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Cognitive-Behavioral Erectile Dysfunction Treatment for Gay Men

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The purpose of the present paper is to assist cognitive-behavioral therapists who are treating erectile dysfunction among gay men. Little information is available to cognitive-behavioral therapists about the psychological and social effects of erectile dysfunction in this population, or how to incorporate the concerns of gay men with erectile dysfunction into a case conceptualization and treatment plan. The present paper provides an overview of the extant research on erectile dysfunction and of its treatment among gay men. The application of clinical research on erectile dysfunction to treatment for gay men will be illustrated using two case examples.

Since the early work of Masters and Johnson (1970), there has been a growing body of behavioral research on erectile dysfunction and its treatment. However, relatively little work has been conducted on erectile dysfunction and behavioral treatment for this condition among gay men. The relative lack of research is partially attributable to the fact that behavioral treatment of gay men until the 1980s was primarily restricted to attempts to change gay men's sexual orientation to heterosexual using aversion therapy (e.g., Dengrove, 1967; McConaghy, 1976), and due to the focus in the sexual dysfunction treatment literature on vaginal intercourse, which gay men do not practice (Campbell & Whiteley, 2006; see Sandfort & de Keizer, 2001, for a review of the literature). The lack of attention to psychological treatment of erectile dysfunction among gay men may lead to misunderstandings between the therapist and gay male patients if the therapist is insufficiently familiar with gay male sexuality and how gay men differ from the heterosexual majority in sexual attitudes and behaviors. Safren and Rogers (2001) suggest that, although the use of CBT in treating gay, lesbian, and bisexual therapy patients may follow the same general principles of CBT in terms of assessment and treatment, the role of sexual orientation and its effects on individuals' thoughts, behaviors, and emotions must be taken into account when conducting therapy with this population.

The present article will provide information on these topics as well as report data on two cases of cognitive-behavioral treatment for erectile dysfunction among gay men. This article will be relevant to single gay men, gay men who are married or in other long-term relationships with male partners, and to bisexual men who identify with the gay male community.

Erectile Dysfunction and Male Erectile Disorder

Male Erectile Disorder in the *DSM-IV-TR* (American Psychiatric Association, 2000) is defined by three criteria: (a) persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection; (b) the disturbance causes marked distress or interpersonal difficulty; (c) the erectile dysfunction is not better accounted for by another Axis I disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

In addition, one must specify whether the disorder is lifelong or acquired, generalized or situational, and due to psychological factors or due to combined factors.

The prevalence of erectile dysfunction ranges from 2% in men younger than 40 years to 86% in men 80 years and older (Heiman & Meston, 1997; Laumann et al., 2007; Prins et al., 2002), with a prevalence rate of 10.4% in the past year among men 18 to 59 years of age (Laumann et al., 1994). Erectile dysfunction is associated with poor psychological outcomes, including anxiety (Corona et al., 2008), depression (Angst, 1998; Araujo et al., 1998), decreased self-esteem (Shires & Miller, 1998), decreased health-related quality of life (Sánchez-Cruz et al., 2003), and

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feelings of isolation and helplessness (Tomlinson & Wright, 2004). Further, such sexual difficulties can negatively affect men's relationships with partners, decrease their confidence in their ability to develop new sexual relationships, and lead to feelings of inferiority when interacting with friends and work colleagues (Tomlinson & Wright, 2004).

Erectile Dysfunction Among Gay Men

According to one study, about 40% of gay men reported ever having difficulties achieving an erection, and 13% reported a current difficulty (Rosser, Metz, Bockting, Buroker, 1997). For maintaining an erection, 46% of gay men reported ever having difficulties, and 16% reported a current difficulty. These percentages are, on balance, higher than those that have been found in heterosexual samples. For example, one study showed that 26% of heterosexual men reported ever having difficulties achieving an erection, and 29% reported ever having difficulties maintaining an erection (Metz & Seifert, 1990). It is unclear whether the differences in proportions of gay and heterosexual men reporting erectile dysfunction are due to more accurate reporting among gay men, differences in recruitment between studies, or actual greater prevalence of problems among gay men versus heterosexual men.

Cognitive-Behavioral and Behavioral Treatments for Erectile Dysfunction

Both gay and heterosexual men with sexual dysfunction demonstrate significantly higher levels of anxiety than the general population (Bancroft, Carnes, Janssen, Goodrich, & Long, 2005). Barlow (1986) initially proposed that anxiety may have differential effects in sexually functional versus sexually dysfunctional individuals: anxiety may increase arousal and erectile functioning in sexually functional individuals but decrease arousal and erectile functioning in sexually dysfunctional individuals. In this model, performance-focused thoughts interact with anxiety to produce sexual dysfunction. Accordingly, therapists must use strategies that target irrational cognitions about sexual performance and their interactions with anxiety in order to effectively treat erectile problems. Men with sexual dysfunction have more negative automatic thoughts during sexual activity compared to sexually healthy men (Nobre & Pinto-Gouveia, 2008). These thoughts may include erection concerns (e.g., "I must achieve an erection"), thoughts regarding anticipation failure (e.g., "this sexual encounter is not going anywhere"), and lack of erotic thoughts.

Cognitive-behavioral therapy (CBT) for sexual problems consists of several components, including education (i.e., information regarding sexual anatomy and stages of arousal), cognitive restructuring (i.e., identification of thoughts and core beliefs that may be influencing sexual functioning), communication training (i.e., learning how to express thoughts and feelings), and sensate focus (e.g., McCabe, 2001; Rosen, Leiblum, & Spector, 1994; see Heiman, 2002, for a review). Sensate focus entails a graded series of tasks for couples to reduce sexual anxiety, starting with nonsexual touch, continuing with sexual touch, and eventually proceeding to sexual intercourse (Masters & Johnson, 1970).

Research examining the effectiveness of CBT in treating erectile dysfunction in heterosexual individuals and couples has demonstrated positive outcomes. An uncontrolled 10-week clinical trial of CBT for men and women with diverse sexual dysfunctions who had sexual partners demonstrated that the proportion of men reporting erectile dysfunction decreased from 71.1% at baseline to 35.6% posttreatment (McCabe, 2001). This form of CBT used cognitive restructuring to reduce anxiety related to sexual encounters and to reduce attention on sexual performance, as well as education, communication training, and sensate focus. Following treatment, patients experienced more positive attitudes toward sex, more pleasure during sex, and decreased perceptions of feeling like sexual failures. A similar study examined the efficacy of a manualized treatment that incorporated education, communication skills, and sensate focus for heterosexual couples in which the man was using sildenafil (Viagra) (Bach, Barlow, & Wincze, 2004). This behavioral treatment resulted in more improvements than the use of sildenafil alone on measures of individual sexual satisfaction, sexual satisfaction among partners, and frequency of intercourse.

To assist clinicians in the assessment and treatment of sexual dysfunction, treatment manuals have been developed (e.g., Wincze & Barlow, 2004; Wincze & Carey, 2001; Wincze, 2009). Wincze and Carey recommend that clinicians first target the patients' interfering thoughts in order to help them focus on sexually facilitating rather than inhibiting sexual thoughts. They suggest that one way of accomplishing this is to have patients recall past thoughts that occurred during sexually satisfying experiences. After patients have identified positive sexual thoughts, they can progress to sensate focus, during which the goal is to think positively about sex and take the focus off of maintaining an erection.

Although there have been researchers who have indicated the benefits of treating sexual dysfunction through individual therapy (e.g., Althof, 2000; Anson, 1995), much of the literature has focused on couples, specifically heterosexual couples (e.g., Rosen et al., 1994; Weeks & Gambescia, 2000). Efforts have been made to address the use of CBT with gay couples; however, for the most part, treatment recommendations tend to be guided by a general framework geared towards heterosexual

individuals. One exception to the lack of inclusion of gay men in the behavioral and CBT treatment literature on erectile dysfunction is a case study illustrating the treatment of erectile dysfunction in a gay male using individual therapy involving CBT as well as psychodynamic strategies (Garippa & Sanders, 1997). Following treatment, the patient felt more self-confident and less worried about negative sexual outcomes. However, although therapy was conducted individually, the patient had a partner and could therefore apply the techniques learned in therapy to his long-term sexual relationship.

Examples of Cognitive Behavioral Treatment for Erectile Dysfunction Among Gay Men

To help CBT therapists who seek to treat erectile dysfunction among gay men, the following section will present topics of special relevance to assessment, case conceptualization, and treatment. These topics are illustrated using two case examples: Robert and John (their identities are concealed to protect confidentiality). These examples highlight how the presentation and treatment of erectile dysfunction may be different among gay men, as compared to heterosexual men.

Case Description of Robert

Robert was a 33-year-old Caucasian gay man who worked for a bank as a manager. He presented for treatment for sexual performance anxiety regarding achieving and maintaining erections during sex with his past partner of 4 years, Andrew. He noted that his anxiety impaired his ability to achieve and maintain erections, and that he did not have either sexual performance anxiety or erectile dysfunction in the first year of his relationship with Andrew. When asked about his preferences regarding sex, Robert reported, "I am totally a top," indicating that he strongly prefers to be the insertive partner in anal sex. He then added, "I don't get much [pleasure] out of oral sex or other stuff," and stated that he viewed other forms of sexual activity as a prelude before anal sex. Robert reported that in his previous long-term relationship before Andrew, he was fully "in control of the relationship." However, in the relationship with Andrew, he believed he had little control. Some areas in which he believed he had little control included decisions about which topics were acceptable to talk about in the relationship, especially the timing and frequency of sex. Robert reported that he preferred to have sex a few times a week, but Andrew wanted to have sex a few times a day. As a result, Robert "began to feel pressured by someone who wants sex all the time," and started to use erectile dysfunction medications whenever he had any type of sex.

When asked if he always had problems attaining and maintaining erections, Robert reported that he had erectile problems during both anal sex and oral sex with Andrew. However, he never experienced erectile dysfunction before meeting Andrew, reported waking in the morning with spontaneous erections before and during his relationship with Andrew, and denied having any erectile problems when masturbating alone. Robert and Andrew had an open relationship, and occasionally they would invite a third person in for a casual sex encounter. He did not have erectile dysfunction when having sex with a casual partner, even when he was the insertive partner during anal sex. Robert reported that he saw a physician for his erectile dysfunction who prescribed erectile dysfunction medications, but told Robert he had no known medical condition that might account for the erectile dysfunction. Robert added that even with use of erectile dysfunction medications, he continued to have trouble attaining or maintaining erections during insertive anal intercourse about 10% of the time.

Robert did not report any symptoms meeting criteria for any disorder on the Mini International Neuropsychiatric Interview (Sheehan et al., 1997), but did report using substances when going out dancing or to parties. Specifically, he reported drinking alcohol and using cocaine once a month and Ecstacy twice a year, but did not meet criteria for a substance use disorder due to the lack of dependence, psychosocial impairment, or distress resulting from use of any of these substances. He reported recurrent inability to attain or maintain erections with Andrew. Robert noted that "I feel terrible" about having erectile dysfunction, and that Andrew was also frustrated and felt unattractive if Robert did not achieve and maintain an erection during sex. Robert and Andrew separated 1 month into treatment, which led to Robert having significant concerns about ever meeting another partner while having erectile problems. Robert's symptoms were consistent with a diagnosis of Male Erectile Disorder, Acquired, Situational, Due to Psychological Factors.

Robert also completed the International Index of Erectile Function (IIEF), a commonly used measure in clinical settings of erectile and sexual functioning (Rosen et al., 1997). At the beginning of treatment for erectile dysfunction, his Erectile Functioning score was 17, which is within the range of patients with erectile dysfunction (patient M=10.7, SD=6.5) but below the range for normal controls (M=25.8, SD=7.6). Robert's Sexual Desire score was 4 and his Overall Sexual Satisfaction score was 2, with both scores well within the clinical range (patient M=6.3, SD=1.9, and M=4.4, SD=2.3, respectively) but below the ranges for normal controls (M=7.0, SD=1.8, and M=8.6, SD=1.7, respectively). Figure 1 displays Erectile Functioning, Sexual Desire, and Overall Sexual Satisfaction scores at the beginning of treatment and every month thereafter until termination of treatment for Robert (and John, described below).

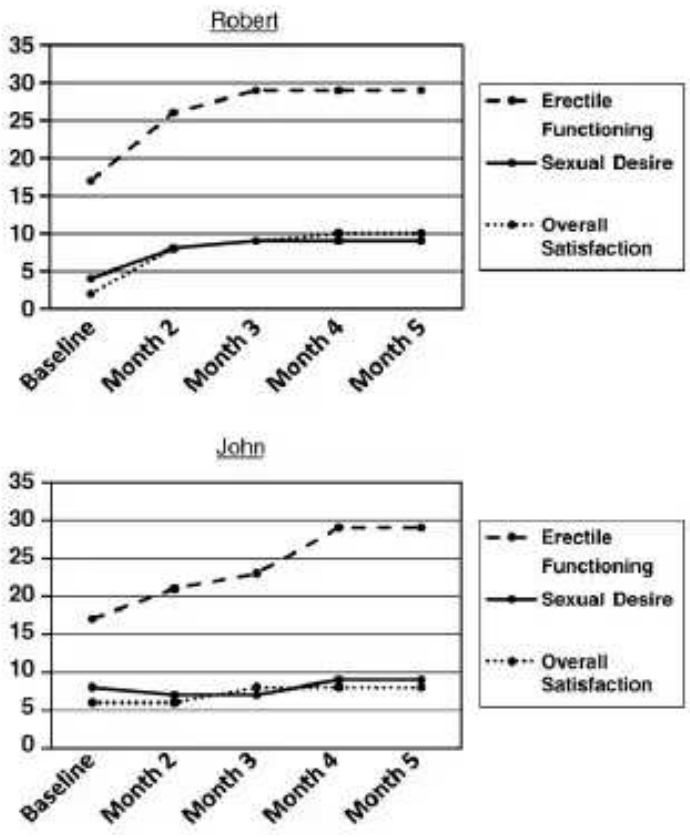

Figure 1. Sexual Functioning for Robert and John. *Note:* Scores for each scale were in the clinical range at the beginning of treatment and in the normal range at the end of treatment (Rosen et al., 1997).

Case Description of John

John was a 43-year-old, single gay man who initially presented for stress management related to a high workload as a real estate agent. He reported a recurrent inability to attain or maintain erections approximately 50% of the time. John also reported anxiety about dating because of his erectile dysfunction, and especially anxiety before and during sex. As well, John reported that a previous sexual partner whom he dated in the 2 months prior to beginning treatment became upset when he was not fully erect during oral sex on two different occasions, and asked if John was truly interested in him. John reported a great deal of embarrassment after this incident, and believed that this was one of the reasons he did not stay with this previous sexual partner. He also wondered if he would have trouble meeting a long-term partner because of his erectile problems. John reported anxiety about having erections during all types of sexual activity, but especially when he was the insertive partner in anal sex. John reported beliefs such as "sex equals performance," and "I am not a real man unless I perform sexually." Similar to Robert, John's diagnosis was Male Erectile Disorder, Acquired, Situational, Due to Psychological Factors. At the beginning of treatment for erectile dysfunction, his Erectile Functioning score was 17, suggesting clinically significant erectile dysfunction. John's Sexual Desire score was 8, which is within 1 *SD* for patients with erectile dysfunction but also within the range of normal controls. His Overall Sexual Satisfaction score was 6, which is well within the clinical range but below the range for normal controls.

Clinical Topics Relevant for Successful CBT With Gay Men

Sexual Self-Labels

Many gay men identify with sexual self-labels about their preferences in anal sex. One study (Hart, Wolitski, Purcell, Gómez, & Halkitis, 2003) suggests that approximately 18% identify as a "top." About 23% identify as a "bottom," or someone who strongly prefers to be the receptive partner in anal sex, and 47% identify as "versatile," or someone who enjoys both insertive and receptive sex roles in anal sex. A remaining 12% do not identify with these labels. Those who do not identify with these sexual self-labels are less likely than those who do identify with a sexual self-label to have had anal sex in the past 3 months. Similar percentages have been found in a recent study of personal advertisements on the Internet (Moskowitz, Rieger, & Roloff, 2008).

It may be useful for a therapist to ask a gay male patient with erectile dysfunction if he identifies as a top, bottom, versatile, or with none of these labels. It may also be beneficial to ask if a gay male patient is avoiding "topping" (being the insertive partner) because of fears of erectile dysfunction. Although there is a lack of research on this topic, it is possible that men who identify as a "top" are more likely to present for therapy with erectile difficulties than other men because of the necessity of having an erection to be the insertive partner. When queried about his sexual interests, Robert identified strongly as a "top." He added that he had tried receptive anal sex, but that he found it painful and it made him feel "out of control." Robert also reported that he thought of oral sex or sexual touching only as foreplay and not as "real sex." John also identified as a "top," but did not have any negative experiences with receptive anal sex. He also reported enjoying oral sex to orgasm prior to having erectile dysfunction.

Homophobia and Internalized Homophobia

Internalized homophobia refers to the internalization of feelings that one's same-sex sexual preferences are wrong, bad, or immoral (Campbell & Whiteley, 2006). The negative effects of homophobia and internalized homophobia on gay men's health are well-documented in the published literature (e.g., Gold, Marx, & Lexington, 2007; Pachankis, Goldfried, & Ramrattan, 2008). Specifically, internalized homophobia is positively associated with depression and negatively associated with sexual satisfaction, comfort with sexual orientation, "outness" (e.g., going to gay bars, being involved in gay

organizations, etc.), and peer socialization (Rosser, Bockting, Ross, Miner, & Coleman, 2008; Rosser et al., 1997). Researchers have noted that internalized homophobia may also be one factor that contributes to sexual dysfunction in gay men (Shires & Miller, 1998), although more research is needed in this area.

Experiences of homophobia and internalized homophobia also had an effect on sexual functioning for Robert and John. Robert reported that he preferred partners who were physically smaller than him and/or less muscular than him. When asked why he preferred this type of partner, he reported that when he thought about being sexual with big, muscular men, he felt like "the skinny, gay kid in the playground" and "wimpy." Robert explained that he had been teased for being gay as a child, and was often afraid that he would be beaten up at school for being gay. John expressed similar concerns, and was also concerned that not being fully erect meant he was not a "real man." Not feeling like a real man was especially painful for John because he had been told that gay men are "not real men," and so it was extremely important that he did not do anything that seemed "weak" or "feminine."

For both Robert and John, fears of not being perceived as or not feeling sufficiently masculine were high during sexual situations.

Relationship to Social Anxiety

Erectile dysfunction can also be related to fears of being judged by other gay men. A gay man with erectile dysfunction may have concerns of being negatively evaluated if other gay men discover that he is having erectile dysfunction. This may be especially important among gay men, who may congregate in common areas and may have greater social interaction with each other due to being a minority within a heterosexual culture. Both Robert and John expressed concern that news of their perceived sexual failures would travel, causing them great embarrassment and decreased opportunities to meet long-term or even casual sexual partners. Social anxiety may also increase erectile dysfunction in less direct ways. For example, Robert expressed concern that "I need my friends to approve of the guy" that he chooses for a sexual partner and that "I don't want my friends to think the guy is not attractive." Further, gay men with erectile dysfunction may also be concerned that if they have erectile dysfunction, they will be unable to maintain a relationship, or will lose their current relationship.

Gay Men Are Not Necessarily Monogamous

Most research on treatment of sexual dysfunction in men focuses on heterosexual men in monogamous relationships. It is often assumed that sexual relationships among gay and heterosexual men are similar (Shires & Miller, 1998), and therefore, understandings of gay sexual relationships are fit into preexisting frameworks of heterosexual relationships (Campbell & Whiteley, 2006). However, there appear to be significant differences in the ways that gay and heterosexual males conceptualize relationships. Compared to heterosexual couples, gay couples may hold more diverse definitions of monogamy. Specifically, some gay men may form emotionally monogamous relationships which are sexually nonmonogamous, or "open." In a qualitative study of 65 coupled gay men, 28 (43.1%) reported that both partners agreed to permit sex outside the primary relationship (LaSala, 2004a). This subset of gay men explained that they did not necessarily associate sex with emotional intimacy and commitment, and believed that an open relationship allowed each partner to experience personal freedom. Further, they stressed the importance of emotional fidelity and did not believe that emotional fidelity was compromised by their open sexual relationship. In another study of 121 gay male couples, 48 couples (39.6%) reported that they were in nonmonogamous sexual relationships (LaSala, 2004b). Similar to the findings of the previous study, no differences were found between couples who were sexually monogamous and non-monogamous on measures of relationship satisfaction and relationship agreement. Shernoff (2006) posits that, despite the fact that nonmonogamy is an accepted part of gay culture, many therapists regard it as problematic as a result of heterosexual norms. Thus, therapists must be aware of their own attitudes regarding sexuality and monogamy in order to effectively work with this population (Nichols, 2000; Shernoff, 2006).

Two different perspectives on sexual monogamy were demonstrated during treatment with Robert. As noted above, Robert initially presented for treatment while in a 4-year relationship with Andrew. Initially, the couple was in a sexually monogamous relationship. Two years into the relationship, Robert and Andrew began an open relationship in which they were allowed to have other sexual partners. Robert initially believed that the open relationship was due completely to his own sexual performance problems. Robert also identified the sexual nonmonogamy as another problem in the relationship on top of the erectile problems. However, through cognitive restructuring exercises regarding his beliefs about the role of sex in a good relationship, Robert learned two lessons. He realized that (a) he did not have high sexual performance anxiety before meeting Andrew, and (b) he rarely had high sexual performance anxiety with casual sexual partners during his open relationship with Andrew. Accordingly, Robert began to realize that his erectile problems may be directly tied to the poor quality of his emotional relationship with Andrew, regardless of whether they were sexually monogamous or not.

Use of Alcohol and Drugs During Sex

Alcohol and drugs can facilitate sex by reducing inhibitions and increasing sex drive, but can also reduce erectile functioning. Certain drugs, such as Ecstacy, methamphetamine, and marijuana, are associated with a high incidence of erectile dysfunction (Smith, 2007). Drug use is common among gay men, and certain drugs, such as amphetamine, Ecstasy, cocaine, and marijuana may be more commonly used among gay men than in the general population (Stall et al., 2001). Erectile dysfunction medications are also common among gay men, and some gay men may choose to combine erectile dysfunction medications with recreational drugs without being aware of possible side effects. In a community sample of gay men, 32% had ever used Viagra, and 18% of these men reported combining Viagra with amyl nitrite ("poppers") (Chu et al., 2003). Amyl nitrite is a recreational drug which leads to relaxation of involuntary muscles around the anal sphincter, and may therefore be used before receptive anal intercourse. The simultaneous use of amyl nitrite and erectile dysfunction medications may lead to marked decreases in blood pressure, which can be very dangerous and possibly fatal (Cheitlin et al., 1998). A key part of treatment for Robert was noting that if he had sex when intoxicated on alcohol, cocaine, or Ecstacy, he had more erectile dysfunction regardless of these substances' dampening effect on anxiety. As such, alcohol and drugs were conceptualized as "safety behaviors" that were used to reduce anxiety but that were also ineffective at promoting pleasurable sexual relations.

HIV and Condom Use

HIV is more prevalent among gay men than in the general male population, as are many other sexually transmitted infections including syphilis and herpes (e.g., Buchacz, Greenberg, Onorato, & Janssen, 2005; Centers for Disease Control and Prevention, 2008; Public Health Agency of Canada, 2007). Although condom use is an effective method for reducing HIV and many other sexually transmitted infections, many men associate condom use with reduced sexual sensation and increased erectile difficulties (e.g., Adam, 2005; Cove & Petrak, 2004). As such, erectile dysfunction may lead to greater engagement in risk behavior among some gay male patients. It is therefore critical that therapists assess sexual risk behavior and condom use with gay male patients. For example, John reported that despite knowledge about the risks inherent in unprotected anal sex, he occasionally engaged in unprotected insertive anal sex. Treatment therefore focused not only on decreasing anxiety in sexual situations, but also on decreasing anxiety regarding the effect of condoms on erectile functioning.

Differences in Normative Sexual Interactions Between Gay Men and Heterosexual Men

Compared to heterosexual men, gay men may be less likely to perceive oral sex as a form of foreplay and may regard it as a legitimate form of sex. In a sample of 12,347 gay and bisexual men, masturbation and oral sex were more commonly practiced than anal sex (Bochow et al., 1994), and were considered "staples" of sexual activity (Davies et al., 1992). By contrast, in a nationally representative study examining sexual behavior in men (97% who had only heterosexual activity) aged 20 to 39 in the United States, 95% of men reported having had vaginal sex, while 75% and 79% of men reported performing and receiving oral sex, respectively (Billy, Tanfer, Grady, & Klepinger, 1993).

Despite these findings, gay men are often influenced by heterosexual norms surrounding sexual behavior. For example, although Robert initially reported that he saw oral sex only as a prelude to insertive anal intercourse, he was later able to see that this was his own perception about sex that was not necessarily shared by his sexual partners. As he progressed in therapy, he was able to learn that he actually enjoyed other forms of sexual activity, and that sexual partners indicated that they enjoyed Robert as a sexual partner regardless of which sexual act completed the sexual interaction.

Cognitive and Behavioral Techniques

Cognitive Restructuring

Consistent with a cognitive-behavioral model for treatment of erectile dysfunction, treatment for Robert and John addressed several maladaptive and irrational beliefs associated with sexual performance anxiety. Psychoeducation on sexual functioning and common maladaptive beliefs experienced by men with sexual dysfunction was provided in face-to-face sessions and in a patient manual by Wincze and Barlow (2004), which was used throughout the therapy. Cognitive restructuring was also conducted to alter maladaptive beliefs. Examples of beliefs addressed in treatment are found in Table 1. For example, John reported cognitions such as, "I should have an erection every time" and "if I don't have an erection, others will find out and I will never meet a [long-term] partner." After identifying cognitive errors, including all-or-nothing thinking, mind reading, and catastrophizing, John then challenged these thoughts: "Does not having an erection once mean I will be single forever?" "Does not having an erection in a situation really mean something is wrong with me sexually?" and "Are there times I have not been erect because I was not interested in a guy?" Through cognitive restructuring, John learned that he does not need to have an erection in every potential sexual situation, and that sometimes not having

Table 1
Examples of Irrational Beliefs Related to Erectile Functioning Among Gay Men

Sexual Beliefs Specific to Gay Men
A good "top" is always erect during sexual encounters.
Gay men must be either the "top" or the "bottom."
Sex=anal sex.
If I am not ready for anal sex, I am a bad partner.
If I am not ready for anal sex, I should not have sex.
Other Sexual Beliefs That May Be Found Among Gay and Non-Gay Men
Beliefs about erections
I need to monitor my erections during sex to stay erect.
If I am not 100% erect, I will have problems having sex.
If I am not erect when initiating a sexual encounter, I will never become erect later on in the sexual encounter.
Something is wrong with my sex drive if I am not always erect.
I need to use erectile dysfunction medications to avoid embarrassment.
Erection= sexual performance.
If I am not always erect during sex, men will not want to have sex with me.
Beliefs about sex
Sex is the primary way to connect with a romantic partner.
I should be able to drink or do drugs and still perform the same sexually.
I must have sex to be a worthwhile human being.
I must always be ready for sex.

an erection may be due to not feeling comfortable with a partner as opposed to something wrong with his penis. John's rational response was, "Erections are a result of being aroused and comfortable."

For Robert, much of his anxiety was related to a perception that he always had to be the insertive anal sex partner. In his previous relationship, Robert reported that Andrew always expected to have anal sex in a sexual encounter, with Robert always being the insertive partner in anal intercourse. Although Robert had previously engaged in other forms of sexual activity to orgasm with other partners, Robert reported several beliefs at the beginning of therapy, including: "Sex isn't worth it if I am not having anal sex," "Being passive [receptive anal sex] is not masculine," and "I need to be hard to have sex." Along with identifying cognitive errors including all-or-nothing thinking, mind-reading, and *should* statements, Robert also disputed his cognitions with questions such as, "Are there other ways I can have sex?" and "Am I 100% sure that all guys expect me to top?" Robert identified evidence that many of his previous sexual partners were "versatile" or "tops," and that the purpose of sex was not to perform sexually for a partner. His rational response was, "Sex is for pleasure, intimacy, and connection." For both Robert and John, cognitive restructuring served to help them identify what they enjoyed about sex. Not only did cognitive restructuring help by reducing sexual performance anxiety, it also helped by increasing sexual desire. Both Robert and John identified appropriate choices for sexual partners and acknowledged the pleasurable aspects of sexual arousal. Therefore, by the end of therapy, erectile functioning, sexual desire, and sexual satisfaction were all in the normal range for both patients (see Figure 1).

Exposures and Behavioral Experiments

Similar to other forms of anxiety treatment (e.g. Coles, Hart, & Heimberg, 2005; Gould, Buckminster, Pollack, Otto, & Yap, 1997), sexual performance anxiety can be addressed using exposure exercises. These exposure exercises can be conducted in conjunction with cognitive restructuring for irrational or maladaptive cognitions specific to the exposure situation. For an example of a fear hierarchy that can be used for sexual performance anxiety, see Table 2. For John, a key problem was his tendency to monitor how erect he was throughout a sexual encounter. After conducting cognitive restructuring regarding his anxiogenic cognitions (e.g, "I should have an erection every time"), John's homework was to use his rational response, "I can stay in the moment during sex," while on a date. The purpose of the rational response was to allow him to refocus his attention on his sexual attraction toward his partner. Next session, John reported being pleased with his decreased anxiety on the

Table 2
Example of a Fear Hierarchy: The Case of Robert

Situation	Pretreatment		Posttreatment	
	Fear (0-100 scale)	Prediction About Ability to Maintain Erection	Fear (0-100 scale)	Prediction About Ability to Maintain Erection
1. Insertive sex using Viagra	25	90%	10	100
2. Insertive sex without Viagra	50	25%	10	100
3. Receptive sex with Viagra	25	70	5	100
4. Receptive sex without Viagra	25	70	5	100
5. Oral sex only with Viagra	N/A*	N/A	5	100
6. Oral sex only without Viagra	N/A	N/A	5	100

Note. *At the beginning of treatment, Robert reported never engaging in oral sex without later engaging in insertive anal sex, so situations #5 and #6 were added later in treatment.

date, and reported that sex was much more enjoyable with an increased attention to sexually arousing stimuli.

Behavioral experiments may incorporate some aspects of an exposure while simultaneously allowing a patient to test his beliefs regarding sex. For Robert, because of his previous partner, he had come to believe that only anal sex was a desirable outcome and that he needed to be the insertive partner during sex. Using a downward-arrow strategy (Burns, 1980; Somerville & Cooper, 2007), Robert identified that another major reason he wanted to be the insertive partner beyond previous experience was his belief that "being a top means being in control." After cognitive restructuring, Robert identified that sometimes he felt frustrated with a fixed role of always being the insertive partner during anal sex, and occasionally wanted "someone else to do some work" during sex. Robert's rational response was, "I am actually happy when there is a balance of control." Robert's homework was to use his rational response on a date that weekend. The next week, Robert reported that he and his date had engaged in oral sex to orgasm. With some surprise, Robert reported that not only did his rational response lead to reduced anxiety, but also that it was a really validating experience." By the end of therapy, Robert reported enjoying not only insertive anal sex, but also receptive anal sex, oral sex, and mutual masturbation as options for sexual activity during dates. Further, more than one sexual partner indicated enjoying Robert as a sexual partner regardless of which sexual act completed the sexual interaction. Robert also reported that he preferred now to have sex without Viagra, as "nothing is wrong with me [sexually] for me to need Viagra."

Exposures and behavioral experiments may potentially be limited when working with single gay men by the availability of sexual partners. In cases where there is no sexual activity for conducting exposures and behavioral experiments, cognitive restructuring may be used instead. However, behavioral techniques are highly recommended when feasible. For gay men with partners, sensate focus techniques are integral to any couples-based treatment (Masters & Johnson, 1970).

Relapse Prevention During Treatment

In order to maintain gains made during erectile dysfunction treatment, it is useful to review treatment progress and identify strategies to continue progress and potential barriers to maintaining change (Ward & Hudson, 1996; Wincze, 2009). Exercises for preventing relapse may include writing about progress toward goals and reviewing core beliefs regarding sex and cognitive and behavioral methods for disputing these beliefs. In the last two sessions, Robert wrote about how he achieved his goals during therapy, and how to avoid relapse. He first discussed triggers for anxiety and barriers for managing anxiety in sexual situations. Triggers included believing he was being pressured by a partner to be the insertive partner for anal sex and not being personally attracted to a prospective partner. Barriers to managing his anxiety in sexual situations included being concerned about what others' think about his choice in sexual partners. Lastly, Robert reported that to support his progress and to avoid relapse, he would do the following: (a) refocus on positive sexual experiences from before his sexual dysfunction problems and from the last 3 months of therapy; (b) continue cognitive restructuring and exposure exercises to keep sexual performance anxiety low; and (c) practice his rational response—"Sex is for pleasure, intimacy, and connection"—before sex and use this rational response to identify if he wishes to have sex with a potential sexual partner. John completed a similar exercise, with triggers including self-monitoring his erections, and barriers to managing his anxiety including thoughts that he must use sildenafil to stay erect. John's homework following termination of therapy was: (a) to focus on sexual arousal and comfort with a partner in potential sexual situations; (b) to remember that "erections are a symptom of arousal, not the cause of it"; and (c) to continue cognitive restructuring and exposure exercises to keep sexual performance anxiety low.

Discussion

Despite the relative lack of research on erectile dysfunction treatment for gay men, CBT may be successfully applied by use of a performance anxiety treatment approach. This approach combines psychoeducation, cognitive restructuring, exposure to sexual performance anxiogenic situations, and behavioral experiments to test maladaptive beliefs. Relapse prevention exercises may also be useful to help a patient to maintain gains.

Limitations of Case Examples

Although the approach outlined in this article may be useful for a variety of gay male patients, there are limitations to the generalizability of these two cases. Both patients were reasonably successful in meeting men to date, which made it significantly easier to conduct exposures to sexual performance anxiety and behavioral experiments, and therefore to produce good treatment progress. Also, neither patient met criteria for another psychiatric or medical diagnosis. It may be more challenging to treat a patient with a comorbid diagnosis such as major depression or a medical diagnosis such as diabetes that may decrease vascular functioning. In these cases, it may be wise to treat the comorbid psychological problem first in the case of a psychiatric diagnosis or to consult with the patient's medical provider in the case of a medical diagnosis. Lastly, both men were Caucasian and

had jobs enabling them to pay for psychotherapy with health insurance coverage. As such, more information is needed with regard to the treatment of sexual difficulties among ethnically diverse and lower-income populations.

Suggestions for Therapists Treating Gay Men for Erectile Dysfunction

To successfully treat gay men, it is important to be aware of differences between gay men and heterosexual men regarding sexual attitudes and beliefs. Several articles and books may be useful for behavioral and cognitive-behavioral therapists treating gay men as well as lesbians, bisexual individuals, and transgender populations (Eubanks-Carter, Burckell, & Goldfried, 2005; Hart & Heimberg, 2001; Martell, Safren, & Prince, 2003; Nichols, 2000; Ritter & Tendrup, 2002; Safren, 2005; Safren & Rogers, 2001), including articles from *Cognitive and Behavioral Practice* (Kaysen, Lostutter, & Goines, 2005; Maguen, Shipherd, & Harris, 2005; Purcell, Campos, & Perilla, 1996; Safren, Hollander, Hart, & Heimberg, 2001). It is not necessary for a therapist to be completely knowledgeable about gay male culture and sexual situations in order to successfully conduct CBT for erectile dysfunction. In cases where a therapist is unclear as to the patient's beliefs, values, or social expectations, it is beneficial to ask the patient himself rather than either assuming that one's knowledge from heterosexual populations is always applicable to gay men, or, on the contrary, assuming that gay men must always differ from their heterosexual peers.

Future Directions

Given the lack of rigorous treatment data on CBT for erectile dysfunction, there is clearly a need for systematic examination of this approach, as well as other approaches that may be useful for gay male couples, such as sensate focus. It is also important to examine treatment outcomes among gay men living with HIV, who may have increased problems with erectile dysfunction following treatment with antiviral medications (Collazos, Martinez, Mayo, & Ibarra, 2002; Lamba, Goldmeier, Mackie, & Scullard, 2004). Given different sexual attitudes and values found among many gay men versus the heterosexual majority culture, future research should also consider including both gay men and heterosexual men in treatment research to compare outcomes between the two groups.

The lack of knowledge about erectile functioning and treatment strategies for erectile dysfunction among gay men may have increased the difficulty for behavior therapists working with this population and may have impaired treatment gains among patients. There is an even greater need for research on gay men who are single, given the focus of most of the sexual dysfunction literature on improving functioning among long-term couples. Despite the relative lack of research, erectile dysfunction in gay men can be treated using a combination of education, cognitive restructuring, and behavioral techniques. Further research will help therapists working with gay men to maximize gains for patients with erectile dysfunction and to further demonstrate the generalizability of CBT for diverse populations.

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