Feminist Sex Therapy in the Age of Viagra™

Pharmacological treatments of sexual dysfunction have opened a new and exciting area for clinical sexology and sex therapy. Used correctly they can help people to overcome fears of and actual sexual dysfunction. Used incorrectly, they can wreak havoc in the relationship or with the individual. The recent pharmaceutical debut of sildenafil citrate (Viagra™), and the ensuing stampede by male consumers to obtain it, is a significant historical moment in our collective sexual history. The advent of a medication that reduces the vulnerability of erections to some psychological and even medical causes of impairment provides many men with a “bionic” insurance policy against shame regarding their sexual performance. Undoubtedly, many men and their partners are well-served by sildenafil citrate (Goldstein, Lue, Padma-Nathan, Rosen, Steers, & Wicker, 1998). Such couples are unequivocally delighted at the remission of erectile problems, enjoying their regained ability to lose themselves in the sexual encounter without worrying about erections. For other couples, sildenafil citrate uncovers relational dilemmas, revealing the inadequacy of the medicalized construction of sexuality. The impact of any new medical innovation that makes it easier for men to have erections and thus to have penetrative sex must be understood within the relational and social context.

Fueled by the media and the anonymity and accessibility of the Internet, millions of patients are requesting pharmacological solutions for
erectile dysfunction. Clearly, not all individuals who would benefit from sildenafil citrate are availing themselves of it; conversely, many inappropriate prescriptions have been written. Our clients and the public in general will not be well-served if sildenafil citrate is used indiscriminately. Any intervention, including psychotherapy, can be misused or abused. Pharmacotherapy is no different. Sildenafil citrate is just the first in a series of drugs that will treat various sexual concerns. Sex therapists should familiarize themselves with the uses, abuses, and misuses of these drugs. Some patients will seek out a nonphysician to avoid confronting a physical defect or problem. The opposite is also true—patients who want to deny a psychogenic etiology of their dysfunction will present to a physician. The solution to this dilemma involves helping both sex therapists and physicians to incorporate these new medications in social and relational context.

Feminist Sex Therapy

Feminist sex therapy has led the field in recognition of the costs of dismembering of sexuality from relational context. Tiefer (1981) identified the influences of the positivist approach and of biologically based explanations of human sexuality in the misdirection of sex therapy’s focus away from sex-role, relational, or psychological issues. Seidler-Feller (1985) questioned the adequacy of sex therapy from a feminist perspective, citing the tendency to implicitly reinforce normative sex roles (Stock, 1983) and the power differential between the sexes that underlies them (Seidler-Feller, 1976). Tiefer (1988) also critiqued the DSM-III (1980) sexual dysfunction nomenclature as focusing exclusively on physical performance while omitting empirically based information on what women consider important in sexual life, including intimacy, negotiation, and communication. Tiefer (1988) adapted Reissman’s (1983) analysis regarding the negative consequences of medicalization for women’s sexuality, pointing out the processes of mystification, moral neutrality, and individualization of sexual problems inherent in the medicalized, traditional approach.

Mystification places definitions of “normal and healthy” sexual functioning in the hands of officially sanctioned experts rather than self-defined enjoyment, more often reflecting these experts’ reality rather than women’s. When medical science alone defines the norms for sex, an objective reality is assumed, leading to a stance of moral neutrality in which “sex is no longer a human arena for negotiation, but an arena where there is an objective standard against which performance can be measured” (Tiefer, 1988, p. 17). McCormick (1994) further identified the “nonconscious
equation of sexual activity with reproductive potential” that influences clinicians to equate sexual dysfunction with “physical failures in the performance of intercourse” (p. 188). In individualizing sexuality and sexual problems, medicalization denies and obscures the effects of social contributions to people’s sexual complaints, including rigid sex roles, unrelenting standards of performance, relationships of unequal power, and histories of sexual victimization.

Tiefer (1996, p. 53) recommended that feminist sex therapy include “corrective genital physiology education, assertiveness training, body image reclamation, and masturbation education.” McCormick (1994) also recommended that therapists treat individuals and couples for deficits in tenderness, poor communication, sexual selfishness, disinterest in oral sex, and unwillingness to cuddle, although she noted that deficits in these areas have not been assigned formal psychiatric diagnoses. A feminist approach to sex therapy uses existing scientific knowledge about biology, medical approaches, and empirically validated treatment techniques while adding the following ingredients:

1. Recognition of social and cultural gender inequality;
2. Recognition of the influence of this power differential in relationships, and a willingness to intervene at this level;
3. Valuing equally the subjective and affective aspects of sexuality, relative to physical performance;
4. Recognition of traditional sex roles as etiologic of many sexual problems, and a willingness to intervene at this level; and
5. Recognition of the unique experiences of men and women regarding sexual socialization, experiences of sexual coercion, sexual decision making, and the influence of relational factors in sexual dysfunction.

How Sildenafil Citrate Works

Sildenafil citrate facilitates erections in men with psychogenic, diabetic, vasculogenic, traumatic, and surgical causes of erectile dysfunction (Goldstein et al., 1998). It is not an “orgasm pill,” does not increase desire, and does not facilitate erection in the absence of psychological or tactile stimulation. Nevertheless, all these factors are interrelated; indirect effects are probably observed. Simplistically, erection is the process of sequestering blood within the penis to increase its size and rigidity (see Melman &
Gingell, 1999, for a complete discussion of the erectile mechanism). Tactile or psychological stimuli, or both, can initiate or sustain the process.

The blood is predominantly sequestered in the corpora cavernosa, two connected spongelike bodies in the penile shaft. The corpora cavernosa comprise a network of arteries, veins, nerves, smooth muscles, and sinuses (i.e., the spaces that actually fill with blood). The tunica albuginea is a thick, fibrous bilayer sheath that surrounds the corpora cavernosa. As the corpora cavernosa fill with blood, the tunica albuginea stretches to its capacity. The veins that drain the corpora cavernosa are compressed against and between the layers of the tunica albuginea, preventing outflow. The bulbocavernous muscles at the base of the penis contract, which raises the pressure above systemic blood pressure and results in a rigid penis.

The lining of the corpora cavernosa and some penile nerves produce nitric oxide (NO). The NO induces the production of cyclic guanosine monophosphate (cGMP), which specifically causes penile smooth muscle relaxation. In a process that is still not completely understood, smooth muscle relaxation leads to the trapping of blood in the corpora cavernosa. The NO also causes the arterioles (small arteries) to dilate, increasing the blood flow into the corpora cavernosa. The cGMP is degraded by phosphodiesterase type 5 (PDE5), an enzyme predominantly found in the penis. When the cGMP is degraded, the smooth muscle returns to its resting (contracted) state, the outflow of blood increases, and the erection resolves.

Sildenafil inhibits the action of PDE5, allowing smaller amounts of cGMP to produce an erection and for that erection to last longer (Goldstein et al., 1998). Similarly, less NO is needed to produce an equivalent amount of cGMP.

Sildenafil has been approved only for use in men; research on its effects in women is ongoing. Preliminary results are conflicting. Initial investigations reported that Sildenafil increased lubrication, genital sensation, ability to achieve orgasm, and sexual satisfaction among women with complaints of sexual dysfunction (Berman, Berman, Lin, & Goldstein, 1999; Berman, Berman, Werbin, & Goldstein, 1999). Application of topical Sildenafil was reported to improve arousal, genital sensation, and ability to reach orgasm in a small sample of women (23) with sexual dysfunction (Kaminetsky, 1999). Others, however, have found little evidence thus far that sildenafil is useful in the treatment of sexual dysfunction in women. Kaplan, Reis, Kohn, Ikeguchi, Laor, Te, and Martins (1999, p. 483), for example, concluded, “Our data do not support the use of sildenafil in treating postmenopausal women with sexual dysfunction.” Its effects and uses for women remain to be fully elucidated. In addition, sildenafil for women carries the same risks of misuse as for males.

There have been some reports of the usefulness of sildenafil in the
treatment of SSRI-induced sexual dysfunction in both women and men (Ashton & Bennett, 1999; Balon, 1998, 1999; Rosenberg, 1999a, 1999b). Men under treatment with SSRI antidepressant medications may experience an incidence of sexual dysfunction as high as 50%. Women also report orgasmic dysfunction, decreased genital sensation, and diminished sexual desire as a result of SSRIs.

Sildenafil citrate is well-tolerated with only minimal interactions with other drugs. The one major interaction is with nitrates (primarily used in the treatment of heart disease), resulting in serious and sometimes even fatal blood pressure decreases. One form of nitrate can be obtained over the counter: isobutyl nitrate, known on the street as “poppers.” Its illicit use involves inhalation of the fumes during sexual activity. It reportedly acts as a sexual stimulant (theoretically as another source of nitric oxide). Patients should be specifically warned against the use of sildenafil with any inhaled, recreational drug agent. It is important for the patient to tell the physician of any sildenafil use.

A high-fat meal will decrease the total absorption and delay the onset of sildenafil citrate. Taking one’s partner out for a romantic (high-fat) dinner and then taking sildenafil with dessert is unlikely to achieve the desired reaction. The most common side effects include headache (16%), flushing (10%), upset stomach (7%), and nasal congestion (4%; Pfizer, 1998). Abnormal vision also has been reported, predominately a bluish tinge to vision, but also blurred vision and sensitivity to light. All of these are mild, resolve with cessation of the drug, and rarely cause the discontinuation of the drug.

☐ Erectile Dysfunction and Sildenafil Citrate: Assessment and Treatment

Medical Considerations in Assessment and Treatment

Patients (and often their sex therapists) assume a sexual dysfunction must be psychogenic, if a recent medical evaluation has not revealed any likely cause. This reasoning is just as error-prone as when patients assume their dysfunctions must be organic because they have a “good” relationship. Not all the causes of erectile dysfunction are known, and we have a limited ability to demonstrate any factor as causative. When in doubt, erectile dysfunction is assumed to be multifactorial.

The therapist should first ascertain if the client’s physician was aware of the sexual dysfunction, so that a focused examination could be per-
formed. An undirected examination is unlikely to uncover the cause of the “unknown” sexual dysfunction. The sex therapist should know what constitutes an appropriate medical evaluation and suggest specialty evaluation when indicated. Even when the dysfunction is clearly situational or the result of psychogenic factors, a medical evaluation is the standard of care.

One concern of the present chapter is when and under what circumstances sildenafil may be appropriately prescribed. The following are our guidelines for the appropriate initiation of sildenafil:

- Rule out medical contraindications for the use of sildenafil. An exercise stress test may be appropriate to demonstrate that the patient can safely tolerate the physical exertion inherent in being sexual. Patients who are using nitrates even on an as-needed basis should not receive sildenafil.

- Rule out medical conditions that may present with erectile dysfunction. Finding reversible causes of sexual dysfunction is important, but identifying and treating chronic medical problems whose first symptom may be erectile dysfunction is equally important. The diagnoses of most concern are diabetes mellitus, hemochromatosis, hypercholesterolemia, hypogonadism, kidney disease, liver disease, prolactinoma, sleep apnea, thyroid disease, and vascular disease. The presentation of erectile dysfunction should always prompt an exploration of alcohol, tobacco, and drug use, with a strong recommendation to quit. Bicycle riding is also associated with erectile dysfunction; this includes stationary exercise bicycles (Solomon & Cappa, 1987).

- Rule out effects from medications or treatments prescribed for other conditions.

- Rule out other sexual dysfunctions or mental health problems that the patient may present as erectile dysfunction. This is meant to include both individual and relationship problems. Substance misuse, as well as substance abuse, can be a major factor in the etiology of erectile dysfunction.

- Sildenafil is readily available from many physicians, over the Internet, and from the black market. Patients often will turn to other sources if the physician refuses to provide sildenafil citrate without a clear medical reason. It is often prudent to give a small prescription of sildenafil while the more intensive evaluation is in process. In addition, the response or lack of response to sildenafil can have diagnostic implications.
• Erectile dysfunction alters relationships, even when the cause is clearly
organic. A referral to a sex therapist should be given in all situations.
The patient should be urged to inform and include his partner in the
decision to use the drug. Sildenafil has potential for use in sex therapy
to help a patient confront the issues that the dysfunction allows him to
avoid.

• Avoid open-ended prescriptions. Patients often stop using sildenafil cit-
rate even when it is effective.

• See both partners together whenever it is feasible.

Feminist Considerations in Assessment and Treatment

What would a feminist approach to sex therapy add to the notion of a
screening protocol for use of sildenafil citrate? The subjective and inter-
personal aspects of erectile dysfunction are sometimes overlooked in the
diagnostic process. Assessment should always include a detailed explo-
ation of the context and process of sexual initiation, sexual behaviors, typi-
cal duration, and physical and affective comfort levels for the activities
and for communication with each other about these activities (Kaplan,
1974). A feminist assessment protocol for any sexual dysfunction, includ-
ing sexual or relationship problems related to the use of sildenafil citrate,
might include the questions below. This assessment includes some stan-
dard questions used in conventional sex therapy, but it emphasizes issues
of communication, negotiation, initiation/refusal, power dynamics, eroti-
cism (genital and nongenital), and meaning. These are concepts that some-
times are given short shrift when the emphasis is on technical aspects of
sexual functioning and when a purely medical approach to diagnosis and
treatment is taken.

History

• Assess individual psychological functioning for each individual, includ-
ing general mental status, recent functioning, overall history, and sexual
history.

• Relationship history: how the couple met, course of relationship.

• Are there unresolved power issues in the relationship?
Pain/medical conditions

- Are intercourse or sexual relations not desired, physically painful, or problematic for either partner?
- Does either partner suffer from any medical conditions that would make penetration or sexual activity painful?

Meaning of sexual functioning/dysfunction

- Role of sex in the relationship: What functions does it serve?
- What is the meaning of erections/intercourse to the individual, to the partner, in the couple’s relationship?
- Why do they want sildenafil citrate, and what are their expectations?
- How much do both partners care about erections, intercourse?
- What would the meaning be of restored erectile functioning in this relationship?

Communication, sexual and otherwise

- How does the couple talk about sex?
- What are they thinking about when engaging in sex with each other?
- Are they able to share their thoughts and feelings with one another during, prior to, and after sex?
- To what degree do they each feel they must “function” to please one another and hide thoughts or feelings that might distract from the focus on “completing” the sexual “act”?
- To what extent is each partner able to be fully “present,” cognitively and emotionally, during sex?
- What priority is placed on having a sense of connection in relationship, emotional intimacy, sexually, and otherwise?

Initiation and refusal of sex/affection

- Can both partners easily initiate and refuse sexual relations?
- Can both partners express nongenital physical affection easily?
Passion and eroticism

- What is the experience of eroticism in relationship? Do the partners have the ability to touch erotically/sensually?
- What is the quality of tenderness and emotional connection?
- Do the partners experience sexual passion with each other? Did they in the past?

Even if significant deficits are reported in the couple’s relationship, sildenafil citrate is not necessarily contraindicated. Rather, all of these areas should be assessed, and the intervention should be directed accordingly to encompass the range of deficits, not limited to physical sexual functioning.

The Gender Politics of Sildenafil Citrate, Part I: Social Context and Historical Precedent

The social impact of the birth control pill in the late 1960s is an historical precedent worth examining in regard to sildenafil citrate. In freeing women from the risk of pregnancy, the pill removed a reason for women not to engage in sex. In a culture that did not, at the time, grant women an internalized sense of sexual agency, many women felt unable either to initiate desired sexual activity or to refuse unwanted sexual activity. With the removal of the risk of pregnancy, women lost their major external justification for sexual refusal. Invoking the fear of becoming pregnant had been the last, and sometimes the only, stopgap women felt they had in verbally resisting unwanted sexual intercourse.

During the sexual revolution of the late 1960s, the new norm dictated that to refuse sex on a date was evidence of sexual “uptightness” or outmoded prudery. It was not the oral contraceptive itself, of course, that was responsible for this change, but the gender politics surrounding sexuality. Women had never been seen as having a true internal locus of control regarding their sexuality. Although the feminist movement of the late 1960s and 1970s succeeded in introducing the concepts of control of one’s body, sexual choice, sexual harassment, and marital and date rape into the social vocabulary, these notions have continued to compete with those spawned by the sexual revolution. In the presence of an aroused male with an erection, women are still seen, and often view themselves, as
responsible for both causing and remedying the male’s sexual tension. Clinical approaches that have ignored the social context of gender inequality have often backfired, hurting the very populations that they were intended to help.

Many women in our culture continue to engage in unwanted sex that is not physically or emotionally satisfying and is sometimes physically uncomfortable. According to Laumann, Paik, and Rosen (1999) one-third of women (compared to one-sixth of men) said they are uninterested in sex. One-fifth of the women (but only one-tenth of the men) said sex gave them no pleasure. Most women can have orgasms easily by masturbating, and their sexual complaints are not generally due to a physical inability to enjoy sex, but are “psychological” in origin. It is clear that, since solitary sexual pleasure is possible for most women, it is sex in heterosexual relationships (in the majority of cases) that is problematic or nonpleasurable to many. Women in lesbian relationships report more frequent orgasms with partners and higher levels of sexual satisfaction compared to heterosexual women (Coleman, Hoon, & Hoon, 1983), but also report a lower frequency of genital sexual contact (Blumstein & Schwartz, 1983; Loulan, 1988) compared to heterosexual women. In contrast, older heterosexual women, whose male partners are more likely to use sildenafil citrate, are more likely to have lower levels of sexual desire than their partners, and may also have a preexisting lower level of sexual satisfaction relative to their partners. In this context, sildenafil citrate may function (like the birth control pill) as a double-edged sword in the sex lives of many heterosexual women and men, by providing a welcome return of sexual intercourse for some while increasing demands for sex without pleasure for others.

**Clinical Illustrations of Treatment of Viagra™-Related Sexual and Relationship Problems**

Feminist therapists who work with heterosexual or homosexual couples will likely encounter, at some point, a relational or sexual conflict related to the use of sildenafil citrate. How might the presence of sildenafil citrate play out in relational contexts? What issues will this pose for the feminist therapist, and how does feminist theory inform our treatment of such cases? The following examples highlight different therapeutic presentations of couples in which the male partner may be prescribed sildenafil citrate. These six clinical illustrations are intended to demonstrate a range of cases that might typically present for sex therapy, as well as the range of possible outcomes involving sildenafil citrate.
Positive Outcomes Examples

Ben and Elaine. The first example illustrates a nonproblematic and positive outcome. This couple exemplifies the ideal situation in which prescription of sildenafil citrate has only positive implications.

Ben and Elaine, both in their late 50s, present as a couple for sex therapy, reporting that Ben has had difficulty achieving and maintaining erections since the onset of his medical condition, diabetes mellitus. Based on their responses during initial assessment to the questions suggested above, it becomes apparent that Ben and Elaine have always had good communication, a mutually satisfying history of sexual functioning, and currently have no major areas of ongoing conflict. Elaine has always enjoyed their sexual relationship and is able to experience sexual pleasure and orgasm through manual and oral stimulation, as well as occasionally during intercourse. Both Ben and Elaine have been able to ask for what they want during sex, and both can freely initiate or decline sexual activity. This type of case represents that most likely to have a positive outcome. Sildenafil citrate is highly successful in assisting men with impaired erectile capacity who are in relationships in which they can experience subjective and physiological sexual stimulation and arousal with a partner who desires and enjoys sexual intercourse.

The positive effects sildenafil citrate can have include these:

- Men who have erectile problems can become very focused on getting and keeping erections. As long as technical competence is the major goal, the affection, tenderness, and communication that enhance sexual intimacy often are diminished. The partner may see the man as more concerned with erectile success than with mutual pleasure. By assuring a man of a lasting erection that will not fade after a few minutes of foreplay, sildenafil citrate allows him to attend to his partner, physically and emotionally, and to become more immersed in sexual activities as emotional experience. (As such, the fact that sildenafil citrate takes 30 to 60 minutes to work is an advantage.)

- Men with erectile problems may rush to insertion, fearing that if the erection is lost, they will not be able to attain another. This is a real fear, especially for middle-aged and older men who may experience a secondary refractory period—that is, the inability to obtain a subsequent erection after a prior one subsides without orgasm (Masters & Johnson, 1966; Moser, 2000).

- In the same way that sildenafil citrate may free men from the distrac-
tion of self-monitoring their erections, it may free their partners from this concern. Many partners of men with erectile difficulties also constantly monitor the status of their partners’ erections, worrying that they are not doing enough, feeling powerless (or impotent) themselves in their inability to help attain or maintain erections, or doubting their sexual skill or attractiveness.

- Perelman (1998) suggested that many men avoid condoms because of fear of erectile failure. By restoring sexual capacity, sildenafil citrate could result in increased condom use.

In the case of Ben and Elaine, the role of a feminist sex therapist would be largely psychoeducational—providing information, discussing possible etiologies of Ben’s erectile dysfunction, and suggesting how sildenafil citrate may affect their relationship as a couple. This approach is consistent with the fundamental beliefs of feminist therapy, which are to demystify the change process, to engage with the clients as equal participants in the change process, and to avoid the role of omnipotent “expert” by acknowledging the clients’ abilities to make informed decisions and use information themselves (Enns, 1997, p. 16). Following the institution of sildenafil, the therapist should continue to track the couple’s progress and adjustment to Ben’s renewed erectile functioning.

**Lou and Jay.** The second positive outcome involves a male couple. Lou and Jay have been in a committed relationship for 17 years. Lou is a 47-year-old entrepreneur who now owns a successful business. Jay is 52 years old, has his own consulting firm, but primarily works in Lou’s business. Both have AIDS, a history of AIDS-related cancers, and numerous opportunistic infections. Despite receiving state-of-the-art antiretroviral drug “cocktails,” both have detectable viral loads. Both have been in treatment for AIDS for more than 10 years.

Lou and Jay are both very knowledgeable about their disease, often bringing copies of the latest studies downloaded from the Internet to their appointments. As can be expected, the stresses from the disease, along with the more mundane stresses from their business and relationship, led both into individual and couple therapy. Each has his own individual therapist and they sporadically see a relationship therapist.

Lou has a history of clinical depression, but he is no longer taking an antidepressant. He does not meet the diagnostic criteria for depression presently. Both partners report a history of erectile dysfunction, mostly difficulty maintaining erections; less frequently, getting erections and lack of desire are also problems. Lou has been much more concerned about his
erectile difficulties. A complete diagnostic work-up was done without finding a treatable etiology, although it is not surprising in light of his numerous medical problems.

Lou followed the development of sildenafil citrate and called the day it was approved by the FDA. He was clearly disappointed when told that it was not in the pharmacies yet. When the first shipment of the drug had arrived, both Lou and Jay came in for a joint appointment to discuss how to use sildenafil citrate, its likely effects, and its possible side effects. A prescription for six sildenafil citrate tablets was given, one of the first prescriptions written.

Lou requested a refill the next day. Clearly, if he had taken sildenafil citrate as prescribed, he would not need a refill yet. When questioned, Lou confessed that the first pill was an amazing success. He gave a pill to Jay, who had an erection “like I was a teenager.” Like two kids in a candy store, they called another couple they knew and shared their supply of sildenafil.

While sharing prescription medication is inappropriate, illegal, and dangerous, it points out the importance for clients of regaining their functioning. Jay did come in for a complete work-up and was eventually given his own prescription. Both have refilled their prescription several times, Lou more frequently than Jay. They say they no longer share prescriptions.

Lou and Jay have seen several positive effects from their sildenafil citrate use: It has clearly drawn them closer together; performance anxiety has decreased; both report impromptu sex without the use of sildenafil citrate. Lou’s mood is clearly more upbeat and his self-esteem has increased. Jay has been more subdued. His health has been deteriorating, but he jokes about having to put on more weight to keep up with Lou.

The most notable effect has been a recommitment to the relationship. With both partners battling fatal diseases, there are obvious strains on the relationship. It seems they were drifting apart prior to the institution of sildenafil citrate; they now seem to have been drawn closer together. Both report an increase in the intimacy of the relationship. Both individual therapists and their relationship therapist report that the therapies are progressing well.

It is a truism that emotional intimacy leads to sexual intimacy. It is also true that sexual intimacy can lead to emotional intimacy. For whatever reasons a couple stops having sex, it generally leads to and may reflect other problems in the emotional aspects of the relationship. Part of the reparative process of the relationship is the reestablishment (or establishment in more severe cases) of the sexual component. Although renewing the sexual relationship too early can be an error, waiting too long can also be problematic.
Problematic Couple Relationships Presenting with Erectile Dysfunction

This second category exemplifies more problematic situations, in which the male’s erectile dysfunction is symptomatic of unresolved relational issues that underlie his lack of subjective arousal with his partner and are expressed in his inability to have erections in sexual interactions. Quite often in such cases, the nature of the erectile dysfunction is highly situational, and these men are capable of achieving erections and ejaculation during self-stimulation as well as with other sexual partners. Many such clients are highly reluctant to discuss their feelings with their partners or to enter couples or sex therapy and explore their feelings in that context. Below are examples of three couples who might seek sex therapy with the complaint of erectile dysfunction. Considerations for assessment and treatment are included.

Joe and Barb: Fears of Intimacy and Loss. Joe, age 52, has had difficulties achieving and maintaining erections since Barb’s mastectomy the previous year. He had always been aroused by the sight and touch of Barb’s body, particularly her breasts. The prospect of Barb’s death from cancer, from which she is currently in remission, deeply frightened him. He did not want to contend with the prospect of life without her. He has not discussed his feelings and reactions with Barb, feeling ashamed and unmanly for having them. Barb has kept her nightgown on from the waist up during subsequent attempts at sexual intercourse, based on her own discomfort with her body and her impressions of Joe’s possible reactions. Joe has withdrawn emotionally from the relationship in response to his fear of loss, vulnerability, and confusion over how to support Barb.

In the age of Viagra™, Joe might receive a prescription without ever being asked to describe the relational context of his erectile difficulties, let alone his feelings about them. In his attempts to produce and maintain erections, Joe has learned to avoid looking at Barb’s torso and to focus intensely on penile sensations. Apfelbaum (1977) described such effective sexual functioning as a defensive style called bypassing, identifying two subtypes: spontaneous and effortful bypassing. The latter, represented by Joe’s approach to Barb, is seen as motivated by performance anxiety, indicating that the client “has the motivation and ability to narrow down their [sic] consciousness at will, to hold an exclusive focus on sensation, tuning out any discordant notes in the relationship” (p. 60).

Apfelbaum (1977) noted that such clients more often present for therapy for postcoital depression than for sexual dysfunction. Sildenafil
citrate will likely facilitate Joe’s ability to produce an erection and decrease the physiological impact of his distracting thoughts, thereby allowing Joe to ignore and override his conflicted feelings about having sex with Barb. Ironically, Joe’s circumvention of actually being emotionally present during the sexual encounter is an heroic attempt to preserve sexual intimacy as this couple once knew it. Sildenafil citrate can be seen as a chemical bypass, a third subtype of Apfelbaum’s (1977) bypassing strategies, providing a powerful pharmaceutical boost when the male’s ability to bypass psychologically falls short of a full erection. Sildenafil citrate could allow this couple to continue “functioning” sexually around the specter of Barb’s cancer through a combination of psychological and medically assisted contortions.

Both Joe and Barb may suffer from believing they “should” be able to “get over” Barb’s cancer and that, with enough effort, they should be able to “get around” this. These beliefs become apparent during assessment, when both partners describe what they are silently telling themselves during each sexual encounter. A crucial aspect of assessment is to help the partners articulate their respective subjective thoughts and feelings during lovemaking, to themselves and to each other. Assessment here serves dually as intervention, as both may begin to experience increased empathy for the other, as well as a learning process of sharing what was previously censored.

Joe and Barb do not know how to have a conversation about the impact of Barb’s cancer and mastectomy on their sexual relationship. Both have engaged in a mutually self-protective dance of avoidance intended to save one another from further pain. Therapy can facilitate the sharing of grief, anger, fear, and insecurity that are elicited specifically in each sexual encounter. A feminist approach also can provide a context in which to examine the cultural hinging of female self-worth on physical appearance, and of male self-worth on strength and mastery. Barb’s cancer has thrown a monkey wrench into the genderized cognitive schema of self-concept for both partners. Joe’s sexual “dysfunction” could serve as a call to attend to these issues, rather than simply bypassing them by using sildenafil citrate. Sex therapy could allow this couple to use a very stressful and tragic event to push them toward a new and deeper level of emotional intimacy.

Ted and Alice: Power, Status, and Erectile Problems. Ted and Alice present for sex therapy with the specific complaint of Ted’s difficulty maintaining an erection. His erections typically subside shortly after vaginal penetration. Two years ago, Alice completed her degree in computer
science, was hired by a rapidly growing company, and had quickly advanced to a high-paying executive position. Ted now earns half of Alice’s salary. His previous role was as sole economic supporter of the family, and he had made most of the major economic decisions. Alice now participates more equally in these decisions. Ted has experienced a growing resentment of her that strikes him as illogical and childish. Alice is now working in a predominantly male environment. Ted, who considers her quite attractive, has begun to feel threatened by her close working relationships with several men, as well as feeling sexually inadequate.

As in the case of Barb and Joe, Alice and Ted do not know how to talk with each other about the impact of the reversal in their economic status in their relationship and Ted’s fear of loss of power. In spite of his conscious belief that sharing decision-making power with Alice does not make him less of a man, Ted is beset by lingering doubts. Exploring the meaning to Ted of his loss of role as primary breadwinner, and his resultant feeling of superfluousness and shame, would set the stage for assessing the meaning of Ted’s erectile difficulties to him. Ted’s loss of erections after penetration is likely linked to concerns with his sexual performance, and the extreme pressure he places on himself to be competent sexually, in contrast to his feelings of uselessness in other aspects of his relationship. A great deal more rides on the success of each sexual encounter for Ted now than in the past.

During the assessment process, Ted shares his embarrassing fears of being found lacking by Alice and then being abandoned or replaced sexually. Sex was the only area in which Ted felt he had something to offer in this relationship; it represented an opportunity to regain his sense of worth as a man, which paradoxically became unattainable once his erections became imbued with so much importance. In each sexual encounter with Alice, Ted had been trying to act as if he felt confident and in control, although the opposite was true.

Alice has felt sympathy for Ted in his predicament, but she also has begun to feel increasingly frustrated, impatient, and disappointed. She feels guilty and selfish that her success has come at such a high price for Ted. She also reluctantly admits that she is angry she cannot have both success in work and happiness in her relationship. She feels almost punished for stepping out of role by Ted’s inability to have erections sufficient for intercourse. Having intercourse with Ted makes Alice feel she is loved and sexually desirable. Alice, like Ted, has also been trying to behave as if nothing was wrong during their sexual encounters. When Ted loses his erection and they cannot continue with intercourse, she experiences it as a rejection of herself as attractive and lovable, and as a painful double-bind in having to pay a price for her success.

If Ted had received a prescription for sildenafil citrate, it is likely his
ability to maintain his erections would be enhanced. This would allow him to feel bolstered by his ability to perform sexually, and it would allow Alice to avoid sexual frustration and the sense of being punished for her success. In this case, the timing of when sildenafil citrate is used might be essential, as its use might not be inherently harmful to the couple. If prescribed initially, the motivation to explore and discuss the issues that likely resulted in Ted’s erectile problems would be vastly decreased. It is quite possible that although Ted’s erectile dysfunction might be ameliorated, it could be replaced by another symptom of his emotional distress—for example, hypoactive sexual desire, a somatic complaint, or some acting-out behavior.

Even in the absence of “symptom substitution,” Ted and Alice will likely have to confront the underlying issues of power and status in their relationship, or they probably will find the emotional gulf between them expanding. Premature prescription of sildenafil citrate might preclude this essential work. A feminist approach to sex therapy with this couple would encourage and teach Ted and Alice to talk about the issues precipitating Ted’s erectile problems, and to develop facility in sharing their anxiety about sexual encounters. This type of conversation may decrease much of the self-pressuring this couple does to “act as if” and, when articulated, can demystify the largely unspoken couple and cultural mythology about the importance of Ted’s erections. The couple also can be encouraged to explore the many other ways they can help each other experience sexual pleasure, which might begin to seem more exciting once erections are seen with a different perspective.

A hallmark of feminist therapy is the reframing of seemingly dysfunctional behaviors as having functional or survival value. The effect is to depathologize the symptom and to understand its meaning in the relationship. Another aspect of a feminist approach is the explicit intent to help the client gain freedom from assigned gender roles and recognize roles that are confining, restrictive, or oppressive for both men and women (Enns, 1997). It must be emphasized that feminist sex therapy would not automatically discount the use of sildenafil citrate for couples in treatment, but would pay close attention to the timing of its implementation. It would not be assumed that a return of sexual functioning would automatically help to mend the relationship, and clients would be encouraged to attend to the message the symptom of erectile dysfunction might have conveyed.

Bob and Carole: Keep It Down, or a Strike Against Alienated Working Conditions. Bob and Carole present for sex therapy due to Bob’s inability to maintain erections during sexual interactions with Carole.
He reports achieving erections during masturbation, often when fantasizing about other women. This couple has had very traditional gender roles in their relationship almost from the beginning. Although it was the initial intent for both to complete their degrees and work, Carole decided to quit before finishing, and then decided she wanted to have children, which was not their initial understanding. Bob felt unable to influence Carole directly in these decisions, and he has never felt he could express himself fully or represent himself well in discussion or conflict with Carole. Although he was in disagreement and resented Carole’s unilateral style, he shouldered the financial responsibility of supporting a family, afraid to rock the boat and endure further discussion and conflict. At the time of therapy, Bob feels trapped and resentful, although he still cares for Carole and their children.

Bob feels (accurately) that he does not have equal power or control in the relationship. He feels manipulated and trapped by his own sense of responsibility. Although he may not immediately articulate this, he likely experiences rage toward Carole for creating a situation in which she always has her way. He may also experience rage at himself for not better representing his own interests in the relationship. Bob’s erectile dysfunction could be seen as a “strike against working conditions” (Seidler-Feller, 1985) in his relationship. What emerges during assessment is that previous to the onset of erectile dysfunction, Bob would become “depressed” immediately following a sexual encounter with Carole. He would be in a bad mood for at least half a day. Carole had noticed this effect, but had not wanted to rock the boat, as most of her needs were being met.

In Bob’s case, it is possible that, if provided with a prescription for sildenafil citrate, he might be reluctant to use it. Wise (1999) described two cases with similar dynamics, in which the husband was angered by his wife’s challenge to his power. Similarly, Althof (1998) cited dropout rates of 20% to 50% in the medical treatment of erectile dysfunction, suggesting the strong need for sex therapists to be attuned to the complex individual and interpersonal factors that may determine resistance to drug treatment. The introduction of sildenafil citrate that is not sensitive to the relational context can have destructive consequences to a relationship, even if the sildenafil citrate remains in the bottle (Wise, 1999).

In the complex cases above, an immediate prescription of sildenafil citrate would likely preclude these couples from addressing the important issues described. The use of sildenafil citrate in such cases is not overtly inappropriate, but instead speaks to the more insidious encroachment of medicalization of sexuality into our relationships, offering a ready panacea for sexual dysfunction at the cost of emotional connection. These cases point to the need for multidisciplinary assessment and the appropriate timing of the introduction of sildenafil citrate.
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issues now. She was secretly relieved when Tom developed erectile dysfunction, and was pleased at the cessation of sexual pressure and demands. Although she is vaguely sorry for Tom, he has not been sensitive to her sexual needs or needs for nonsexual affection over the years in their marriage. Both Tom and Nicole have come to accept a basically distant marital status quo. The quality of the relationship is not sufficient to sustain Nicole’s desire to engage sexually with Tom, which otherwise might motivate her to pursue medical remediation for her postmenopausal sexual symptoms.

Women in general, and particularly older women, are often undiagnosed and underserved by medical and psychotherapeutic practice in the area of sexual difficulties; they are also frequently reluctant and embarrassed to act as their own advocates with medical professionals and therapists. With regard to sildenafil citrate, one group of urologists noted that 15 female spouses (55 to 75 years old) of male patients prescribed this drug had developed frequent, urgent, burning urination, diagnosed as cystitis (Little, Park, & Patton, 1998). Although “honeymoon cystitis” is not necessarily a sign of an unwilling or unhappy partner, it further demonstrates the need for involvement of both partners in treatment.

Men experience age- and illness-related decrements in their erectile ability. With sildenafil citrate, men like Tom may want to renew sexual intercourse. If Tom is prescribed sildenafil citrate, he may assume that because Nicole provided him with sexual intercourse in the past, she will again now. If she does not want to lose Tom, because of either emotional or economic factors, Nicole may reluctantly cooperate again with non-rewarding, often painful sexual intercourse in response to Tom’s sexual pressure.

If Tom and Nicole enter couples sex therapy, they may be presented with more beneficial options. For better or worse, the availability of sildenafil citrate has created a crisis that may lead to the dissolution or the reinvigoration of their relationship. The couple must be helped to determine if sufficient motivation exists, or can be developed, to create the conditions under which they would want to have an improved sexual relationship. This requires first addressing broader relationship issues of reciprocity, mutuality, and empathy for the other’s position. If the couple is prepared to do this work, they may be able to approach the previously abandoned arena of their sexual relationship. If either partner refuses to engage in this work, Tom will have to choose between foregoing a sexual relationship, seeking extramarital sexual outlets, or leaving the relationship entirely. These alternatives, however painful, should be addressed as part of therapy. In the best of outcomes, the introduction of sildenafil citrate could serve as a catalyst for change, presenting a challenge and an opportunity for both partners to move toward creating a more intimate relationship.

This type of case presents the therapist with an ethical dilemma. The
therapist must avoid colluding with the heterosexual imperative, or the “cult of intercourse” (Hite, 1976), and also avoid joining with the male partner and cultural context in pressuring the female partner to explore or engage in unwanted sexual contact. On the other hand, the therapist cannot ignore the desire of the male partner to be able to express his sexuality. It is incumbent upon the sex therapist to be aware of the cultural and possible economic pressures already bearing on Nicole, in the case above, to submit to unwanted intercourse as her “wifely obligation.” Because this context is so common and pervasive that it may recede as “ground” rather than emerge as “figure,” the therapist must swim against the tide of the couple’s taken-for-granted social reality, as well as the therapist’s own internalized socialization. Even if economic circumstances cannot be changed in therapy, identifying and naming the money issue as a variable that may dramatically impact Nicole’s options is appropriate and necessary within the scope of feminist sex therapy. Medical treatment for Nicole’s physical symptoms presents a potentially seductive pseudosolution to the therapist. Hormone replacement therapy, the application of topical estrogen cream, and the use of lubricant could provide a remedy for Nicole’s physical discomfort, and the advantages and disadvantages of these options can certainly be discussed when appropriate. But the therapist must first and foremost consider and ask the couple, “Why would (or should) Nicole want to engage in sex with Tom?” and “Must sex include sexual intercourse?” There is considerable social pressure on the therapist to try to “fix” Nicole, yet it is imperative that the therapist resists this pressure, while helping the clients to articulate their choices and the reasons they might have for making them.

The Gender Politics of Sildenafil Citrate, Part II: Effects on Heterosexual Relationships

Although men have generally welcomed sildenafil citrate as a panacea for erectile problems, references to the ambivalence felt by some women have begun appearing anecdotally. Erectile dysfunction may function in some relationships as the “canary in the mine” of relationship problems, a somatic marker of individual or relational distress, as vaginismus or orgasmic dysfunction might for some women. Now men can produce erections in situations where in, the past, they might have wilted. Pharmacetically enhanced erections can increase the ability to disconnect from affect, thereby obscuring relational disconnection, or they can spotlight that tendency.
The presence of erectile dysfunction changes the dynamics of communication and affection in a relationship beyond the reduction or cessation of sexual intercourse. Men with erectile problems often refrain from any expressions of tenderness for fear of raising false hopes in their partners. Women may do likewise to avoid inducing pressure or guilt in their partners.

The implications for sex therapists of the larger cultural context of sildenafil citrate’s introduction demand that we remain acutely aware of the positioning of this drug in our clients’ lives and in the larger culture. We need to be cultural resisters rather than accomplices to these trends as we conduct our therapy with individuals and couples. Women’s psychological and physical health have not, to date, been well-served by the medicalization of sexuality.

**Summary**

Sildenafil citrate is a boon for couples in which the male’s erectile difficulties are not symptomatic of relational distress. However, when lack of emotional intimacy, power struggles, or failure to create the conditions that would generate sexual desire characterize relationships, sildenafil citrate may delay attending to relational intimacy. Although a common, cultural male fantasy is to be able to function like a machine, as the sexual equivalent of the Energizer bunny, both men and women lose something if medical interventions allow us to function without the necessity of emotional connection. By lowering the threshold for physical or psychological stimulation to result in the physical ability to have sexual intercourse, are we improving sexuality or increasing our alienation from one another? Is the ability to perform like a sexual machine desirable, individually or on a cultural scale? What does this medically augmented ability of the body to function even in the presence of relational disengagement do to the subjective experience and deeper meanings of sex? Sildenafil citrate may well function as yet another double-edged sword on the frontier of both women’s and men’s sexual development and exploration. We must continue to pose these questions, in our theory building and in our practice, to counteract the potential for alienation and mechanization of sex. Instead, we must seek to foster a model of sexuality as having the potential for a human, connective experience.
References


