

Clinicians' Forum

From time to time, the editors of *Menopause Management* field interesting clinical questions and dilemmas. In this forum, our Editorial Advisory Board members, experts in a range of fields related to midlife women's health, tell readers how they handle these situations.

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Question: How would you manage and counsel patients with sexual problems related to a male partner's erectile dysfunction?

Answers:

The potential sexual consequences to the woman when her partner has erectile dysfunction (ED) are many. These include reduced arousal and desire, perhaps associated with self-blame; feeling insufficiently attractive, or "old"; or even fears that there may be another woman involved with her partner. There may be difficulties focusing because of distractions caused by worrying about the cause

of the erectile dysfunction, even the safety of potential treatments.

Another consequence of this situation is reduced arousal, associated with the need to "use" the (temporary) erection before it is lost. Unfortunately, the woman's lack of arousal and excitement due to the hurried nature of the situation will be obvious to her partner. This will, in turn, limit his sexual excitement and, therefore, his erection.

Dyspareunia often results from the hurried entry and "stuffing" of the semi-firm penis into the vagina, usually with the assistance of many fingers. There is often a lack of any intense arousal or orgasm—again due to the limited sexual play and brief, often aborted, intercourse attempt.

A woman whose partner has erectile dysfunction may fail to initiate sexual activity with that partner or "notice" his attempts at initiation because she fears any obvious enthusiasm on her part might be perceived as "pressuring" him. Unfortunately, this compounds his feelings of inadequacy and unattractiveness, and worsens his erectile dysfunction.

I would recommend that both partners be seen by healthcare practitioners, individually and together, if possible, in order to better explain the logic/normality of the changes in the woman's sexual function in the context of her partner's ED.

Practitioners must explain the need for the subjective arousal/excitement of both partners. Sexual excitement is "contagious" but, unfortunately, so is the lack of it. If phosphodiesterase inhibitors are going to be used, their benefit depends on the subjective excitement of the male partner. Moreover, if injected prostaglandin E₁ (PGE₁) is to be used, without both partners' excitement the method is disappointing and is usually quickly terminated.

I would recommend that the male partner be assessed for his erectile dysfunction from a biopsychosocial perspective (alternatively, the healthcare

practitioner may be able to do that herself/himself). Simply put, there are three basic aspects to this. First, there is a need to assess whether the sleep-induced and masturbatory erections are firmer than those with the partner. If so, psychological assessment is necessary in addition to any medical treatment. Second, whenever any other phase of the sex response is altered—for example, desire or ejaculation—a full inquiry must be made into mood, endocrine status, and prostate health. Third, before any erectile enhancement is prescribed, an assessment of the male partner's cardiac status, use of other medications, and general health and mood are necessary, as ED can be the presenting symptom of generalized cardiovascular disease or depression, and it is necessary to exclude serious cardiac compromise that could make orgasm or intercourse dangerous.

—Rosemary Basson, MD, FRCP (UK)

The first issue to discuss with the woman is how much she is really disturbed by the course of events. The second issue is whether she feels any responsibility. Does she have vaginal dryness, dyspareunia? Has she had a major change in libido? If so, was it a sudden change? Have the woman and her male partner been having other, nonsexual difficulties? Have they had a successful and active sex life prior to the partner's development of ED?

We can then go on to discuss the partner. Is he healthy? Does he have diabetes? Is he on any new medications: selective serotonin-reuptake inhibitors or beta-blockers?

At this point, the physician's goal is to address as many of the woman's issues as possible—both physical and emotional—and, of course, to "fix" whatever we can. Before referring the woman for sex therapy, she should be

advised as a first step to have her partner referred to his internist. It's important that the discussion not end here, but to make sure that you make an appointment for a follow-up after the partner's initial evaluation to help with the next step.



Lila E. Nachtigall, MD

The next step, after the partner's visit to the doctor, is to find out if he received satisfactory counseling and help. Is he now using one of the phosphodiesterase inhibitors? If so, will your patient now need other treatment, either for vaginal dryness or libido or arousal issues? Does the couple need further expert advice from a marriage counselor or a sex therapist? Sometimes, just referring the couple to a good book on the topic, or giving simple explanations about alternatives to intercourse is all that is needed.

Above all, being a sympathetic and attentive listener is key. This will allow the patient and/or the couple to feel comfortable about returning for further consultation if their needs have not been met.

—Lila Nachtigall, MD

Men and women often react differently to ED. For a man, erections can, by themselves, be seen as a means of affirming one's manhood, expressing one's power and potency, reassuring one's partner, and preventing conflict. For a woman, erections may symbolize a partner's desire for and interest in her sexually and emotionally.

The result is that problems with having reliable erections can mean different things to men and women. The man with ED may experience feelings of embarrassment, humiliation or sadness. "Is this the beginning of the end?" he may

wonder. His partner may be threatened, frustrated or suspicious: "Does he still love me and find me sexually desirable?" And just as the meaning of erections differ from one couple to the next, the absence of erections causes varying responses. For some couples, it's a minor annoyance, leading to a greater focus on "outercourse"—massage, sensual touching and oral stimulation. For others, it may signal the first step toward a sexless future.

In counseling patients, it is important to assess what the couple means when they complain of ED. Are they referring to unreliable erections, getting and losing erections before the woman has an orgasm, ejaculating overly rapidly, having erections but feeling little? Assessing both the physical causes and the psychological and interpersonal contributions to the erectile difficulty is crucial for a successful outcome. The goal of treatment should be not only helping the man and his partner to cope with ED, but helping them to develop realistic expectations about their sexual life. Determining the "conditions" or circumstances each needs in order to achieve an erection or to enjoy sex is critical. These conditions can be as simple as feeling safe, clean and mentally or physically relaxed, to a need to feel emotionally intimate and attracted to one's partner.

Education is often helpful, particularly about the changes in sexual response with aging, stress and/or medication. Women need to appreciate that men cannot "will" an erection, that the penis is attached to both the "heart" and the "head." A man who feels anxious, threatened, preoccupied or depressed may have difficulty getting or maintaining an erection. Reviewing the various vascular, hormonal and medication-related causes for ED is important, as well as helping a woman depersonalize the meaning of the erectile difficulty.

Affirming the couple's feelings of frustration or distress is necessary, as

well as presenting and discussing the various treatment options that are currently available. Is the couple interested in trying one of the newer oral medications for ED? Would they rather explore new ways of expressing and experiencing sexual intimacy? Do they need to alter their sexual "script"—that is, the how, when, where and what they do during a sexual encounter? It is important to be respectful of the couple's wishes in this regard, since for some women a partner's enthusiastic return to reliable erectile response can "destabilize" an existing nonsexual equilibrium in the relationship. This is particularly true if the woman has been enjoying "sexual retirement" or has negative associations with sex because of a disappointing past sexual life.

Couples also need to be counseled that while sex is perfectly natural, it is not naturally perfect. There will be times when, despite their best efforts, things will not go smoothly. Anticipating how to deal with less-than-perfect sex is essential, as is counseling couples to go slowly at first. For many couples in which ED has been a problem, physical intimacy has been put "on hold." These couples need to be reminded to first reconnect emotionally, and then affectionately, before attempting intercourse. "Foreplay" should begin 24 hours before actual intercourse!

—Sandra R. Leiblum, PhD



Sandra R. Leiblum, PhD

First, the healthcare provider must be specific about the problem the patient reports. The major categories of women's sexual problems that occur in response to a partner's ED are low desire, low arousal or orgasmic disorder. How much does the problem bother

her? This helps the provider know how motivated the woman is to try to help the situation. If she is mildly concerned but also very relieved for herself, there may be little reason for her to really want to help. If she is very concerned and fearful of the consequences (that he finds her unattractive, has another love interest, is unhealthy, is a workaholic), that may be propel her—even too forcefully—into getting help for herself and especially him. I would be straightforward in reflecting that she may be conflicted about approaching the issue for fear she would, in the former case, have to be more sexual than she wants to be if he gets “better” and, in the latter case, she might find out something personally upsetting. Both of these examples help illustrate why it may not be a simple matter to approach solving sexual problems for the persons experiencing them.

Second, if the woman is interested in addressing the issue, I try to give some basic information about approaches, ranging from less to more medical, and see how this suits the situation. I would ask the male partner for a consultation, either with the female partner or without her, depending on his comfort level. From that interview I would have a good idea of whether to head in a medical direction, given factors like the presence of illness or injury, the use of alcohol and cigarettes, medications, mood disorder and major stress. A medical workup would be the most clinically relevant first step. If none of these issues were present or the man had already been given a medical checkup I would suggest either individual or, more often, couples therapy to address the sexual problems (or relationship problems, if present). Often the female partner does not want to be part of the treatment if couples therapy is recommended. I prefer that both partners participate, and there are some data showing this to be effective but not enough comparative data to make clear

recommendations in favor of couples over individual treatment.

Third, if I began seeing the couple or the male partner, even if the problem is more medically based, I would try to explore what they would enjoy in terms of shared touch. Sometimes, without erections or the possibility thereof, neither wants to do much sexual touching (especially older couples) as it reminds them too much of what they do not have. But they might be willing to do comfort and companion sensual touching. If erections are possible with the use of medication (phosphodiesterase inhibitors), then I would encourage the couple to continue to do some sensate-focus exercises because they usually help a couple get back into sexual experiencing when they have been concerned about it. Which raises another point—if couples try one of the phosphodiesterase-inhibitor medications, tell them not to expect things to change all at once but rather to get easier with time. Anxiety or worry about erections, for both partners, can take some time to ease. All the more reason to try sensate-focus exercises, which help each person stay in the moment and in their physical experiencing. The exercises are simple but require some practice to do them correctly, so that they are helpful to the sexual experience. Incidentally, there are several books for couples in which one partner has a sexual problem affecting the other (see Resources). Patients sometime find these references helpful.

There are many other situations that may come up. Sometimes there are more hidden relationship problems or a lack of attraction that no one really wants to acknowledge or admit. And sometimes those “reasons” are post hoc. It is not uncommon for a couple to want a professional to say it is okay not to be sexual. Many couples become nonsexu-

al and remain loving and interested in the other as an intimate companion, although this pattern appears easier (and more culturally accepted) for women than for men. The real responsibility of the clinician is to find out the right solution for the given individuals in the particular relationship they have formed.

—*Julia R. Heiman, PhD*

Resources

- McCarthy B, McCarthy E. *Couple sexual awareness*. New York: Carroll and Graf, 1998.
- McCarthy B, McCarthy E. *Rekindling desire: a step-by-step program to help low-sex and no-sex marriages*. New York: Brunner/Routledge, 2003.
- Metz M, McCarthy B. *Coping with erectile dysfunction*. Oakland, CA: New Harbinger, 2004.
- Zilbergeld B. *The new male sexuality*. New York: Random House, 1999.



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