both consider appealing. They are encouraged to experiment and be creative.

Next, touching the genitals and breasts is introduced, first as a non-sexual touch, later with the instruction to sexually arouse the partner (Nobre & Gouveia, 2000). In this „genital“ step of SFE it is important to repeat the instruction that the main goal of the exercise is not to experience sexual arousal but to focus on the sensations produced by the touch and experience of touch. Even if the man does not achieve erection, it is important to experience comfortable touch from the genitals. Usually, at this stage, when there is no organic cause to the ED, men do experience firm erections. Yet, penetration is not allowed. If a man experiences sexual arousal and erection, it is allowed either to reach orgasm with the help of the partner (but no penetration) or with his own hand. The same applies to the other partner. They are instructed to stop the stimulation once erection is firm and to concentrate on another body part till erection disappears. This will show the partners that losing erection during sexual play is not important; with the adequate stimulation erection will re-appear. Thus,

they learn that normally, during sexual activity, erection will wax and wane and not to get stressed about losing erection. Furthermore, it reduces the pressure to focus on firmness of erection (Masters et al, 2006).

The final stage of SFE is genital touch with arousal and penetration. The instruction is to penetrate with the penis but then, not to focus on reaching orgasm, but to the sensations in the penis (the warmth and the touch and contractions). This step can also involve trying different positions in penetration. In different positions different parts of the vagina or anus are stimulated and the penis is at different angles during penetration, which can produce slightly different sensations in the penis. Furthermore, in heterosexual couples, with the upper position of the woman, the woman has more control of the deepness and the speed of penetration. Masters and Johnson call this a sensual intercourse, as opposed to sexual intercourse (in sexual intercourse people are focused on reaching orgasm and ejaculation, in sensual intercourse people are focused on the sensations they experience in their genitals).

Furthermore, the couple is encouraged to introduce anything they believe it could increase the sexual arousal in any of the partners. It can be any form of sexual prompts: visual (watching pornography or sensual images or romantic scenes), tactile (in addition to human touch, different sex toys can be introduced: vibrators, cock-rings, etc), smell (e.g. candles), sounds (such as music or dirty talk or whatever they find arousing), role play (putting on particular clothes or role playing specific scenes or situations), sexual fantasy (use of fantasies, except for increasing sexual arousal can also be used to distract clients from anxiety concerns about performance and thus reduce the spectatoring role).

One of the most frequent resistances is expressed as claims of not having enough time to do the exercises. The therapist should openly discuss this question and ask the couple how motivated they are to solve the problem (if all the other daily tasks are put before the SFE) and if there are some hidden motives (unconscious, not even known to the client who uses it) that maintains the ED.

It is valuable to keep in mind that SFE should always be individualized and tailored to the individual case/couple. Each and every exercise should be modelled depending on the information we get from the patients – what they like, what make them anxious, what are their preferences, what is their idiosyncratic way of getting aroused and sexually responsive.

9.4 Mindfulness

Similar to SFE is the practice of mindfulness. It is an active and nonjudgmental awareness of one's body and bodily functions (Mize, 2015). The patient is taught to focus on a specific bodily sensation. In the beginning, the patient should be taught this technique in a non-sexual area because sexuality is a problematic topic (and the reason for contacting a professional), which produces emotional reactions (in our culture people often link sexuality with anxiety, shame and secretiveness) (Lew-Starowicz, 2021; Kimmes et al, 2015). Therefore, it is prudent to start with a body part or function that is not anxiety provoking, e.g. breathing or taste (this is similar to non-genital touching in the first step of SFE). The patient is instructed to be aware, to „watch" or to observe the rhythm of breathing, without interfering with the process of breathing (usually, the instruction is: „We breathe all day long, can you focus on your breathing, without changing the rhythm or any other aspect of your breathing, just observe whether you are inhaling, or exhaling; try to focus how deep in your chest can you sense the air that is coming from the outside to your body, …).

In the next step we advise the patient to try to focus on his sexual sensations (the touch on the genitals, on the breasts or on some other erogenous zone). This can be done at first during masturbation. The focus should be on all the sensations the person experiences, without thinking about erection. In the next step, the same can be done during sexual exchange with a partner.

Mindfulness improves ED by reducing anxiety that inhibits a sexual response and focusing attention on physical and mental sexual stimuli over distractors (Bossio et al, 2018). Mindfulness can be taught in a group setting. Such groups can enlarge the normalization effect compared to individual therapy (Bossio et al, 2018). The important part of the therapy is to do it regularly at home.

Be cautious with this technique in patients with somatization disorder or panic disorder, because these patients are keeping an eye on their physiological functions all the time and this exercise can make them even more aware of the body. For that reason, in such patients, this technique should be avoided. Also, mindfulness technique is contraindicated in cases of trauma because body scanning can allow traumatic memories to become conscious (Kimmes et al, 2015).

9.5 Cognitive restructuring

Another sexological device is cognitive restructuring. In this technique, firstly dysfunctional sexual beliefs should be recognized. Many men with ED develop these dysfunctional beliefs related to sexual performance. For example, a man can have a belief „I will probably fail" or „I have to have an erection" or „If I do not get an erection, I will fail as a man" etc. When such negative thoughts and related emotions are established, the person is asked to evaluate how adaptive they are and what are advantages and disadvantages of such beliefs. In the next step evidence for the belief and evidence against the belief is evaluated. Finaly, the client is encouraged to find alternative beliefs which are questioned the same way (are they adaptive?, what evidence do we have for them and against them?). When the person finds thoughts (beliefs) that are suitable for him, these should be practiced (Lew-Starowicz et al, 2021).

If patients are not able to recognize their negative, dysfunctional beliefs they can be asked to remember the last time they had an unsatisfying sexual encounter. Then, they are asked to vividly remember the situation in their mind and to describe how they felt and what they were thinking about (men will usually recognize that they were thinking about their erections and had fears of losing erection and then we should focus on the particular dysfunctional belief). The same can be done with successful sexual situations, to find positive and adaptive thoughts.

9.6 Management of anxiety

As anxiety is a predisposing factor for ED as well as a maintaining factor, it is important to address anxiety and to teach patients with ED how to diminish this negative feeling (Arbanas, 2016). Also, anxiety and depressive symptoms (the link between depression and ED is bidirectional – depression can lead to ED, but ED can lead to depression too; we should not forget about the negative effect of many antidepressant drugs on erectile function) are frequently found among men with ED (Bilal & Abbasi, 2020). Any technique focused on reduction of anxiety (such as progressive muscle relaxation, autogenous training, abdominal breathing, mindful breathing etc.) is a useful part of sex therapy. Anxiety can be alleviated also by exposing to the feared situation in fantasy (imagining having coitus or penetrating) or by assertiveness training (Masters et al, 2006).

9.7 Increasing sexual arousal

Discussing with a patient about arousal stimuli can have both a diagnostic and therapeutic purpose. People may have different stimuli that arouse them the most – it could be visual stimuli (e.g. watching someone who is sexually appealing to the person, watching porn etc.), olfactory stimuli (e.g. different scents), fantasy, touch, role play (e.g. participating in a specific situation) etc. In some cases, men will not have enough of such stimuli during sexual intercourse and this may lead to the loss of erection. For example, if a man is homosexual, but in a heterosexual relationship, the stimuli during their sexual encounter will not be arousing enough and he will need to fantasize about other men. Or, if a man has a specific paraphilic preference, sexual activity without them (at least in fantasy, if not in reality) will lead to ED. Discussing sexual fantasies, sexual orientation issues or paraphilic preferences should be part of every sex therapy. It has two roles. The first one is to establish the whole set of stimuli that are important for a particular man and to discuss with him if these topics are ego-syntonic (and therefore, the person can incorporate them in his sexual activities) or ego-dystonic (in which case other acceptable stimuli are to be found). The second is to discuss with both partners how they can make the encounter between them more sexually arousing for the man with ED (it is important to keep the balance of power in the couple and ask the same questions the other partner without the ED and making appropriate accommodations for the other partner too) and introducing those stimuli that are both welcomed by both partners and sexually appealing.

In some men, who masturbate in a specific, idiosyncratic way, stimulation during partnered sex is not specific and strong enough to maintain erection or to produce plateau and orgasm. Therefore, it is prudent to ask men about their masturbatory practices, especially if they have situational ED with no problems in masturbation. In such cases, masturbatory training and re-framing their masturbatory practices can be helpful.

9.8 Improving communication

Patterns of communication between partners can have a great impact on their sexual lives too. Therefore, communication training is an inevitable part of sex therapy. Partners are taught how to communicate in the session with the advice to practice it at home. Ways of telling things (so called „you talk“ should be switched to „I talk“ – for example instead of saying “You should wear more attractive clothes” the person should say “I like when you wear attractive clothes”) influence emotional reactions in the other partner. Partners are

taught how to communicate sexual thoughts and feelings (Nobre & Gouveia, 2000). Focusing on interpersonal issues (including communication issues) proved more effective compared to therapy focused on a sexual problem (Leiblum, 2002).

9.9 Psychotherapy

Along with these more specific and structured interventions, during sex therapy we will advise some non-specific, but intimacy enhancing suggestions. The couple is instructed to engage in pleasurable (nonsexual) activities together. Spending time together (e.g. playing a sport or some game, waking around, going to the cinema, cooking a meal together, sharing past good times etc) will make them more connected and intimate. Furthermore, mutual physical contact, such as bathing together or massaging one another, will enhance this even more. Also, encouraging partners to say good things to a partner is considered a good way of establishing better relations (Nobre & Gouveia, 2000).

All the interventions mentioned so far are behavioural or cognitive in their essence. Yet, patients with personality pathology (such as borderline or narcissistic personality disorder patients) or those who are involved in a pathological relatedness or patients with panic disorder will usually not benefit from such techniques in the treatment of their sexual problems because sexual dysfunction in their cases can be more deeply rooted. In such cases dynamic interventions should be added to the so far mentioned ones (Gabbard, 1994; Kaplan, 1988).

Nevertheless, even in behavioural therapy, when resistances to therapy appear, the therapist can use dynamic psychotherapy to address these resistances (Gabbard, 1994).

Dynamic approach consists of the detailed analysis of the motives that may be in the background of the erectile dysfunction. For example, a man can develop ED due to a fear of contracting AIDS or because he perceives his female partner as a motherly figure (not suitable to have sex with) or a homosexual man may experience religious prohibitions (if his religious upbringing and his sexual orientation interfere and produce shame and guilt) (Simpson, 1985). Or, maybe, in a partnership where a man feels dominated by his partner, ED can be the only way to gain control (by being unable to produce adequate erections, the person becomes the one with the „power“ in a relationship) (Gabbard, 1994). Furthermore, parental transferences to the partner can be uncovered and explored.

Some people find it difficult to participate in sex therapy. Some of the main complaints are: occasional experiences of difficulty in practicing present moment mindfulness at home, being hard do refrain from sexual intercourse while practicing SFE (Bilal & Abbasi, 2020). In the end, we should emphasize there are also contraindications for sex therapy. The first and most important one is sexual abuse in the couple. To proceed with sex therapy, it is important that both partners feel safe and secure. Some of the homework assignments (in SFE) should be stopped if they are uncomfortable, painful or if a person feels his/her boundaries have been crossed. If there is an ongoing abuse, the person will not feel safe enough to voice such objections.

Also, in cases of severely compromised partner relations there is no place for sex therapy. Such couples should first focus on their relationship (in a partner or marital therapy) and only after they solve the underlying issues they should continue with sex therapy. Several studies show that the therapists' global rating of the sexual relationship at the outset of therapy is a predictor of therapy outcome (Hawton et al, 1992).

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