1
Overview

We began our second edition with the statement "Interest in sexual behavior increased dramatically in the last two decades." Now, 14 years later, the "interest" has continued unabated and there are new developments in many fields that have contributed to our assessment and treatment of sexual dysfunction. While most major contributions have come from urology and cognitive-behavioral psychology, we have also benefited from a diverse array of other specialties including gynecology, primary care, cardiology, evolutionary psychology, neuroscience, epidemiology, and anthropology. The term "sexual medicine" combines medical practice and psychology and may be the best term that defines the state of the science today and reflects the contributions of multiple subspecialties from both fields. This term is not without its detractors, however, who fear an overmedicalization of the field and focus on function rather than the complexities inherent in dealing with any human sexuality issues (Tiefer, 2007, 2009). It is our intention in this third edition to bring to the reader the relevant developments in *all* fields that have brought us to our current status for the assessment and treatment of sexual dysfunction for men and women. The treatment model that is emphasized in this book is the *biopsychosocial model* as described by Berry and Berry (2013). This model emphasizes the multidimensional and multicausal phenomenon of sexuality that demands psychological and biological treatment strategies (McCarthy & McDonald, 2009b).

We are now more aware than ever that the assessment and treatment of sexual problems is an area that demands integration of a multidisciplinary approach. While there are certainly sexual dysfunction cases that have a purely medical or a purely psychological etiology and may benefit from a specific medical or psychological intervention, most cases benefit from at least a multidisciplinary assessment to allow for the most focused and efficient treatment. Even when sexual problems are identified as having a

purely medical or purely psychological etiology, the best treatment strategy may utilize both medical and psychological interventions. For example, men experiencing erectile dysfunction (ED) following prostate cancer surgery may benefit greatly from psychological input that helps them and their partners to accept changes in their sexual behavior and that also provides guidance in maintaining or even increasing sexual intimacy. On the other hand, a young man with no medical problems who is experiencing ED may benefit from a program using phosphodiesterase type 5 (PDE-5) inhibitors (Viagra, Cialis, Stendra, or Levitra) as an adjunct to a psychological program that is focused on building confidence and sexual approach behavior. There is no human problem that we can think of that benefits so dramatically from an integrated multidisciplinary approach than the assessment and treatment of sexual dysfunction. To achieve the most comprehensive and effective assessment and treatment approach, we endorse the "*concurrent* multidisciplinary approach" advocated by Binik and Meana (2009).

Binik and Meana (2009) explain that approach involves a coordinated and concurrent treatment among different disciplines. This is an improvement over the "serial multidisciplinary approach" in which one specialty would refer to another specialty for treatment and wait for a referral back once a specific problem was resolved. The concurrent model endorses coordinated ongoing collaboration and treatment. Although untested by controlled outcome research, it is intuitive that the concurrent model is more efficient and most likely shortens overall treatment by months. In addition, it is much more likely that the concurrent approach will help patients with compliance and investment in treatment. The reason for this is that patients are easily discouraged and embarrassed by their sexual problem and may avoid treatment if they encounter any barriers or "slowdowns."

We both have experience in working in a Men's Health Center that embraces the biopsychosocial model utilizing the concurrent approach and we are exposed to the advantages of such a model on a daily basis. On staff in the facility are two psychologists, two primary care physicians, three urologists, one physician's assistant, one physical therapist, one registered nurse, three medical assistants, and various support personnel. Such comprehensive treatment centers are rare at this time but most likely will become the norm in the future.

NEW MEDICAL DEVELOPMENTS

In our second edition of this book, we identified Viagra (sildenafil) as a new pharmacological agent that was promising to bring dramatic changes for the treatment of ED. Since its introduction on March 27, 1998, Viagra has been followed by other pharmacological agents: Levitra (vardenafil),

approved on August 19, 2003; Cialis (tadalafil), approved on November 21, 2003; and Stendra (avanafil), approved on April, 27, 2012. In addition to three dosage levels in pill form, Levitra is also now marketing a sublingual delivery with faster absorption under the name Staxyn (vardenafil HCl) approved on June 18, 2010. Cialis has developed a new approach also by introducing a low-dose daily pill. All of these agents have increased the options for treatment and have provided effective solutions for a wider population.

In addition to the increase in choices of PDE-5 inhibitors, the last 14 years have seen advances in the use of testosterone therapy for treating male sexual dysfunction. Although the use of testosterone therapy for treating ED and low libido in males has been in practice for well over 75 years (David, Dingemanse, Freud, & Laqueur, 1935), there has been a recent upsurge in interest in hormone replacement therapy for men and a variety of new and more effective delivery systems have been developed and are now available. Testosterone can now be applied daily in a gel form to the shoulders or in an applicator under the arms. In 2008, the U.S. Food and Drug Administration (FDA) also approved the use of Testopel, a pellet form of testosterone surgically implanted under the skin that lasts 3–6 months. Unlike some of the other delivery systems, Testopel carries no danger of transference to women and children.

The use of PDE-5 inhibitors and testosterone replacement therapy has been "game changing" in the treatment of male sexual dysfunction in the past 14 years. While there have been some advances in the medical treatment of female sexual dysfunction during the same time period, the advances have been far less dramatic and have not captured the attention of the news media as have the treatments for males. The use of the transdermal testosterone patch has shown some efficacy in treating postmenopausal women with low sexual desire (Buster et al., 2005; Simon et al., 2005). In addition, Meston, Rellini, and Telch (2008) have shown some benefit of gingko biloba extract on women experiencing low sexual desire. Neither of these pharmacological approaches have gained widespread use and have not enjoyed convincing controlled research support but do nonetheless represent some of the current efforts and hopes for further advances to come.

Medicine has also brought to our attention during the past 14 years the importance of the metabolic syndrome and cardiovascular disease in contributing to sexual dysfunction in men and women. The metabolic syndrome is characterized by abdominal obesity, dyslipidemia, and hypertension and was described almost 40 years ago (Haller, 1977; Singer, 1977). The relationship between the metabolic syndrome and sexual dysfunction in men and women has increasingly become a focus of our attention and is now routinely screened for and treated as part of an overall approach to the assessment and treatment of sexual dysfunction in men and women

(Esposito et al., 2005; Meuleman, 2011). Men and women presenting with sexual dysfunction who fit the criteria for the metabolic syndrome are likely to be encouraged to make important life-style changes such as diet, weight loss, and exercise as part of an overall treatment program that addresses sexual dysfunction.

We have also become increasingly aware of the relationship of cardiovascular disease and ED in males (Jackson, 2009; Miner & Kuritzky, 2007). ED may be an early warning sign of a future cardiovascular event. Since penile arteries are the smallest arteries in the male vascular system, they may be the most easily compromised as vascular disease progresses. Because of our awareness of this relationship, men presenting with ED are now more likely to be screened to determine the overall health of their vascular system. Assessment and treatment of vascular disease are consequently becoming a familiar part of our overall treatment for sexual dysfunction in men.

One additional new development in the past 14 years has been the focus on penile rehabilitation following prostate cancer surgery. In spite of advances in robotic surgery and "nerve-sparing" procedures, almost all men following this treatment experience a period of ED. The period of ED may be as brief as a month or may last up to 2 years or more before there is partial or full recovery. For some men there is no recovery at all and a variety of pharmacological protocols and surgery may be chosen to restore erections. During the period of time following prostate surgery the penis is continuously flaccid and consequently may be susceptible to permanent damage due to a decreased oxygenation of the blood that may result in fibrosis (scarring), loss of flexibility, and shortening. It is now common urological practice to engage men in a penile rehabilitation program prior to surgery and within 3 months following surgery. The program combines the use of PDE-5 inhibitors, vasoactive urethral gels, or vasoactive injections for the purpose of stimulating blood flow to the penile tissue. An important part of penile rehabilitation is couple therapy, which helps couples increase intimacy and sexual pleasure without a focus on intercourse (Alterowitz & Alterowitz, 2004).

NEW DEVELOPMENTS OUTSIDE OF MEDICINE

The assessment and treatment of sexual dysfunction derives benefits from a variety of disciplines. In addition to technical and procedural advances, our knowledge base of human sexuality is always increasing with new information coming from such diverse disciplines as epidemiology, anthropology, and evolutionary psychology. This is extremely important since imparting accurate information to sexually troubled men and women is a major

ingredient in most treatment protocols. When a therapist or physician is describing normative sexual behavior in terms of age, gender, or function to a worried patient, such information is dependent on the scientifically sound observations of researchers. Over the past 14 years we have benefited from the efforts of many scientific studies that will be cited throughout this third edition.

There have also been some advances in specific areas of psychotherapy for the treatment of sexual problems. We agree with Binik and Meana (2009) that it is inaccurate and misleading to refer to what we do in the treatment of sexual dysfunction problems as "sex therapy." While the psychological treatment of sexual problems may include specific psychotherapeutic procedures such as cognitive-behavioral therapy or *in vivo* desensitization, there is no actual discipline of "sex therapy" that is promulgated from a described theoretical basis. Rather, "sex therapy" is at best a combination of providing information and applying therapeutic techniques for treating sexual problems and treating all relevant contributing factors. Nonetheless, the term "sex therapy" is universally used in spite of the fact that it is subject to a variety of definitions and a potpourri of procedures. We are not attempting to disabuse our readers from using this term but rather alerting those readers to the inaccuracy of the term.

Keeping in mind that there is no specific discipline of sex therapy, we do note advances in the psychotherapeutic treatment of sexual problems over the past 14 years. Most noteworthy are contributions from cognitive-behavioral therapy that have described important process issues contributing to sexual dysfunction vulnerability (Nobre & Pinto-Gauveia, 2006a, 2006b; Gomes & Nobre, 2012) and outcome studies that have identified the efficacy of therapeutic techniques for specific populations (LoFrisco, 2011). We also have greatly increased our knowledge base over the past 14 years in many diverse areas such as masturbatory behavior (Gerressu, Mercer, Graham, Wellings, & Johnson, 2008), aging and sexual activity (Kontula & Haavio-Mannila, 2009), and diabetes and female sexual functioning (Giraldi & Kristensen, 2010) to name a few. Throughout the text, we will cite relevant studies that have helped to increase our knowledge base for better patient care.

In addition to advances in specific therapeutic techniques for treating sexual dysfunction and advances in our knowledge base concerning human sexuality, the past 14 years have witnessed an unprecedented mass media marketing campaign for the treatment of ED. Daily TV ads for Viagra, Cialis, and Levitra have not only increased our awareness of the problem of ED but have legitimized the treatment of all sexual problems. We have also been inundated with information available on the Internet about every conceivable sexual problem. We can now view a video lecture on "penile rehabilitation" or treatment for genito-pelvic pain/penetration disorder

(vaginismus) including ordering information for a set of dilators. We can now order any sex toy anonymously from our home computer, view any type of pornography imaginable, or follow a detailed "sex therapy" course. Unfortunately, it is not always easy for people to sort out fact from fiction and some people may invite harm rather than cure. For example, there are some websites for insecure and unsuspecting men who wish to enlarge their penis. The techniques for penis enlargement are usually endorsed by so called "experts" and presented as "proven" but the actual results are bogus at best and physically harmful at worst.

Those of us who treat sexual dysfunction problems in today's world are faced with a much more knowledgeable patient population who may harbor strong ideas about the course of treatment. Today's patient population seeking help for sexual dysfunction problems may also be more convinced about certain false beliefs "because they read it on the Internet." This requires today's health professionals who treat sexual problems to continually keep pace with new developments.

THE CURRENT DIAGNOSTIC SCHEME

Although several diagnostic approaches have been proposed to classify the sexual dysfunctions (e.g., Schover, Friedman, Weiler, Heiman, & LoPiccolo, 1982), the diagnostic scheme that has been most widely adopted for sexual dysfunctions is that contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This series of manuals was developed to aid mental health care professionals in the diagnosis and treatment of the so-called "mental disorders." (The first edition of the DSM appeared in 1952, and new editions appeared in 1968 and 1980; the third edition was revised in 1987; the fourth edition was published in 1994 and its text revision, DSM-IV-TR, in 2000; the fifth edition, DSM-5, was published in May 2013.) Although the manual was not developed for sex therapists, it contains diagnostic categories and criteria for the most commonly seen sexual difficulties.

There are 10 major diagnostic categories for sexual dysfunction in DSM-IV-TR: hypoactive sexual desire disorder (includes males and females), sexual aversion disorder, female sexual arousal disorder, male erectile disorder, female orgasmic disorder, male orgasmic disorder, premature ejaculation, dyspareunia, vaginismus, and substance-induced sexual dysfunction. All 10 of the dysfunctions identified in DSM-IV-TR should be further conceptualized along two dimensions. First, they may be characterized as "lifelong" (also known as "primary") or "acquired" (also known as "secondary"). Second, a dysfunction may be "generalized" (i.e., occurring across all sexual situations and partners) or "situational" (i.e., limited

to certain situations and partners). These distinctions are believed to be important with respect to both etiology and treatment. DSM-IV-TR represented an improvement over previous editions of the DSM but was still far from perfect. The primary limitation within sexual dysfunction diagnosis is the inherent subjectivity of criteria in most categories. Terms such as "minimal sexual stimulation" or "normal sexual excitement" leave much to clinical judgment.

Despite their limitations, DSM-IV-TR classifications continued to be used in professional journal articles, by most health professionals (from whom referrals may originate), and by insurance companies (for third-party reimbursement). It should be noted, however, that most insurance companies still do not reimburse for treatment of sexual dysfunction. Often, a diagnosis of anxiety disorder or depression is justifiable.

The work on DSM-5 began in 2006 with the appointment of David Kupfer, MD, as chair and Darrel A. Regier, MD, MPH, as vice chair of the DSM-5 Task Force (Zucker, 2010). The entire process of developing DSM-5 has had its share of controversy and is much too involved to be reviewed in this book. Readers interested in the issues and details can simply Google "DSM-5 Controversies" for further information. DSM-5 purported to make changes based on advances in research and new understandings of mental health problems, and consequently ended up eliminating some diagnostic categories, refining some existing categories, and creating new ones. Our book will subscribe to the DSM-5 categories but it is worthwhile to address briefly the changes compared to DSM-IV-TR. Although there have been many published articles related to the new sexual dysfunction categories and reasons for change, a succinct review of all of the major issues can be found in the April 2010 issue of *Archives of Sexual Behavior*, (Vol. 39, No. 2, pp. 217–303). A summary of the changes found in DSM-5 compared to DSM-IV-TR can be found in Table 1.1.

The major issues as can be seen in Table 1.1 are that the categories of female sexual arousal disorder and hypoactive sexual desire disorder are now collapsed into the single category of female sexual interest/arousal disorder, and dyspareunia and vaginismus are now collapsed into the single category of genito-pelvic pain/penetration disorder. Additionally, the category of sexual aversion disorder has been removed entirely as a sexual dysfunction disorder and has been classified as a specific phobia disorder. Further discussion of reasons for these changes will be addressed in the text under each disorder.

Sexual Deviations, Dysfunctions, and Dissatisfaction

The DSM diagnostic scheme includes the sexual deviations (i.e., paraphilia), as well as sexual dysfunctions. Paraphilia is a disorder in which

TABLE 1.1. Comparison of Diagnostic Categories between DSM-IV-TR and DSM-5

DSM-IV-TR categories	DSM-5 categories
Male erectile disorder	Erectile disorder
Female orgasmic disorder	Female orgasmic disorder
Male orgasmic disorder	Delayed ejaculation
Premature ejaculation	Premature (early) ejaculation
Female sexual arousal disorder	Female sexual interest/arousal disorder
Hypoactive sexual desire disorder (including both males and females)	Male hypoactive sexual desire disorder
Dyspareunia; vaginismus	Genito-pelvic pain/penetration disorder
Sexual aversion disorder	(now classified under specific phobias)
Substance-induced sexual dysfunction	Substance/medication-induced sexual dysfunction

an individual experiences recurrent and intense sexual urges and fantasies involving either (1) nonhuman objects (i.e., a fetish), (2) suffering or humiliation of oneself or one's partner (i.e., sadomasochism), or (3) nonconsenting partners (e.g., pedophilia, exhibitionism, frotteurism). Assessment and treatment of the paraphilias are not covered in this book. (Interested readers are referred to *Archives of Sexual Behavior,* 2010, Vol. 39, No. 2, pp. 304–426; Kafka, 2000; Laws, 1989; Laws & O'Donohue, 1997; Wincze, 2000.)

However, knowledge of the assessment and treatment of paraphilia or atypical sexual behavior (that does not meet the criteria for paraphilia) is important for assessment and treatment of sexual dysfunction. Unusual types of sexual preferences or stimulation are at times at the root of sexual dysfunction in both men and women. Incorporating or controlling the atypical sexual behavior of one partner within a couple's sexual practices may be an important component of the treatment of sexual dysfunction. Therapists treating sexual dysfunction problems can best serve their patients by being knowledgeable of and comfortable with "atypical" sexual behaviors.

In addition to being willing to explore, understand, and accept a person's unusual sexual practices and preferences, the therapist dealing with sexual dysfunction problems must also understand and accept that not everyone is concerned or distressed by their sexual dysfunction. Indeed, DSM-5 includes the criteria of distress and/or impairment.

Thus, a person may be "dysfunctional" but not necessarily dissatisfied. In a landmark study published in the *New England Journal of Medicine*, Frank, Anderson, and Rubenstein (1978) investigated 100 happily married heterosexual American couples. These researchers attempted to determine

the frequency of sexual dysfunctions experienced and the relationship of these problems to sexual satisfaction. Although over 80% of the couples reported that their marital and sexual relations were happy and satisfying, 40% of the men reported erectile and ejaculatory dysfunction, and 63% of the women reported arousal or orgasmic dysfunction! Even more surprising was the finding that the number of dysfunctions was *not* strongly associated with overall sexual satisfaction. These findings have been corroborated in a similar study conducted by Nettelbladt and Uddenberg (1979) in Europe. These authors reported that sexual dysfunction was *not* significantly related to sexual satisfaction in their sample of 58 married Swedish men.

These empirical findings remind us that sexual health involves more than just intact physiology and typical "functioning" (i.e., progression through desire, arousal, and orgasm phases). In our culture and in many others as well, sexual health is enhanced to the extent that it occurs in a rich interpersonal context that involves respect and trust, open lines of communication, and mutual commitment to all aspects of the relationship. (This is not to say that other approaches to sexual behavior are wrong, but rather to describe the conditions under which sexual satisfaction is maximized.) Sexual health is most likely to occur in individuals who are psychologically as well as neurologically, hormonally, and vascularly intact. Because existing diagnostic schemas, which focus exclusively on sexual "functioning," cannot encompass the richness of sexual health, such schemas (and diagnoses in general) have been criticized (e.g., Schover et al., 1982; Szasz, 1980; Wincze, 1982). This limitation notwithstanding, most scientist-practitioners find the DSM classification scheme useful for communicating among themselves, for presenting information about subclasses of problems, and for treatment planning. Indeed, the existence of the diagnostic system allows researchers to conduct epidemiological studies in order to determine the frequency with which disorders occur.

PREVALENCE OF THE SEXUAL DYSFUNCTIONS

With the recent explosion of interest in sexual dysfunction due to pharmacological treatments, there is every reason to believe that sexual dysfunctions are prevalent psychological disorders in the general population. Simons and Carey (2001) point out that although sexual disorders tend *not* to be included in large-scale epidemiological studies, there have been a multiplicity of empirical studies since 1990 that provide data on sexual dysfunctions. Comparing various prevalence rates across studies can be misleading, however, because studies differ in research methodology, definition of sexual disorders, and the sample under study (e.g., a sample

drawn from a diabetes clinic cannot be compared to one drawn at random from a community). Nonetheless, we now have some confidence in the prevalence range for most sexual dysfunctions within the general population. Community samples indicate a current prevalence ranging up to 3% for male orgasmic disorder, 5% for ED, 3% for male hypoactive sexual desire disorder, 10% for female orgasmic disorder and 5% for premature ejaculation (Simons & Carey, 2001). These prevalence data are consistent with anecdotal evidence from practicing social workers, psychologists, psychiatrists, and primary care nurses and physicians whose patients complain frequently about sexual dysfunction problems.

ETIOLOGY OF THE SEXUAL DYSFUNCTIONS

To treat sexual dysfunction or dissatisfaction effectively, it is helpful (but probably not necessary) to understand how that dysfunction or dissatisfaction developed. Unfortunately, our understanding of the cause(s) of the sexual dysfunctions remains incomplete. Moreover, much of our understanding comes from clinical observation rather than well-controlled research. As in the study of disease and psychopathology, this is not unusual; however, we do need to be mindful of the methodological limitations of such quasi-experimental research, cautious about our judgments, and continually open to new clinical and research data.

With these caveats in mind, we are nonetheless confident about the following general statements regarding the etiology of the sexual dysfunctions:

1. In most cases, sexual difficulties are multiply determined; that is, there is usually not just a single cause for a problem; rather, one can expect to find an array of factors that contribute to the development of a sexual difficulty. Appreciation of this principle can help to explain why treatments need to be customized to the individual, as well as why treatments need to be empirically eclectic, multimodal (Lazarus, 1988), or broad-spectrum (LoPiccolo & Friedman, 1988) rather than dogmatically designed and narrowly focused.

2. Within such a multicausal context, causes can be organized for communication purposes into three temporal categories (Hawton, 1985). First, "predisposing" factors are those prior life experiences (e.g., childhood sexual trauma) and inherited characteristics (e.g., diabetes) that make a person vulnerable to certain types of dysfunction. These predisposing factors serve as diatheses that place an individual at risk; predisposing factors may be necessary, but they are rarely sufficient to produce a dysfunc-

tion. Second, "precipitating" (or triggering) factors (e.g., stress associated with job difficulties) are those life events and experiences associated with the initial onset of a symptom or dysfunction. A precipitating factor serves as the proverbial "straw that broke the camel's back." Third, "maintaining" factors (e.g., lack of privacy, performance anxiety) are those ongoing life circumstances or physical conditions that help to explain why a dysfunction persists.

3. Causes can also be classified, again for heuristic purposes, into three human systems or frames of reference. First, causes may be inherently biological or medical. Thus, for example, the presence of penile microangiopathy (i.e., small-vessel disease) in a middle-age male diabetic can cause erectile difficulties. Similarly, the hormonal changes that can accompany menopause in women can produce vaginal dryness and dyspareunia. Second, causes can be psychological in nature. Gross disturbances in reality testing (e.g., paranoid delusions), major depression, and serious anxiety disorders have all been implicated in the pathogenesis of sexual dysfunction. Equally important psychological contributions to dysfunction include negative body image and performance anxiety (fear of negative evaluation, hypervigilance, or rejection). Finally, causes can arise from a person's social context. At the dyadic level, factors such as poor communication and relationship inequalities can foster sexual dysfunction. Larger sociocultural influences, such as sex-role or religious proscriptions, may also have an impact upon sexual functioning. We are also increasingly aware of the importance of the environment under which sexual activity occurs. In this respect, we have found the lack of privacy, the presence of pets, and disparate work schedules all have been identified in certain cases as significant contributors to sexual dysfunction.

In summary, we propose that the etiology of most sexual dysfunctions will be multiply determined, involving the transaction of biological, psychological, and social factors over a period of time. Thus, a major challenge for us as health professionals is to recognize these multiple sources of influence, and to appreciate that sexual dysfunction represents but one manifestation of a complex process. As our knowledge of etiology increases, it is likely that we will also develop more reliable and valid assessments, as well as more efficacious treatments.

ASSESSMENT AND TREATMENT

We have divided this book into four discrete sections. Part I follows the new DSM-5 classification system and includes the description and clinical

presentation of each disorder. The description is the DSM-5 criteria, while clinical presentation is how each disorder may be presented by patients. In many cases, for example, there may be a very different presentation of a specific disorder depending on the age of the patient. In addition to the description and clinical presentation, we present information on the prevalence of the disorder and its etiology. We also use clinical case material to illustrate each disorder.

In Part II, we discuss the assessment model for sexual dysfunction and identify both medical and psychological assessment considerations. Further, we identify the common ingredients that are found in all assessment protocols and we identify assessment procedures that are unique to very specific types of problems.

Part III discusses both medical treatment and psychological treatment for sexual dysfunction problems. As in Part II, we identify procedures that are common across all disorders as well as protocols that are specific to each disorder. We also discuss the strategies for working with couples as well as those for working with individuals without partners.

Finally, in Part IV we address important issues for all health care professionals who may wish to become more directly involved in assessing and treating men and women experiencing sexual dysfunction. We feel that it is important to understand the unfortunate development of a plethora of inadequate treatment programs and pharmaceutical products promising complete cures for sexual dysfunction problems and why consumers are susceptible to such quackery. We will also discuss how health professionals can receive legitimate training in this field.

Throughout our book, we are strong advocates of the biopsychosocial approach to health care, which received increased attention in the training of many health care professionals as early as 1977 (Engel, 1977). This model has important implications for both assessment and treatment that will become manifest throughout this book. Clearly, this model requires continuing efforts to stay abreast of developments—not only in one's own discipline but also in related disciplines.

Second, we are equally committed to the scientist–practitioner model of health care training and delivery. This model, espoused by the American Psychological Association as its primary training approach, has been much misunderstood, misapplied, and subsequently criticized. However, as we understand it, this model requires practicing clinicians (1) to stay abreast of recent scientific developments and, more importantly, (2) to adopt an empirical approach to their work. We discuss each of these "requirements" in turn.

It is important to stay current and remain informed of recent advances, controversies, and other developments in our field. Certainly, the arrival of effective pharmacological treatments and other medical interventions for

some sexual dysfunction problems is a prime example of this. All clinicians working with male ED must now be informed of the advantages and limitations of PDE-5s and other medical approaches.

The recommendation that one adopt a scientific approach to one's work requires careful, ongoing assessment and critical self-evaluation (see Barlow, Hayes, & Nelson, 1984; Carey, Flasher, Maisto, & Turkat, 1984). We believe that a scientific approach is especially necessary in a controversial and understudied area such as human sexuality because there is an increased probability of conjecture and subjective (or even distorted) information. Thus, the scientist-practitioner approach, which sensitizes one to the need to be critical of current "knowledge," is especially valuable in a field that is susceptible to potentially harmful information.

Third, we believe that, throughout history, a wide variety of sexual practices and orientations have been inaccurately labeled as psychopathological, deviant, or abnormal. Therefore, with some obvious exceptions (e.g., coercive sexual practices with a nonconsenting partner), we try not to make value judgments regarding the "rightness" or "wrongness" of practices that are not universally approved in our culture (e.g., sexual activity involving more than two individuals). Instead, we call for continued research and study of these practices to increase our understanding of the richness and diversity of human sexual expression.

We have attempted to prepare a book that is equally applicable to male and female, as well as to gay, bisexual, and straight concerns. At points where our coverage seems biased or one-sided, please understand that this was not our intention; such instances may reflect the state of current knowledge or our inability to express ourselves as well as we would have liked.

Finally, we would like to encourage all professionals to adhere closely to the ethical principles of their disciplines. Because our own professional training is in psychology, we follow the guidelines proffered by the American Psychological Association. Further information is available from the *Casebook on Ethical Principles of Psychologists* (American Psychological Association, 1987), or from the state licensing boards of the various professions.

CASE ILLUSTRATIONS AS USED IN THIS BOOK

We are very sensitive to our patients' sexual orientation, cultural and ethnic background, and religious beliefs or nonbeliefs, and we strongly advocate that all health professionals also subscribe to a nonjudgmental sensitivity for their patients. When treating sexual problems, we often run into situations where a person's personal beliefs or cultural heritage may be in conflict with sexual goals. In all cases, we make every attempt to understand

the important influences on a person's beliefs and work within their belief system to obtain the goal(s) they wish to achieve. Whenever possible we try to include input from a patient's religious or cultural leader with the patient's consent if the sexual goals seem to be in conflict with beliefs. For example, exposure to erotica or masturbatory practice as part of therapy may be an effective and logical procedure for a specific sexual dysfunction problem but conflict with a person's religious or cultural beliefs. Such therapy suggestions may benefit from a person's religious leaders' guidance. When therapy procedure designed to meet a patient's goals conflict with the person's cultural or religious beliefs and the procedures are not endorsed by the person's cultural or religious leader, then the therapist must search for an acceptable alternative—albeit not as effective in the therapist's experience.

In presenting cases throughout this book, we make every effort to disguise the demographic information so that the identity of the patient cannot be determined. The important factors of diagnosis or treatment protocol, however, will not be changed.

Guilford Publications
370 Seventh Avenue, Suite 1200
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com