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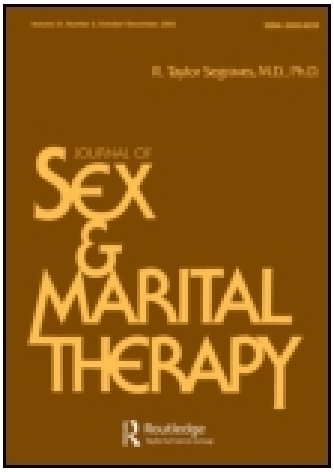

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Assessment, Treatment, and Relapse Prevention: Male Hypoactive Sexual Desire Disorder

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Assessment, Treatment, and Relapse Prevention: Male Hypoactive Sexual Desire Disorder

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There is a dearth of conceptual, clinical, and empirical work in the area of male hypoactive sexual desire disorder. Instead, the sexual medicine approach has focused on erectile dysfunction and premature ejaculation. This conceptual/clinical article focuses on a couple, integrative, psychobiosocial approach to understand, assess, treat, and relapse prevention of this very important problem. The hope is to generate conceptual, clinical, and research interest in this largely ignored dysfunction.

There is a very extensive and sophisticated literature on female hypoactive sexual desire disorder (HSDD) with the major breakthrough concept of "responsive sexual desire" (Basson, 2001). In contrast, there is a dearth of conceptual, clinical, and empirical work in the area of male HSDD (inhibited sexual desire). The focus of interventions for men has been performance problems—erectile dysfunction (ED) and premature ejaculation (PE). In addition, there has been a major paradigm shift toward the medicalization of male sexuality (Rowland, 2007). This includes pro-erection medications and the use of testosterone injections or gels as the first line of treatment for male sexual desire problems.

Maurice (2006) has written an important chapter on male HSDD using a biopsychosocial model for assessment and treatment. This article will explore a couple-oriented, integrative, psychobiosocial approach to primary and secondary male HSDD, including understanding, assessment, treatment, and relapse prevention.

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Contrary to the public perception of male sexuality as being natural and simple, male sexuality is multi-causal, multi-dimensional, and complex, with large individual, couple, cultural, and value differences (McCarthy & Metz, 2007). Most men learn sex, via masturbation between the ages of 10 and 16 (Bancroft, Herbenick, & Reynolds, 2003). In couple sex, the adolescent/young adult male experiences easy, predictable, and most important, autonomous sexual function. In other words, he can experience desire, arousal, and orgasm and need nothing from his partner. The most common sexual problem is PE which does not usually negatively affect sexual desire (Metz & McCarthy, 2003). Male sexual socialization and these early learning experiences unfortunately set the man up for sexual dysfunction and inhibited desire with his aging and the aging of the relationship (McCarthy, 1999).

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PRIMARY HSDD

There is shockingly little written about primary male HSDD. The core issue is usually a sexual secret. By order of frequency, this includes; 1) a variant arousal pattern (deviant arousal is much less common); 2) a preference for masturbatory sex rather than intimate couple sex; 3) a history of poorly processed sexual trauma; or 4) a conflict about sexual orientation. The issue is not the lack of sexual desire, but a secret/shameful desire/arousal pattern. Many of these men enter new relationships with the hope that this time the desire problem will not reoccur. Often the newness and romantic love/passionate sex allows sexual desire and function, but this usually fades after weeks or months, seldom lasting more than 2 years (Fisher, Aron, Mashek, Li, & Brown, 2002). The pattern of primary HSDD effects as many as 10% of men. It is a painful, frustrating pattern that he shares with no one, especially not his partner.

A key element in assessment is to destigmatize the problem and to elicit the sensitive/secret material during the individual sexual history. It is crucial for the clinician to be accepting and nonjudgmental. The use of open-ended questions and wide-ranging exploration of sexual strengths and vulnerabilities is important. A helpful question is to explore the number of orgasms per month and the means of reaching orgasm. For example, the clinician affirms the normality of masturbation and erotic fantasies, and then explores the role and meaning of this in the man's desire/arousal pattern.

A key in understanding variant arousal is the powerful combination of shame, eroticism, and secrecy resulting in a narrow, controlling pattern, which typically began in childhood or adolescence (Abel, Weigel, & Osborn, 2007). A key element in the use of internet porn, or erotic visual or written material, is whether it is broad-based and eclectic as opposed to narrow and controlling. Can this material be used as a "bridge to desire" in partner sex or does it serve to "wall off" the male in a narrow, controlling arousal pattern?

The traditional focus on childhood sexual abuse and trauma is on female victims. Processing and resolving trauma is particularly difficult for men because of the secrecy and stigma, as well as fears around homosexuality since the perpetrator was almost always an older adolescent or adult male. Males usually do not disclose this history to anyone, especially not their partner (Maltz, 2001).

A common pattern of male prejudice against gays is centered on the fear of homosexual orientation. Whenever a man has a sexual problem, the common hypothesis is to probe whether he is gay, which is unfortunate as well as incorrect. The best estimate is that 3–6% of men have a gay sexual orientation, an intimate and erotic commitment to sex with other men. Conflicts around sexual orientation need to be carefully assessed because a gay orientation does subvert desire for heterosexual sex, but it is important to realize that this is not among the most common secrets.

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SECONDARY HSDD

By far the most common male desire problem is secondary HSDD. This is most often caused by a reaction to sexual dysfunction, especially ED, but can also be a reaction to chronic PE as well as developing ejaculatory inhibition (EI), which increases significantly with age (Metz & McCarthy, 2007a).

In HSDD, the man has lost his comfort and confidence with arousal, intercourse, and orgasm. He falls into a pattern of anticipatory anxiety, tense and failed intercourse, and embarrassment and avoidance. When couples stop being sexual, whether at 40, 60, or 80 it is the man's decision in over 90% of cases (Friedman, Goldstein, Hatzichristou, Krane, & McKinley, 1994) The decision is typically made unilaterally and conveyed nonverbally. Sex has become a source of frustration and embarrassment, so he gives up and avoids.

In the psychobiosocial model of assessment and treatment (Metz & McCarthy, 2007b), it is crucial to comprehensively assess the potential causes and dimensions that inhibit sexual desire, from anxiety (psychological) to side effects of medications (biological) to partner blame-counter blame (relational).

The traditional male learnings of total predictability, autonomy, and perfect intercourse performance are the core issues in secondary HSDD. The major change strategy to adopt is the Good Enough Sex model of male and couple sexuality (Metz & McCarthy, 2007b). The new learnings are that the essence of couple sexuality is giving and receiving pleasurable touch and that he can accept variable, flexible sexual response rather than clinging to the perfect intercourse performance criterion. If he chooses to utilize a pro-erection medication, this is integrated into the couple style of intimacy, pleasure, and eroticism rather than be a stand-alone intervention (McCarthy

& Fucito, 2005). The most challenging concept is that 85% of sexual encounters flow to intercourse, and if that does not happen he transitions, without panicking or apologizing, to either an erotic, nonintercourse scenario or a cuddly, sensual scenario. This is much more easily accepted by the woman because variable, flexible sexual response is congruent with most women's sexual experiences. Males worry about "settling" or "feminizing" their sexual response. In truth, men who cling to the perfect intercourse performance model are the ones who stop being sexual in their 50's or 60's (Foley, 2005). Men who adopt the Good Enough Sex model can enjoy sexuality in their 60's, 70's, and 80's. As the couple age, they need each other more as intimate, erotic friends, with sex more genuine, involving, and satisfying.

Approximately two out of three couples have stopped being sexual by age 75. Those men and couples who accept the challenge of a broad-based sexuality can take pride in beating the odds and enjoying variable, flexible sexuality into their 80's (Landau et al., 2007).

As men age, their vascular and neurological systems become less efficient. Interestingly, there are fewer changes in men's hormonal systems, although for men with testosterone deficits, injections or gels are a very valuable therapeutic resource. Beginning in their 40's, psychological, relational, and especially psychosexual skill factors become more important for men as does establishing positive, realistic sexual expectations.

The keys to sexual desire are positive anticipation and feeling you deserve for sex to be satisfying at this point in your life and relationship. Sex transitions from being automatic and autonomous to being intimate and interactive. Rather than sex being about predictability and control, sexual desire is about comfort, anticipation, and receptivity/responsivity.

Desire is the core component in healthy sexuality. Desire problems, especially a nonsexual relationship, have a major impact on male psychological well-being as well as the relationship. In assessing desire issues it is crucial to conduct a comprehensive individual sexual history with the man and woman separately, examining strengths, vulnerabilities, and their evolving couple sexual style. It is important to assess whether the man is sexual by any means (masturbation, cybersex, massage parlor, affair). It is particularly important to carefully assess his use or misuse of Viagra, Cialis, Levitra, testosterone, penile injections, external pumps, or other sexual aides. Does he (and his partner) view the sexual problem as primarily about function or desire?

The couple psychobiosocial, integrative approach emphasizes sexuality as multi-dimensional and interpersonal, and advocates using all resources—psychological, medical, relational, and psychosexual skills—to revitalize sexual desire and function. Motivation is a major factor to assess and change. The prime intervention is to cognitively restructure sexuality and desire as an intimate, interactive process and adopt the Good Enough Sex model. The focus is on desire, pleasure, and satisfaction rather than intercourse and orgasm

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(Foley, Kope, & Sugrue, 2002). Basson's (2006) concept of "responsive sexual desire" can be very helpful in rebuilding the man's comfort and confidence with desire and function. He can learn to view his partner as his intimate, erotic friend with the focus on sharing pleasure, not performing for her.

An individualized relapse prevention program is an integral component of successful treatment. Male sexual socialization values predictability, control, and performance which is the opposite of what predicts successful treatment and maintaining treatment gains. It is far too easy to slide back into the frustration/avoidance cycle. A proactive relapse prevention approach is vital. Specifically, this entails not terminating treatment until he has had at least one negative sexual experience (even if it has to be simulated), and practices ensuring that a lapse does not become a relapse. This could involve implementing an alternative scenario—either an erotic, nonintercourse experience or a cuddly, sensual scenario. Another strategy is his commitment to initiate sex 1–3 days after a dissatisfying or dysfunctional encounter. He enlists her as his ally in confronting the poisonous cycle of anticipatory anxiety, tense and failed intercourse, and embarrassment and avoidance. The more the man and couple affirm the Good Enough Sex model, the greater the probability of maintaining and generalizing sexual gains.

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CASE ILLUSTRATION—ERIC AND DAWN

Dawn dragged Eric, her husband of 23 years, into couple sex therapy. Eric was very embarrassed and negative about seeing a therapist, much less a sex therapist. Eric is a successful IT manager, and prides himself on being a good problem-solver. Eric strongly maintained that his sexual dysfunction was a result of aging (he was 56) and the medications he was taking to control blood pressure and cholesterol. Eric had consulted his physician, tried two pro-erection medications (Levitra and Viagra) with minimal improvement, as well as a single trial each of a penile injection, external pump, and Medicated Urethral System for Erections (MUSE). This reinforced his belief that ED was an irreversible medical problem.

Eric felt Dawn was being irrational and stubborn. They'd had a satisfying sex life for over 20 years, enjoyed their three children, and had a good life and marriage. Why couldn't she accept that he had done all he could, that sexual dysfunction doesn't mean a loss of love, and that she could cherish the positive memories and accept the present reality? Dawn felt increasingly frustrated with Eric and the situation, believing he was "stonewalling" her. In consultation with girlfriends and internet sites, she kept questioning whether Eric had a secret life—whether with a girlfriend or another man. This infuriated Eric. Dawn and Eric were caught in a bitter, escalating blame-counter blame cycle.

The first couple session was tense, nonproductive, and demonstrated how the sexual dysfunction had drained the relationship of intimacy and satisfaction. Dawn felt desperate and tearful, and Eric felt defensive and increasingly fed up with Dawn's emotionality.

The next step in the assessment process is the individual sexual histories. Between sessions, Eric and Dawn were asked to read Chapter 2 of *Rekindling Desire* (McCarthy & McCarthy, 2003), which set the stage to consider the individual responsibility/intimate team approach to sexual desire. In his individual history, Eric was urged to be as disclosing as possible about his sexual strengths and vulnerabilities both before meeting Dawn and during their marriage. The clinician asked open-ended questions to elicit a genuine sexual story, with an invitation to disclose sensitive, secret material. For example, the question "As you look back on your first 18 years before you left home for college, what was the most negative, guilt-inducing, embarrassing, or traumatic thing that happened to you sexually?" This allowed Eric to reveal his unprocessed experiences of being fondled and orally stimulated to orgasm by a cousin, who was 7 years older, at ages 12–14. Eric had harbored a fear of homosexuality since then. Eric was very anti-gay in his social/political views. The cousin has died of AIDS in his mid-40's, and Eric never shared his deeply ambivalent feelings, especially not with Dawn. It was clear to the clinician that the conflict for Eric was about sexual trauma, not a personal conflict about sexual orientation. Eric had layers of guilt and shame that interfered with his present sexuality.

Eric was not a "touchy/feely" man, and proceeded to intercourse and orgasm as soon as possible. In truth, he enjoyed masturbatory sex more because it allowed him to indulge in erotic written materials. He never used erotic materials with Dawn, and felt guilty about his erotic fantasies. Eric was functional when he masturbated (2–3 times a month)—another shameful secret.

Eric had not liked the side effects of erection medications, and he actively was adverse to injections, the external pump, and especially the MUSE system. Eric almost pleaded with the clinician to help convince Dawn that giving up couple sex was objectively the right decision. The clinician asked Eric if he were willing to read scientific material about male sexuality. He agreed and was asked to read 20 pages from *Men's Sexual Health* (McCarthy & Metz, 2007). Eric surprised himself and the clinician by doing extensive reading in the book.

Dawn's sexual history also contained complex material, all of which she was willing to share with Eric. As an adolescent, Dawn had a number of negative experiences, but saw marital sex as compensating for these and enhancing her personal and couple life. She very much wanted to maintain a sexual life with Eric, and was hurt and confused by his avoidance, which she took very personally. What Eric experienced was a frustrated, demanding

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Dawn; however, Dawn's primary emotion was hurt. She very much wanted to be Eric's intimate, erotic friend.

The couple feedback session is the core of this therapeutic approach (McCarthy & Thestrup, 2008). The clinician believed Eric and Dawn were well-intentioned and both wanted a satisfying, stable marriage. However, their misunderstanding about touching and sexuality was playing a powerful role in tearing them apart. The clinician spoke first to Dawn about her psychological, relational, and sexual strengths and vulnerabilities. Much of this was new to Eric, especially her negative experiences and feelings about sexuality before they met and the meaning for her of healthy marital sexuality. Eric reassured Dawn that his sexual avoidance was about his anxiety and shame, not about his love or attraction for her. Eric understood why the clinician had lobbied him to share his sensitive/secret sexual story.

As he heard the clinician describe Eric's psychological, relational, and sexual strengths and vulnerabilities, Eric's self-understanding and acceptance was enhanced. He was very worried about Dawn's reaction, but as the clinician had said, Dawn was empathic and supportive, although surprised. Dawn restated how much she wanted Eric to feel good about her and their sexual life rather than feel shamed or a failure.

The clinician recommended a 6-month good faith effort to revitalize intimacy, touching, and sexuality in their marriage. He said that three out of four couples are able to do this, and strongly felt that Eric and Dawn could be a satisfied sexual couple, but that they needed to approach sexuality as an intimate team. The big challenge for Eric was to adopt a broad-based approach to touching and sexuality, and make the "wise" choice to adopt the Good Enough Sex model and drop the demand for perfect erection and intercourse performance. Eric could accept this as good for him and their marriage rather than feeling burdened by the fear of disappointing Dawn and embarrassed by his perceived sexual failures.

The therapeutic strategy (McCarthy & Ginsberg, 2007) is the opposite of that recommended by Maurice (2006). The focus is on rebuilding desire, especially positive anticipation of giving and receiving pleasure-oriented touch (responsive sexual desire). There was not a prohibition on intercourse, but there is a confrontation with the concept of intercourse as a pass-fail test. Specifically, this involves exercises/interventions to increase comfort, attraction, and trust and adopting an anti-avoidance approach to sexual touching.

Dawn found the concept of variable, flexible sexual response acceptable and inviting. She used the sexual exercises and therapy sessions for guidance in how to comfortably implement their new couple sexual style. The understanding that Eric benefited from Dawn's sensual and sexual responsiveness was particularly liberating. Dawn urged Eric to utilize fantasies/role enactment arousal and to "piggy-back" his arousal on hers. By far the most helpful guideline was for Dawn to guide intromission at high levels of arousal.

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Eric found the office therapy more difficult than the sexual exercises done at home. Talking about emotional and sexual vulnerabilities felt like punishment to him even though it was obviously not the therapist's intent nor was Dawn motivated to put Eric down.

Dawn wanted to confront the sexual avoidance pattern so it no longer dominated their marriage. The therapeutic intervention which enhanced Eric's psychological coping was an agreement that the first 20 minutes of the therapy session would focus on "hard issues," and Dawn agreed to be the notetaker. She divided the notes into three columns: hard realities; unhealthy cognitions and emotions; and healthy attitudes, behaviors, and emotions. The most difficult challenge for Eric was dealing with dissatisfying or dysfunctional sexual encounters. Dawn's perspective was that she was glad they had tried and she enjoyed cuddling warmly as a way to end the encounter. Eric continued to feel badly about unsuccessful experiences. What made a difference for Eric was to engage in one-way sex where he pleasured Dawn to orgasm, and then he felt free to engage in self-stimulation to orgasm as she rubbed his chest and stroked his face.

The hardest emotional issue involved the use of erotic fantasies. Fantasy is perhaps the most personal and sensitive aspect of sexuality. Again, Dawn took the lead in saying that she used fantasies during couple sex as a bridge to higher arousal with Eric, and she felt good about that. If Dawn felt the freedom to enjoy erotic fantasies, why shouldn't Eric? For Eric, erotic fantasies and shame were strongly intertwined. In truth, he preferred written and visual material to imagery—could that be incorporated into couple sex? These were not easy issues for Eric and Dawn, either emotionally or practically, but they needed to be addressed if Eric's sexual desire was to remain positive and resilient.

For Eric, there were three key components in building strong, resilient sexual desire: openness to using all his intimate and erotic resources to enhance desire for couple sex, including written erotic materials; seeing Dawn as his intimate, erotic friend and especially letting her guide the transition to intercourse at high levels of arousal; and adopting the Good Enough Sex model, especially his transition, without apologizing, to erotic, nonintercourse scenarios.

In terms of relapse prevention, Eric and Dawn were given relapse prevention guidelines (Metz & McCarthy, 2004), and were asked to choose 2–4 guidelines that they committed to implement. For Eric, the crucial strategy was to ensure that a "lapse"—a negative sexual experience—did not result in a "relapse." He asked Dawn to initiate an encounter within 3 days and took Cialis. Dawn focused on two strategies—an agreement to have a sensual, nondemand pleasuring date at least every other month and to arrange for a weekend away as a couple at least once a year. They also agreed to call for a "booster" session if they went for a month without a significant sexual experience. They were committed to maintaining a healthy marital sexuality.

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SUMMARY

Male HSDD (inhibited sexual desire) is a largely ignored area, both in terms of research and clinical assessment and treatment. This conceptual/clinical article discussed causes and treatment of primary and secondary male desire problems. The hope is that the issues raised will encourage both researchers and clinicians to focus on this very important problem.

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