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Sexual Medicine, Sex Therapy, and Sexual Health Care

CHARLES MOSER, M.S.W., Ph.D., M.D. AND MAURA DEVEREUX, P.A.-C.

The goals of both Sexual Medicine and Sex Therapy are similar and include restoration and/or enhancement of the sexual experience, but the practices of sex therapy and sexual medicine have little in common. Although each ostensibly acknowledges the importance of the other, the literature is lacking substantially in articles or chapters that discuss the integration of the two approaches. The area that has the most obvious overlap is the evaluation and treatment of sexual dysfunctions. Both sex therapists (i.e., individuals with training in a variety of psychotherapeutic disciplines) as well as clinical sexologists and sexual medicine practitioners, who may include physicians, physician assistants, and nurse practitioners, believe their respective approaches are essential for a complete evaluation. The perspectives of each discipline (or set of disciplines) are different, and the methods used to attain their goals differ. In this chapter, we will discuss the commonalities and differences between the two approaches.

Definitions

“Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity” (Pan American Health Organization, 2000, p. 6). Sexual health includes the enhancement or optimizing of sexual functioning.

Sexual medicine is a relatively new medical specialty that focuses on medical aspects of sexual concerns and the sexual aspects of medical concerns. Sexual medicine practitioners seek to help patients with their sexual concerns by surgical and pharmacological interventions. They seek to intervene with the physiological aspects of sexual functioning. Nevertheless, expert sexual medicine practitioners recognize the importance of counseling, and many have become quite adept at both the psychological evaluation of individuals who present to them, appreciate the importance of sex therapy, and are adept at motivating patients to see sex therapists. It is clear that counseling can help turn apparent pharmacologic failures to successes (Banner & Anderson, 2007; Melnik, Soares, & Nasselo, 2007). Sexual medicine also involves the general

medical care of sexual minority patients, treatment of gender dysphoria, treatment and prevention of sexually transmitted infections, etc.

Sex therapy is a specialization of general psychotherapy treating sexual concerns, though there is some debate about whether this area requires any specialized training (Binik & Meana, 2009). This chapter focuses on sexual dysfunctions, but sex therapists also treat other sexual concerns. Some individuals would distinguish sex therapy (psychotherapy to address sexual dysfunctions) from clinical sexology (psychotherapy to address other sexual and gender concerns, e.g., gender dysphoria, paraphilias, alternative sexual lifestyles). Expert sex therapists recognize that a variety of medical conditions can present with sexual symptoms and that, sometimes, the sexual symptom leads to the diagnosis of a non-sexual medical condition (e.g., heart disease).

Comparing the Perspectives

Historically, within the field of sex therapy, the couple has been viewed as the client (Masters & Johnson, 1970). It is the couple who has the problem. Their sex life is shared, even if the presenting problem is assigned to one partner. A couple who feels sexually fulfilled even if the sexual functioning is sub-optimal does not have a problem. A couple who is not sexually fulfilled even if their sexual functioning is adequate does have a problem. Sex therapy (and other) techniques can be employed to improve or enhance their sexual functioning. Sex therapy employs a series of techniques to help the couple break the dysfunctional style that brought them to treatment. Even if the problem is primarily physiologically based, sex therapy techniques can help the couple develop alternative ways to compensate for the physiological limitations.

Sexual medicine practitioners attempt to intercede surgically or pharmacologically to enhance sexual functioning that has diminished as a result of various physical conditions. For example, it is well known that the treatment for prostate cancer may damage the nerves involved in erections. Various pharmacological and surgical treatments can compensate for that damage. Sexual medicine practitioners recognize that physical problems can have psychological manifestations as well (e.g., anxiety, feelings of inadequacy).

In some cases, modifying the treatment for other medical (or psychiatric) concerns can eliminate sexual side-effects related to that treatment. For example, the sexual medicine practitioner may choose alternative medications for hypertension or depression, change the dosing or timing of those medications, or add other medications specifically to overcome the sexual side-effects of the original medication. It is also possible for pharmacological enhancement of sexual functioning to help alleviate the sexual sequelae of "purely" psychogenic sexual dysfunctions.

Both sexual medicine practitioners and sex therapists may recommend adoption of a healthy lifestyle (e.g., quitting smoking, losing weight, increasing exercise, decreasing alcohol consumption). Sexual concerns often have

both organic and psychogenic causes and ramifications. Both aspects must be addressed.

Reasons for the Discord Between Sexual Medicine and Sex Therapy

Experienced practitioners from both disciplines recognize that most individuals present with mixed etiology. Each discipline will admit that an evaluation by practitioners of the other discipline is often prudent, but there are obstacles to establishing dual evaluation as the standard of care.

The most obvious obstacle is that sex therapists and sexual medicine practitioners are not evenly distributed in each locality. The clustering of *expert* sex therapists and sexual medicine practitioners is even more skewed. It may not be possible logistically for an individual to be evaluated by practitioners of each discipline. Even if practitioners of both disciplines are available, financial and insurance limitations may restrict the access to other services. Not all patients/clients can afford (in time or money) both evaluations, and many American practitioners do not accept any or all insurance plans. This problem is confounded by the large number of uninsured individuals, at least in the United States, and the reluctance of large health care organizations to hire sex therapists and sexual medicine practitioners. Another major obstacle to an integrated health care approach is patient choice. Individuals may say that they do not want a “pill” to obscure the problem; they wish to have the clinician treat the underlying cause. Other individuals may indicate that psychotherapy is too time consuming, too psychologically invasive for them, or too expensive and want a pill (or similar “quick fix”) to alleviate their problems. Many individuals report having seen incompetent or judgmental sex therapists or sexual medicine practitioners previously. Such experiences have led them to seek interventions from practitioners of the other discipline and to reject contact with members of the “offending” discipline.

Lesser reasons for the discord between disciplines include fears that another practitioner will “steal” their patients; mistrust of or disbelief in the other approach(es); distrust of the motivation of other practitioners (e.g., beliefs that physicians are bought off by pharmaceutical companies, that therapists are anti-physician); and fears that the other discipline will influence inordinately one’s approach (as if that is undesirable). Few sexual medicine practitioners attend conferences focusing on the latest advances in sex therapy, and few sex therapists attend conferences focusing on latest advances in sexual medicine.

Determining Causation: Psychogenic or Organic or Both

In this section, we will attempt to discuss the problems involved in making an accurate diagnosis and determining etiology. Some practitioners believe that classifying the etiology of the problem correctly is the solution to the turf battle between sex therapists and sexual medicine practitioners. Their reasoning suggests that psychogenic problems should be routed to the sex

therapists and the organic problems routed to the sexual medicine practitioners. It is just not that simple. Essentially, all sexual concerns have both components present, and both may need to be dealt with in order to achieve successful outcomes.

The mind-body relationship is possibly most obvious in sexual concerns. In general, there are no physiologic problems that do not have psychological sequelae, and almost by definition, psychogenic sexual concerns affect physiologic function. If an individual experiences anxiety that inhibits sexual response, then that is a psychogenic problem with a physiological response. If an individual is upset by decreased sexual function due to a medical illness (e.g., diabetes, prostate cancer), then that is a physiologic problem with a psychological response.

In an age of direct marketing of drugs by pharmaceutical companies to American consumers, it is not uncommon for individuals to present with "erectile dysfunction" because it is the only sexual concern they can name. After taking a sex history, the practitioner may determine that the individual's erectile functioning is not impaired, but that there is, in fact, a different sexual problem (e.g., rapid ejaculation). Similarly, a radio or television show may highlight a particular problem, which sounds close enough to the viewer's own concern that it is reported as the problem. For example, an individual may characterize a lack of arousal with his partner as a generalized lack of desire or as erectile dysfunction. Occasionally, sexually healthy individuals can be convinced by the media that they have serious sexual problems (e.g., "sexual addiction").

It is problematic when professionals adopt the patient's diagnosis without conducting an adequate history (and a physical, for sexual medicine practitioners). Regardless of the nature of the presenting complaint, it is always a clinician's responsibility to make the correct diagnosis. A patient may report abdominal pain, but it is the physician's responsibility to distinguish nephrolithiasis from appendicitis. Patients may say they are sad or suicidal, but the psychotherapist needs to distinguish between major depression and bipolar illness.

In many cases, the sequence of diagnoses is meaningful. The clinical approach in treating a man who first reported lack of desire that then led to erectile dysfunction should be different from treatment of a man who first reported erectile dysfunction that then led to lack of desire.

Language and the Assessment Process

Patients often do not have the vocabulary to describe their symptoms. The terms they know are slang, vulgar, or cutesy (e.g., "My down there is not working right"). The patient often feels uncomfortable using such terms with a professional, and they are difficult for the professional to interpret correctly.

Professional terms are not value-free, and their definitions are evolving. For example, the term “premature ejaculation” is giving way to “early” or “rapid ejaculation” among clinicians colloquially. The diagnostic criteria for each of these remain vague, of limited utility, and provide good examples of value-laden terminology. Recent proposals suggest that 1 minute should be the minimum acceptable duration of intravaginal ejaculatory latency (McMahon, 2008). Unfortunately, such definitions only pertain to heterosexual men in penile-vaginal coitus. “Homosexual premature ejaculation” is an afterthought. More to the point, it has been, in essence, defined out of existence. Similarly, some women attain orgasm early in the sexual experience and then decline further stimulation, because of increased genital sensitivity. This can be misconstrued as sexual aversion, an inability to lubricate adequately, or dyspareunia. Nevertheless, it may be equivalent to “premature ejaculation” in men.

Assessment

Appropriate guidelines for assessment of sexual concerns change over time, so these recommendations should be seen as a starting point and not exhaustive.

Patients (and often their sex therapists) assume a sexual dysfunction must be psychogenic when a recent medical evaluation has not revealed a likely cause. This reasoning is just as error-prone as when patients assume their dysfunctions must be organic because they have a “good” relationship with their partners.

The sex therapist should first ascertain if the client’s physician was aware of the sexual dysfunction and the reason for the exam, so that a focused examination could be performed. An undirected examination is unlikely to uncover the cause of the “unknown” sexual concern. The sex therapist should know what constitutes an appropriate medical evaluation and suggest specialty evaluation when indicated. Even if the sexual concern is clearly situational or the obvious result of psychogenic factors, a medical evaluation is the standard of care. The sex therapist should be aware of the common medical conditions that can result in sexual dysfunction (e.g., diabetes mellitus, hemochromatosis, hypogonadism, kidney disease, liver disease, prolactinoma, sleep apnea, thyroid disease, prostate disease, vascular diseases). Adverse medication effects or medication interactions should also be considered.

A thorough medical evaluation should include a complete history and physical. Occasionally, the onset of diminished sexual functioning is the first sign of heart disease, diabetes, or other disease. If the patient is known to be suffering from a medical condition that could result in sexual dysfunction, the onset or worsening of the sexual functioning may signal progression of the disease. Special attention to substance use, misuse, and abuse is warranted.

Just as a thorough medical exam is the standard of care, a thorough psychological assessment is also the standard of care. A sexual complaint may

be the presenting symptom when the patient has a non-sexual psychiatric disorder. The couple as well as the individuals in the couple need to be assessed medically and psychologically.

Psychosocial Considerations in Assessment and Treatment

The subjective and interpersonal aspects of sexual dysfunctions are sometimes overlooked in the diagnostic process. Assessment should always include a detailed exploration of the context and process of sexual initiation, sexual behaviors, typical duration, and physical and affective comfort levels for the activities and for communication with each other about these activities (Kaplan, 1974). This assessment includes some standard questions used in conventional sex therapy, but it emphasizes issues of communication, negotiation, initiation/refusal, power dynamics, eroticism (genital and non-genital), and meaning. These are concepts that sometimes 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 (Stock & Moser, 2001).

History

- Assess psychological functioning for each individual, including 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 and 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 treatment/therapy, and what are their expectations?
- How much do both partners care about intercourse and other sexual activities?
- What would the meaning be of restored sexual 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 non-genital physical affection easily?

Passion and eroticism

- What is the experience of eroticism in the 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?

All of these areas should be assessed, and the intervention should be directed accordingly to encompass the range of deficits and not be limited to physical sexual functioning.

A Case Example

Mr. and Mrs. A have been married for 30 years. This is the first marriage for each. They have two daughters, 28 and 25 years of age. Mr. A is a 65-year-old obese attorney who has diabetes mellitus, hypertension, depression, and a history of a myocardial infarction that occurred at age 60. Mrs. A is a 62-year-old obese high school teacher who suffers from hypothyroidism and who completed menopause 10 years ago. They do not smoke. There is minimal alcohol use (averaging less than one drink per person per month). They both report a good marital relationship but admit to having grown apart over the years.

They describe their sex life as having been excellent early in the marriage and marital coitus as having been frequent (three to seven times per week). Both report that they were orgasmic during coitus and that conflicts about sex were minimal. Each reports having engaged in some additional masturbation in the early part of their marriage. Both deny extramarital affairs. Over time, the stresses of work, child rearing, and health problems led to decreasing frequency of coitus and eventuated in the complete cessation of their partnered sexual activity 3 years ago. Neither reports any masturbation

in the last 4 years. Prior to cessation of coital attempts, Mr. A noted increased difficulty in maintaining erection, and Mrs. A noted some dyspareunia, an increase in post-coital urinary tract infections, and decreased desire.

About 2 years ago, news reports about drugs to treat erectile dysfunction led Mr. A to obtain a few tablets of sildenafil (Viagra™) from a friend who had a prescription. He surreptitiously took a pill one night, began masturbating to attain an erection in the bathroom, and emerged to display his first erection in years to his wife. She responded with a complete lack of enthusiasm, basically saying, "Get that thing out of here." Mr. A never took another sildenafil tablet and never broached the subject again. Mrs. A began hearing about a new medication to treat low sexual desire in women and wondered why she had given up on sex so easily. She remembered how badly she felt about her response to her husband's attempt at rekindling their sex life. After some discussion, they decided to seek treatment. Both agreed that other marital issues also needed attention.

How would this case typically be handled? Unfortunately, inadequate clinical care is provided too often by clinicians of every variety. In the following sections, average treatment will be illustrated. The average quality of care will then be contrasted with optimal sexual medicine and sex therapy practice, demonstrating that clinicians can work together to ensure integrated, high quality of care.

Among both general psychotherapists and health care practitioners, there is a reluctance to deal with sexual concerns. Generalists say that they have not had the requisite training or experience to add these techniques to their practices, and they are correct. Some generalists are interested in and would like to develop these skills and knowledge base, but do not have time or resources to do so. Some professionals decline to see these patients, while others do so under protest. As mentioned previously, expert care may not be available in all communities, so professionals who are at least willing to see these patients may be the alternative to no care whatsoever. For the purposes of this chapter, we will call these individuals "the less than enlightened" group.

The Less-Than-Enlightened Sex Therapist

Subsequent to Mr. and Mrs. A's admission of marital problems, the sex therapist decides to initiate traditional marital therapy to deal with these problems. The therapist hopes to ameliorate at least some of the major marital problems, increase communication skills, and re-establish the marital dyad. Upon attaining these goals, short-term, goal-focused sex therapy could then build on the

new intimacy of their relationship. The sex therapist requests that Mr. and Mrs. A undergo medical evaluations with their primary care physicians to ensure that the medical causes of sexual dysfunction were being dealt with or ruled out.

The therapist's decision to focus on marital concerns initially rather than to deal with sexual concerns from the outset may signify less comfort with sex therapy or even with sexuality for this therapist. Nevertheless, Mr. and Mrs. A's presenting problem is sexual, and their sexual concerns should be treated in a timely fashion. Even if the therapist feels that other marital issues take precedence, the couple should be told the rationale for not dealing with their sexual concerns at the beginning. Too often, the marital therapy drags on and the sexual concerns are not resolved adequately.

Unfortunately, the role of medical factors is often ignored or relegated to last place. Without input from a sexual medicine physician, the sex therapy can become merely a series of exercises to promote sensual touching and intimacy but without the good erections and adequate lubrication that they seek.

Although the relationship may be strengthened by marital therapy, the couple becomes resigned to a less than satisfactory sex life. Many relationships are vibrant, fulfilling, and loving without sex, but our bias is that a physically and emotionally fulfilling sex life would make any relationship better.

The Less-Than-Enlightened Physician

Mr. and Mrs. A have a variety of medical problems that could interfere with their sexual functioning. After brief office counseling and appropriate consultation, their primary care physician concludes that a medical work-up will delineate all the couple's medical problems.

Physical and laboratory evaluation confirm Mr. A's diagnoses. The physician believes that since Mr. A can walk up two flights of stairs without difficulty or stopping, he can engage safely in sexual activity. Mr. A's depression, hypertension and diabetes appear controlled adequately on his current medication regimen. Therefore, no further evaluation is needed.

Physical and laboratory evaluations also confirm Mrs. A's diagnoses. No obvious cause of her dyspareunia is found, and the physician surmises that her vagina is atrophic secondary to lack of estrogens. The physician reviews the latest data on risks and benefits of hormone replacement therapy with her and concludes her risk of complications is too great to initiate this treatment. She is offered lubricants and post-coital antibiotics if urinary tract infection

symptoms arise after intercourse. The physician supports referral to a marital or sex therapist, suggesting the patients return as needed.

With appropriate release of information forms signed by the patients, the physician sends copies of his work-up to Mr. A's cardiologist and psychiatrist and Mrs. A's gynecologist. (The primary care physician manages Mr. A's diabetes and hypertension and Mrs. A's hypothyroidism.) Of note, the primary care physician does not think that the sex therapist would be interested in his work-up, so the sex therapist is not copied.

Mr. A is told his problems are "all in his head." The physician neglects to prescribe a phosphodiesterase type-5 inhibitor (PDE-5, e.g., sildenafil, vardenafil, tadalafil) with appropriate instruction in its use. It does not occur to the physician to recommend a change in Mr. A's anti-depressant, even though most anti-depressants are notorious for causing erectile dysfunction. All blood pressure medications can cause erectile dysfunctions, but the effect tends to be idiosyncratic (i.e., it can vary from patient to patient and can be dose-dependent). Changes between classes or even within a class of antihypertensive drugs can be useful. Pointing out that lifestyle changes can improve sexual functioning (Hannan, Maio, Komolova, & Adams, 2009; Harte & Meston, 2011) provides added motivation to make these changes, but again, the physician does not discuss these changes.

Most physicians (and nurse practitioners and physician assistants) have little training in the medical work-up and treatment of sexual dysfunction, or desire to acquire that training. Few are aware of the sexual side-effects of the drugs they use commonly and treatments they provide. It is important that a focused sexual medicine evaluation by an expert be initiated before concluding that the physiological causes of the sexual problem have been investigated adequately.

The Expert Sex Therapy Perspective

After appropriate individual and couple psychological evaluations, Mr. and Mrs. A are given options as to how to proceed. They choose to try to regain their sex life before tackling other marital issues. The sex therapist begins with a variety of non-genital touching exercises to be completed at home. The response and resistance to these exercises guide the next sex therapy assignment for these patients. The therapist pays attention to other marital issues and may attempt to intercede if they become salient during sex therapy.

The sex therapist makes a referral to a sexual medicine physician and obtains a release so physician and therapist can share information. Both physician and therapist work together and support the couple in continuing with both medical and psychological interventions.

The sex therapist considers requesting that the physician prescribe a PDE-5 inhibitor, if it is not medically contraindicated. With the use of these drugs, erectile difficulties may no longer be blamed or scapegoated for his avoidance of intimacy. The option of taking the PDE-5 circumscribes some “excuses” for avoiding sexual contact (as in, “My lack of an erection means I am not turned on by her” or “I would fail if we tried to have sex.”) The meaning and feelings engendered by having an erection can be explored in therapy. PDE-5s also shorten the refractory period, so that it is easier to attain another erection. In older men, the refractory period is apparent after loss of erection even without ejaculation.

If Mrs. A still is experiencing dyspareunia, other non-penetrative sexual activities can be explored. The PDE-5 can help Mr. A maintain an adequate erection longer, so he no longer has to rush to use the erection before he loses it. Mr. or Mrs. A can be sure that Mrs. A is adequately lubricated in order to decrease her dyspareunia.

The sex therapist may request that the physician perform a pelvic exam to determine the extent to which organic factors contribute to Mrs. A’s dyspareunia and lack of desire. Despite the lack of specific complaints, the presence of depression, anxiety disorders, and other psychiatric issues may be uncovered. Mrs. A’s possible dissatisfaction with her role in both society and marriage may be and can be explored.

The sex therapist will dispel myths about sexuality and aging. Issues surrounding retirement planning, relationships with their children (and possibly grandchildren), and developing new shared activities for the couple will help re-establish the couple’s intimacy. Other marital issues will be dealt with during the sex therapy process.

The Expert Sexual Medicine Perspective

The sexual medicine physician will perform a complete history and physical exam, with appropriate laboratory studies on both Mr. and Mrs. A. Their medical problems will be managed in a comprehensive manner. When medical specialty care is needed, the sexual medicine physician will coordinate care with the other specialists and primary care physicians. It is possible that Mr. and Mrs. A will have different sexual medicine physicians, so each will coordinate care with the other.

A series of trials to find medication regimens that are less disruptive to sexual functioning than their current antihypertensive and anti-depressant drugs will be undertaken. The goal is not just to attain “readings” in the normal range, but to maximize sexual functioning. An example is Mr. A’s testosterone level. Low normal

testosterone levels may not be adequate for appropriate nitric oxide synthetase functioning, which could limit the effectiveness of PDE-5 medications.

The sexual medicine physician may discuss the risks and benefits of vaginal estrogens to treat Mrs. A's atrophic vagina, recognizing that her quality of life may take precedence over relatively rare side-effects or the increased risk of other medical problems, depending on her particular history. The sexual medicine physician ensures that the individuals are physically capable of engaging in sexual activities and may suggest changes in position or activities to accommodate any physical deficits.

Referral to a sex therapist is offered early in the process. If the patient declines the referral, the sexual medicine physician will offer it, again, as the medical evaluation and treatment progresses. Whenever possible, the sexual medicine physician ascertains that the partner also receives an expert sexual medicine evaluation.

Just as the sex therapist is expected to have knowledge of sexual medicine, the sexual medicine physician is expected to have knowledge about the sex therapy process and sexuality in general. The sexual medicine physician may appropriately be called a sex counselor, but does not have the time or training to engage in sex therapy with patients.

The Combined Approach

The hallmark of the combined approach is interdisciplinary respect and evidence-based treatment. In communities where expert sex therapists and sexual medicine physicians both practice, each should be a resource to the other. In communities where one or both experts are lacking, each should attempt to obtain expert consultation from other practitioners. Currently there are Internet based email discussion lists for both sex therapists and sexual medicine physicians, where informal consultations can be obtained. The relationship between sex therapists and sexual medicine physicians should be collegial, with each attempting to educate the other whenever possible.

After the presenting problem has been ameliorated, both sex therapists and sexual medicine practitioners will see the patient in follow-up at set intervals. Too often after successful outcomes, the couple's dysfunctional relationship styles will re-emerge. At these follow-up appointments, the possibility of further enhancement of sexual functioning will be offered. Sexual functioning is not static; it is neither good nor bad, neither healthy nor disordered. It is a continuum, where improvement can always be sought.

Other Resources

There is a variety of resources for the couple that may be useful in some situations. Sex coaches (individuals who give advice about sex), sex educators, physical therapists (including those who specialize in the treatment of pelvic floor problems), pharmacists, herbalists, stores that sell sex aids and toys, and Internet support groups all can be useful in specific situations. These resources are often not regulated by professional or government licensing authorities. Caveat emptor.

Conclusion

The professionals who treat sexual concerns are hampered by the isolation of their various disciplines. In the end, this results in a disadvantage to the patient. All patients deserve a thorough evaluation of their sexual concerns, which can best be attained by a team approach. Clinical excellence should integrate the various approaches. Professionals should be aware of the methods and latest advances in all aspects of sexual medicine and sex therapy.

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