After Sildenafil: Bridging the Gap Between Pharmacologic Treatment and Satisfying Sexual Relationships

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Erectile dysfunction is a prevalent and distressing problem. The availability of sildenafil citrate has significantly altered the way in which erectile dysfunction is treated. While this medication is extremely effective in restoring erectile function, it is often necessary to ensure that the partner is actively involved in treatment since many men are in relationships characterized by sexual apathy and avoidance as well as relationship conflict. These problems, if left untreated, can thwart the transition from sexual abstinence to sexual intimacy. Suggestions are offered for evaluating and intervening with men and their partners who are planning to resume a sexual life with sildenafil treatment for erectile dysfunction.
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Sexual dysfunction is highly prevalent in the United States in both men and women. A number of surveys have reported sexual problems in 10% to 52% of men and 25% to 63% of women.[1] Recent data from the Massachusetts Male Aging Study indicated that 34.8% of men aged 40 to 70 years had moderate-to-severe erectile dysfunction.[1]

In the recent reanalysis of the National Health and Social Life Survey,[1] a variety of negative feelings and interpersonal frustrations were associated with the report of sexual problems, including diminished physical satisfaction, lower emotional satisfaction, and reduced general happiness. Several studies have reported a significantly higher incidence of depressive symptoms in men with erectile dysfunction regardless of age, marital status, or comorbid disorders.[2–4]

As the most common sexual dysfunction of middle-aged and older men, erectile dysfunction is often a source of considerable distress. Defined as the inability to achieve or maintain an erection sufficient for satisfactory sexual activity, erectile dysfunction to some degree affects some 30 million men in the United States.[5] Although 80% of erectile dysfunction has a primary organic cause, psychological and relationship factors are nearly always present as well. In most instances, erectile dysfunction is caused and maintained by a combination of neurologic, vascular, pharmacologic, hormonal, affective, cognitive, lifestyle, and interpersonal factors. Effective treatment in couples with long-standing sexual problems usually requires a skillful blend of biological, psychological, and relationship interventions.

Recent advances in treatment permit most men with erectile dysfunction to select from a variety of treatment options. They include injection therapy and vacuum-pump devices, which have been proved effective. However, many men discontinue injection after 1 or 2 years.[6–8]

The introduction of the new oral medication sildenafil citrate has greatly altered the medical management of erectile dysfunction since it was approved by the FDA in March 1998. The availability of a safe, effective oral medication has enabled men who previously may have avoided treatment to consider a reentry into the sexual arena. Often, they seek the medication on their own, without consulting or, at times, even informing their partners. With motivated men and receptive partners, the success rate with sildenafil treatment is about 75%.[9] Less is known about treatment success with couples for whom there has been chronic sexual or marital conflict, sexual apathy or hypoactive sexual desire in one or both partners, or individual psychopathology or paraphilias.

When treating such couples or individuals, education, clarification, and psychological counseling are necessary before sexual activity—with or without sildenafil—can

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be successfully resumed. Without an exploration of each partner's beliefs about using a pharmacologic adjunct during sex and without an exploration of desires and fears about resuming physical intimacy, treatment may fail to bring about mutually satisfying sexual activity. With preparation, there is the strong possibility of a felicitous return to sexual activity.

THE IMPACT OF ERECTILE DYSFUNCTION ON THE INDIVIDUAL AND THE RELATIONSHIP

When a man first experiences erectile difficulties, his initial response may be to minimize the event, attributing it to inadequate rest, stress, or overindulgence in food or drink. Chronic erectile difficulties, however, often lead to feelings of humiliation, shame, and depression. In an effort to restore their confidence after an episode of erectile dysfunction, men will initiate sex at times when they are not really in the mood or when they chance to awaken with a firm erection. These attempts usually fail since they are accompanied by performance anxiety and little genuine sexual desire. A vicious cycle develops in which anxiety accompanies sexual activity and impedes erectile response, creating further anxiety and feelings of shame and frustration.

When erectile dysfunction continues, sexual initiation declines. Along with the disappearance of intercourse comes the avoidance of affectionate touching.[10] Many men and women feel that it is better to avoid something that "cannot be taken to completion" and that sex without intercourse is not really sex. Despite psychoeducational attempts to challenge their concept of what constitutes sex and efforts to expand their sexual repertoire, many couples continue to embrace the goal of penile-vaginal intercourse.

Usually, the wife's or partner's initial reaction to erectile failure is supportive, rather than critical. She may minimize the event by telling her husband that he is overworked or overstressed, reassuring him by saying, "Not to worry; it'll be better tomorrow." Over time, she may begin to experience and express anger, frustration, criticism, or even suspicion. She may begin asking herself, Does he still love me? Is he having an affair? Have I gained too much weight? To reduce her own frustration or to protect her husband from experiencing another disappointing encounter, she may collude with him to avoid sex altogether.

Over time, the relationship may begin to feel increasingly empty.[10] Where once small tensions could be easily dissipated by playful or affectionate touching and sexual interludes, there now exist few safety valves for tension release. Polite but platonic relating may replace spontaneous and easy intimacy. For some couples, physical and sexual abstinence becomes normative and predictable, even preferable.

The Sexual Equilibrium

As Levine[11] has noted, a sensitive balance exists between a person's sexual behavior and the partner's sexual responses, which constitutes the sexual equilibrium. The sexual equilibrium can easily be shifted by a change in one or the other partner—in either the sexual or the nonsexual sphere. Since each partner is simultaneously responding to the other's characteristics, a change in one will often trigger a change in the other. When erectile dysfunction occurs on a regular basis, it destabilizes the couple's sexual equilibrium and typically leads to sexual avoidance in one or both partners, often resulting in attraction to others, pornography, or chat rooms on the Internet, where they can indulge in sex or sexual fantasies without fear of failure or frustration.[11] Alternatively, sexual abstinence can occur, resulting in a new asexual equilibrium that can last for months, years, or even decades.

Case example. Robert, a successful CEO but very conventional and conservative man in his early 60s, had enjoyed tepid but regular intercourse with his wife of 35 years. While the relationship lacked passion, it worked. As he grew older, however, Robert needed more stimulation to obtain an erection, but his wife refused to actively stimulate him either manually or orally. His erections waned and then disappeared. His wife was not unhappy with this state of affairs because she had always simply acceded to, rather than sought, sex. Robert, however, was devastated. He had always prided himself on looking and feeling younger than his years, and a regular exercise program kept him fit. He sought therapy when he became aware of experiencing increasingly angry and critical feelings toward his wife and a strong feeling of attraction toward a young secretary in his office. As a devout Catholic, he was acutely distressed by what he regarded as disloyal and unacceptable feelings toward his wife.

After several sessions of individual therapy devoted to exploring his feelings of resentment toward his wife for her lack of intellectual and physical stimulation, he agreed to conjoint couple's sessions. His wife was a religiously devout, sexually inhibited woman who acknowledged no sexual desire. She was, however, devoted to her husband and to his well-being and happiness. It was possible to capitalize on these feelings of devotion and a wish to "do the right thing" by suggesting that sex would be more satisfying to her husband and enhance his feelings of adequacy and efficacy if she could be more sexually active. Moreover, in order to obtain erections, he needed her active involvement during sex. Robert had always wanted to experience oral sex, and up until this point, she had refused. Now, she indicated a willingness to try it at least one time. Subsequently, Robert went to see his doctor to be prescribed sildenafil. When a trial of sildenafil was suggested, his wife was willing to participate.

With sildenafil and erotic stimulation, Robert was able to achieve an erection firm enough for successful inter-

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course. His wife's realization of how important this was to him served to reinforce her new behaviors. Now, with a more responsive partner, Robert was able to recommit to his marriage in a genuine rather than perfunctory way.

The Aftermath of Chronic Erectile Dysfunction

To summarize, chronic erectile dysfunction can lead to sexual apathy as well as sexual avoidance. The reasons for this are complex and include the belief that erections are necessary for satisfying sexual exchange, male embarrassment or humiliation about undertaking sex without the assurance of an erection, hypoactive sexual desire in one or both partners, a lack of satisfaction with the past sexual relationship, preexisting individual psychopathology, and significant prior or current relationship discord.

THE INTRODUCTION OF SILDENAFIL

Sildenafil citrate, a potent inhibitor of phosphodiesterase type 5, is the first oral medication used in the treatment of erectile dysfunction that has been shown to be safe and effective. In double-blind, placebo-controlled clinical studies[12,13] conducted with more than 3700 patients with erectile dysfunction of both psychogenic and organic etiology, successful outcome has been reported in about 7 of 10 men. The most commonly reported adverse events are headaches, flushing, and dyspepsia, all of which tend to be mild and transient.

Sildenafil has made it possible for many couples to resume a sexual life, and its availability has radically changed the nature of erectile dysfunction treatment. However, in actual clinical practice, as opposed to clinical trials, the prescribing physician does not typically interview the partner of the man with erectile dysfunction or evaluate the existing relationship between the patient and his mate. Chronic or even acute hypoactive sexual desire or other sexual dysfunctions in either the patient or partner are usually not assessed prior to sildenafil treatment.

While sildenafil has clearly been shown to be efficacious in facilitating erections with appropriate stimulation,[9,12] it does not restore sexual desire, overcome sexual resistance, or treat relational discord. It is particularly important, therefore, to develop realistic expectations and receptivity in couples when there are indications of hypoactive sexual desire. The following case illustrates the kind of issues that arise when the wife displays sexual apathy.

Case 1: Arlene and Al

Arlene, an obese but well-groomed and energetic 56-year-old woman, initiated the request for sex therapy because of her total lack of sexual desire. She reported that she had once enjoyed an active and uninhibited sexual life, even to the point of calling her husband, Al, at work and inviting him to come home early. Al would happily oblige, since sexual activity was an important ingredient in his sense of well-being and masculinity. However, 3 years earlier, at age 53, Arlene had experienced a rapid and dramatic loss of sexual interest that was associated with the onset of menopause and increased irritation and anger at Al. Arlene was placed on estrogen replacement therapy, which alleviated vaginal dryness. The physical sensations of arousal were present, but she said, "I can't get emotionally aroused."

Adding to the problem was Arlene's long-standing dissatisfaction with her husband. His general obsessive style and the amount of time he spent at the office continued to exasperate her. Now that Al was having difficulty maintaining his erections during intercourse and even achieving erections, Arlene had become increasingly less willing to engage in any form of sexual exchange. As she said, "The only thing I really like is intercourse—and if he can't do it, I'm not interested."

Although Arlene's menopausal changes appeared to contribute to the problems, they were not the sole cause of her lack of libido, nor was Al's erectile dysfunction the only stumbling block to resuming sexual activity since he was quite willing to try sildenafil. Rather, Arlene's long-standing anger and disappointment with Al had to be addressed before she would become amenable to resuming a sexual relationship.

After 4 marital therapy sessions in which Arlene had an opportunity to recount her various disappointments with Al, her anger began to diminish, especially as Al began making notable behavioral changes. As had been repeatedly requested of him, Al began returning home from work earlier and spending more companionable time with Arlene. As the emotional atmosphere improved, it was possible to discuss the role of physical intimacy in their marriage. Who was sex for? Could (or would) Arlene derive any pleasure from sexual activity?

Initially, Arlene agreed only to nongenital touching, a foot massage. From there, she became more receptive to such nonthreatening activities as hand holding and writing messages on each other's back, initially while clothed and then while naked. Over time, she spontaneously initiated kissing, to which Al eagerly reciprocated.

Al was instructed to try sildenafil on his own, during masturbation, to see if he noted improvement in his erectile response. Arlene was enthusiastic about this, even saying that she wanted to be present to watch. As she observed Al's erection growing, she participated by stroking and kissing him, although she refused to be touched herself.

By the 12th session, Arlene and Al had begun engaging in regular sensual massage and more consistent genital touching. By the 15th session, they were having intercourse. Arlene said she was open to intercourse because she knew she would no longer feel frustrated. By the final session, they independently reported significant marital and sexual satisfaction.

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Comment. Men in their 50s who experience erectile difficulties often are married to women who are perimenopausal or postmenopausal. Many women have lost their appetite for sexual activity or even discontinued sexual activity because of inadequate lubrication and painful intercourse or because of disaffection or dissatisfaction with their longtime mates.

In the case of Arlene and Al, therapy was directed at creating the circumstances under which Arlene would become willing to engage in sex and involved negotiating compromises in the nonsexual relationship as well as suggesting exercises for a slow but sensual reentry into the sexual arena before engaging in intercourse. Masturbation provided a good transition step—one that Arlene shared initially as an observer and then as an active partner.

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Case 2: Susan and Sam

Susan and Sam had a bitter, querulous, and tense marital relationship: each felt cheated and deprived. Their problems began shortly after they got married, but worsened when Sam was diagnosed with Hodgkin's disease at the same time that Susan was pregnant with their second son. Susan wanted to feel special and sheltered at this time, but Sam received all of the sympathy and attention because of his diagnosis. Susan's antipathy and rage escalated over the years. She thought that Sam did not make enough money and that he was uncommunicative, passive, and generally inadequate. She made no attempt to disguise her critical and contemptuous feelings. Sam felt that Susan was hypercritical and unsupportive. Sex, always infrequent, dwindled to nothing when Sam developed erectile dysfunction. Now Susan had further ammunition to express her rage and disappointment in the marriage.

After 4 sessions of marital therapy, with the focus on communication and an acknowledgment of their mutual pain and disappointment, Susan announced that she thought Sam should try sildenafil, saying, "I'm too young to give up sex for the rest of my life; I used to be a very sexual person and I'm not going to dry up now!" Sam was loath to try the drug initially, fearing that it would not work and there would be no other viable options. We worked on this issue until Sam agreed to give the medication a try on the condition that Susan would keep her feelings of disappointment to herself if it did not work.

It is crucial to anticipate how couples will feel and what they will do if sildenafil does not result in an erection. It is important, too, to explore unrealistic expectations regarding both treatment success and treatment failure—that is, the fear that if the man becomes too enthusiastic about sildenafil-stimulated sex, the woman will be unable to refuse sex, or the alternative fear that if sildenafil does not initially (or ever) work, their sex life is over.

Sam and Susan decided to try sildenafil on their 10th anniversary, and to their relief, it worked. They were enthusiastic about how normal their encounter had felt. For the first time in our joint sessions, Susan had no complaints about Sam. Her attitude toward him softened, and she became more supportive about his work-related anxieties. Over the next few months, intercourse was successful each time they used sildenafil. A follow-up phone call revealed that life had greatly improved for them. Sam was employed at a new, higher-paying job, and their marital tension was low. Sexual intercourse, while infrequent, was successful and satisfying when they used sildenafil.

Obviously, not all conclusions of marital therapy lead to reconciliation. Often, where a truly hostile relationship exists and where optimism that problems can be resolved is missing, the fact that intercourse may be possible but resisted can serve as a powerful statement that the relationship is over.

ASSESSING THE SEXUAL RELATIONSHIP

When treating men with erectile dysfunction and their partners, it is important to conduct a thorough individual and couple assessment. Each partner's motivation and desire for sex must be ascertained, as should the level of sexual comfort and ease of arousal experienced, both alone and with each other. It is also important to explore how both individuals feel about using medication to treat erectile dysfunction. Myths and misconceptions need to be identified and challenged. Sildenafil does not work in an emotional or sexual vacuum, but only in response to effective sexual intimacy.

It is reasonable to expect that both partners will feel somewhat awkward and uncomfortable during the initial reentry into sexual intimacy and may need help in negotiating the transition. It is important to remember that some men secure and fill their sildenafil prescriptions without first discussing taking the drug with their partner. Their partners may be less than enthusiastic, particularly if they have been happily sexually retired.[10] For some women, the resumption of sex may uncover unresolved inhibitions or conflicts about body image, power, and loss of control. One 56-year-old woman, for example, noted sadly that she had gained some 30 pounds since the last time she had engaged in sexual activity, and she felt keenly self-conscious during her husband's attempts to provide sensual caressing. Another woman wondered if she was ready for the possible frustration and disappointment of an unsuccessful attempt at intercourse. Still other women worry about the possibility of experiencing dyspareunia. Many perimenopausal and postmenopausal women may report diminished lubrication or subjective arousal and reduced genital sensitivity. Clinicians may need to instruct them about the use of lubricants when resuming sexual intercourse.

Women and men should be closely questioned as to whether sex was something that was valued and then lost or something that was easily relinquished. For some

couples, there is concern that they will be obligated to engage in sexual intercourse more frequently than they would like simply because it is now possible. Women may worry that if they are not enthusiastic lovers, their partners will abandon them. The fears of both partners need to be voiced and addressed.

Years of avoidance and failure may be difficult to surmount without adequate preparation. This includes developing appropriate transition-into-sex behaviors, such as affectionate overtures, sexual teasing and innuendo, suggestive touching, and setting aside time and privacy for sexual encounters.

For some couples, there may be a downside to having successful sexual relations. For instance, if erectile dysfunction has dictated the amount of distance or closeness in the relationship, eliminating it may lead to other sexual dysfunctions or an increase in relational conflict.

Individual conflicts about becoming sexually active should be explored. For example, does either of the partners experience homosexual or paraphiliac attractions that have thwarted or interfered with heterosexual intercourse? Do both partners feel competent in initiating and conducting themselves sexually?

Most importantly, what is the level of satisfaction with the relationship, historically and currently? As Althof[10] has noted, while many women will be delighted to resume intercourse and are pleased about the improvement in their husbands' moods, others will prefer their asexual relationship, particularly if their past sexual life had been unrewarding.

REESTABLISHING A SATISFACTORY SEXUAL RELATIONSHIP

If both partners are comfortable with and committed to using sildenafil to enhance their sexual relationship, several steps can facilitate the transition to and continuation of mutually satisfying sex:

1. Misconceptions and expectations should be reviewed and challenged if unrealistic. At this time, couples need to be reminded that sex is not always wonderful but sometimes just okay. There will also be times when it is impossible to become aroused. Couples should be reminded that sildenafil will not work without sexual stimulation and does not increase desire.
2. It may be important for couples to rewrite or update their sexual script—the how, what, where, when, and why of sexual exchange,[14] particularly if a pill is needed as a prelude to intercourse and because this pill must be taken an hour before sexual activity. Couples should be encouraged to develop and maintain sexual flexibility—alternative ways of being together sexually—and to share sexual encounters that do not routinely include intercourse as a necessary ingredient.
3. It is important for both partners to articulate their conditions for having good sex. For the woman, this may include more emphasis on sensual touching and a much longer prelude to actual sexual activity such as enjoying intimate time together for hours, not just minutes, before the initiation or expectation of sexual intercourse.
4. Other sexual problems should be addressed and treated (e.g., premature ejaculation, ejaculatory delay, feelings of sexual inadequacy).
5. Other existing medical problems that may interfere with desire or arousal, such as depression or hormonal deficits, should be addressed and treated.
6. Nonsexual relational issues should be addressed and resolved, if possible.
7. Strategies should be devised for dealing with episodes of unsuccessful intercourse.

CONCLUSION

Most couples are delighted to resume a sexual life, and as demonstrated by clinical trials, many men with erectile dysfunction and their partners are satisfied with sildenafil treatment. Clinicians should be aware, however, that the availability of sildenafil as a treatment for erectile dysfunction can cause or uncover relationship problems in couples who have become accustomed to the lack of sexual intercourse. In these cases, couples need preparation and counseling in order to resume a mutually satisfying sexual life. Sildenafil often reduces the worry about erectile dysfunction and helps to facilitate a return to sexual intimacy, particularly in motivated couples. For such couples, appropriate medical evaluation and psychological counseling and/or education, along with the availability of sildenafil, can lead to greater sexual pleasure and enrich the lives of both men and women.

Drug name: sildenafil (Viagra).

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REFERENCES

1. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999;281:537–544
2. Feldman A, Goldstein I, Hatzichristou DG, et al. Impotence and its medical and psychological correlates: results of the Massachusetts Male Aging Study. J Urol 1994;151:54–61
3. Shabsigh R, Klein LT, Seidman S, et al. Increased incidence of depressive symptoms in men with erectile dysfunction. Urology 1998;52:848–852
4. Araujo AB, Durante R, Feldman HA, et al. The relationship between depressive symptoms and male erectile dysfunction: cross-sectional results from the Massachusetts Male Aging Study. Psychosom Med 1998;60: 458–465
5. NIH Consensus Panel on Impotence. NIH Consensus Conference. JAMA 1993;270:83–90
6. Weiss JN, Badlani GH, Ravalli R, et al. Reasons for high drop-out rate with self-injection therapy for impotence. Int J Impot Res 1994;6:171–174
7. Sundaram CP, Thomas W, Pryor LE, et al. Long-term follow-up of patients receiving injection therapy for erectile dysfunction. Urology 1997;49:

932–935
8. Flynn RJ, Williams G. Long-term follow-up of patients with erectile dysfunction commenced on self injection with intracavernosal papaverine with or without phentolamine. Br J Urol 1996;78:628–631
9. Padma-Nathan H, Steers WD, Wicker PA, for the Sildenafil Study Group. Efficacy and safety of oral sildenafil in the treatment of erectile dysfunction: a double-blind, placebo-controlled study of 329 patients. Int J Clin Pract 1998;52:375–380
10. Althof SE. New roles for mental health clinicians in the treatment of erectile dysfunction. Presented at the 24th annual meeting of the Society for Sex Therapy and Research; March 5, 1999; Boston, Mass
11. Levine SB. Sex Is Not Simple. Columbus, Ohio; Ohio Psychology Publishing Co; 1989
12. Goldstein I, Lue T, Padma-Nathan H, et al, for the Sildenafil Study Group. Oral sildenafil in the treatment of erectile dysfunction. N Engl J Med 1998; 338:1397–1404
13. Morales A, Gingell C, Collins M, et al. Clinical safety of oral sildenafil citrate (Viagra) in the treatment of erectile dysfunction. Int J Impot Res 1998;10:69–74
14. Rosen RC, Leiblum SR. Assessment and treatment of desire disorders. In: Leiblum SR, Rosen RC, eds. Principles and Practice of Sex Therapy: Update for the 1990s. New York, NY: Guilford Press; 1989:19–47

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