

# Helping people with sexual problems: combining psychological and pharmacological approaches



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When discussing sexual difficulties, I prefer the term “sexual problems” rather than one of the current popular catch phrases, because of the heterogeneous nature of the problems in sexual relationships between two people. A tendency to “medicalize” sexual problems and turn them into “disorders” or “dysfunctions” is common today, but that is not always appropriate or helpful.

Until recently, the main forms of help available for sexual problems were psychological or psychotherapeutic. With the advent of sildenafil (Viagra®), we have entered a new therapeutic phase, in which pharmacological agents have therapeutic impact. This is stirring up the way we think about sexual problems, and I am sure that in the long run this will not only provide new pharmacological solutions but also a better understanding of this wide range of problems.

Let us consider psychological treatments first. Few if any of these have passed the “well-established efficacy test,”<sup>1</sup> for two principal reasons. First, because one is usually dealing with a sexual relationship rather than an individual, the complexity of the objectives and outcomes make straightforward assessment difficult. For example, when a man presents with an erectile problem, in most cases the sex therapist will be seeking to change how that man and his partner relate sexually. The focus in sex therapy is not only on improving the man’s erections, but, properly and appropriately, on

helping that couple to enjoy their sexual relationship more and benefit from enhanced intimacy.

Second, because of this inherent complexity of treatment objectives, the field of sex therapy has not paid the necessary attention to demonstrating the efficacy of its methods. The price: in our present health care system, managed care usually does not cover the cost of such treatments. Sex therapists are going out of business, fewer people are seeking training as sex therapists, and we are losing important and valuable skills.

In addition, after providing sex therapy for more than 30 years, I have no doubts of its value to many couples and individuals; but I have also learned that we sex therapists understand only a part of what we are doing. An experienced and competent sex therapist can do certain things well. We can help couples to improve their communication—often of fundamental importance; we can help couples work out better ways of resolving conflicts that affect their sexual relationship; and we can help the individual person, and his or her partner, appraise and reconstruct problematic sexual meanings which may have originated much earlier. In a reasonable proportion of cases, one or more of these three functions may be all that is required to help that couple establish a more rewarding sexual relationship. However, a fourth, “gray area” exists—the interface between such psychological processes and the physiological mechanisms involved in sexual response. In that gray area, we sex therapists have been groping in the dark.<sup>2</sup>

The advent of this new pharmacological era promises to throw light on this gray area. Drug treatments such as Viagra, which affect peripheral mechanisms involved in genital response, are likely to be helpful in men who are experiencing an age-related or, in some cases, disease-related impairment of erectile responsiveness; but their value in cases where problems exist in the relationship is again uncertain. In some cases, the specific improvement in erections may provide the positive element to improve the relationship; in others, the drug-induced erection may only be scratching the surface. The huge demand for sildenafil suggests that it might be widely useful; however, the high level of discontinuation reminds us that, apart from its expense, a drug is often not effective on its own.

The promise of this new era is twofold. First, we now have the means of combining psychological and pharmacological modes of treatment, a combination with a potentially rosy future. Second, new research opportunities allow us to investigate this interface between psychological and physiological processes. With the much-needed theoretical models that have begun to surface, I predict that this “gray area” will be much better illuminated before long.

This brings me to another crucial issue—gender. It has been recognized for some time that psychological methods of treatment appeal more to women than to men.<sup>3</sup> Men have a tendency to look for physical explanations and solutions for their sexual problems. Men conceptualize their sexuality in terms of “genital response”—the phallocentrism of male sexuality has a long history. Women tend to conceptualize their sexualities much more in terms of their relationships. Yet questions have been raised by many women, as well as the pharmaceutical industry, about the use of Viagra for women. As Rosemary Basson explains in this issue, the initial evidence suggests that this drug has no simple role for women with sexual problems. It may prove to be helpful for certain types of difficulties, and it may have a place in combination with psychological methods, but its usefulness in women is likely to be very different from that in men.

This culturally sensitive gender difference may have a biological as well as a cultural explanation. The phallocentrism of the male is central to his reproductive role. Reproduction, at least until this modern era of assisted reproduction, depends on an erect penis de-

positing semen inside the woman’s vagina. Hence, whether reproduction is on the agenda or not, this phallocentrism is likely to prevail for the foreseeable future.

The sexual response of a woman, on the other hand, whether in terms of arousal or orgasm, beyond facilitating the male’s potential impregnation is not relevant to her reproductive role. Therefore, the sexual response of the woman has been a separate issue of sexual pleasure, which can be, and often has been, suppressed and inhibited by social constraints. We have seen a lessening of the social suppression of female sexuality over the past 100 years or so, and as these changes occur, the important differences, and some similarities, between male and female sexuality become more apparent.

Politically, the issues surrounding sexual problems and treatments are complex. Much of the current wave of biomedical research is being driven by commercial forces. It is interesting how, in recent decades at least, the medical profession and the pharmaceutical industry

have paid scant attention to the sexual needs of women. The negative effects of oral contraceptives on the sexuality of many women for example, a particular research interest of mine,<sup>4</sup> has been largely ignored, whereas in the process of developing hormonal contraceptives for men, possible sexual side effects have been high on the agenda. It may take the

development of an oral contraceptive lacking such negative sexual effects on women before the medical profession and the pharmaceutical industry consider such effects seriously. Similarly, for both genders, the sexual side effects of the SSRI antidepressants have received little attention until alternative drugs, which are free from such side effects, became available. This has resulted in a major effort by pharmaceutical companies to find solutions to such side effects.<sup>5</sup> The possibly vain hope that there might be a big market for Viagra-like drugs for women has resulted in a spate of interest in female sexuality.

Although cautious about such commercial forces, I am also optimistic that, at this very interesting time, we will learn more about many of these issues and in the process enhance our capacity to help people with their sexual lives. However, although we should welcome any pharmaceutical benefits that might be gained from all this, we are in danger of losing important opportunities to help people with the psychological aspects of their sexual lives. ❏

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## References

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