A Bibliography of 34 Counter-Narrative Sources
Prepared for the FDA 'Patient-Focused Drug Development Public Meeting and Scientific workshop on Female Sexual Dysfunction'
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Introduction

In 2010, The New View Campaign compiled 27 counter-narratives to present evidence that challenged the perceived value and need for Flibanserin, a drug proposed to treat 'Hypoactive sexual desire disorder,' a subset of 'Female Sexual Dysfunction.' The counter-narratives were published studies that highlighted the social, cultural, psychological, and interpersonal factors at the core of women's sexual dissatisfactions and treatment needs.

Since 2010, researchers have continued to produce overwhelming evidence that sexual problems are linked to contextual and relational factors far more than to physiological shortcomings.

Below are another 34 counter-narratives to the medicalized view of women's sexual problems. These abstracts extend the 2010 bibliography, representing 2010-2014 research published in well-respected journals without industry conflicts of interest.

These studies

- explore the myriad traditions of safe and effective non-pharmaceutical treatments for women's sexual difficulties,
- examine the complex workings of female sexuality as rooted in health, psychology, education, and policy,
- acknowledge the abundant promises and negative outcomes that a sexual pharmaceutical can yield.

The bibliography of independent, peer reviewed published works is organized as follows:

I. Efficacy of diverse psychological treatments
   - o psychological, psychosocial, cognitive behavioural, mindfulness training, and sex therapy interventions

II. Exploring multivariate factors contributing to women's sexual problems
   - o sexual attitudes, body image, social identity, other illnesses, and stress as they affect women's sexual problems

III. Theorizing sexual function and desire

IV. Contentions over DSM diagnostic criteria
   - o why the APA no longer considers 'hypoactive sexual desire disorder' to be a legitimate diagnostic label

V. Lessons from male sexual pharmaceuticals
- why men discontinue sexual pharmaceutical drug use

I. Efficacy of diverse psychological treatments

1) Frühauf, S., Gerger, H., Schmidt, H.M., Munder, T., & Barth, J. (2013). Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis. *Archives of Sexual Behavior, 42,* 915-933.

Psychological interventions are promising treatment options because sexual dysfunction is frequently caused and maintained by psychological factors. We conducted a systematic review and meta-analysis of all available studies from 1980 to 2009 on the efficacy of psychological interventions for patients with sexual dysfunction. A total of 20 randomized controlled studies comparing a psychological intervention with a wait-list were included in the meta-analysis. Psychological interventions were shown to especially improve symptom severity for women with HSDD and orgasmic disorder.

2) Günzler, C. & Berner, M.M. (2012). Efficacy of Psychosocial Interventions in Men and Women With Sexual Dysfunctions—A Systematic Review of Controlled Clinical Trials: Part 2—The Efficacy of Psychosocial Interventions for Female Sexual Dysfunction. *Journal of Sexual Medicine, 9,* 3108-3125.

We identified 15 randomized controlled trials that investigated female sexual dysfunction and two further studies that examined male and female sexual dysfunction together. Most trials explored sexual pain disorders. Studies used either a Masters and Johnson approach or a cognitive-behavioral treatment program. Both approaches showed significant improvements compared with a control group. Benefit was not always maintained over the (variable) follow-up period.

3) Hucker, A. & McCabe, M.P. (2014). An Online, Mindfulness-Based, Cognitive-Behavioral Therapy for Female Sexual Difficulties: Impact on Relationship Functioning. *Journal of Sex & Marital Therapy, 40(6),* 561-576.

This article evaluates an online treatment for female sexual difficulties, Pursuing Pleasure, a mindfulness-based, cognitive behavioral therapy. In Study 1, 26 women completed treatment and changes were compared with a waitlist control group (n = 31). In Study 2, 16 women from the control group then completed treatment. Both treatment groups showed significant improvements in sexual intimacy and communication, and emotional intimacy improved significantly in the Study 1 treatment group. Most improvements were maintained at follow-up.

4) Brotto, L.A., Seal, B.N., & Rellini, A. (2012). Pilot Study of a Brief Cognitive Behavioral Versus Mindfulness-Based Intervention for Women With Sexual Distress and a History of Childhood Sexual Abuse (CSA). *Journal of Sex & Marital Therapy, 38(1),* 1-27.

Recent evidence for the benefits of mindfulness, which emphasizes present-moment non-judgmental awareness, provided the impetus for this pilot study. Twenty partnered women with sexual difficulties and significant sexual distress, and a history of CSA were randomized to two sessions of either a cognitive behavioral (CBT, n = 8) or mindfulness-based (MBT, n = 12) group treatment. Women in the MBT group experienced a significantly greater subjective sexual arousal response to the same level of genital arousal compared to the CBT group and to pre-treatment. Both groups experienced a significant decrease in sexual distress. **These data support the further study of mindfulness-based approaches in the treatment of sexual difficulties characterized by a disconnection between genital and subjective sexual response.**

5) Silverstein, R.G., Brown, A.C., Roth, H.D., & Britton, W.B. (2011). Effects of mindfulness training on body awareness to sexual stimuli: Implications for female sexual dysfunction. *Psychosomatic Medicine, 73(9),* 817-825.

Negative self-evaluative processes interfere with the ability to attend and register physiological changes. This study explores the effect of mindfulness meditation training on interoceptive awareness and the three categories of known barriers to healthy sexual functioning: attention, self-judgment, and clinical symptoms. Forty-four college students (30 women) participated in either a 12-week course containing a “meditation laboratory” or an active control course. Interoceptive awareness was measured by reaction time in rating physiological response to sexual stimuli. Psychological barriers were assessed with self-reported measures. Results show that women who participated in meditation training became significantly faster at registering physiological awareness to sexual stimuli compared with active controls and also improved on self-judgment, anxiety and depression.

6) Pereira, V.M., Arias-Carrión, O., Machado, S., Nardi, A.E., Silva, A.C. (2013). Sex therapy for female sexual dysfunction. *International Archives of Medicine, 6(1),* 37-54.

This study reviews randomized clinical trials that present psychotherapeutic interventions for female sexual dysfunctions. Through a search in three databases (Medline, Web of Science and PsycInfo), 1419 references were found. Twenty-seven articles met the inclusion criteria for this review. Sex therapy, as proposed by

Masters and Johnson, Heiman and LoPiccolo, is still the most commonly used form of therapy for sexual dysfunctions. Orgasmic disorder and sexual pain (vaginismus and dyspareunia) are the most extensively studied disorders and those in which sex therapy seems to have better outcomes.

7) Stephenson, K.R., Rellini, A.H., & Meston, C.M. (2013). Relationship Satisfaction as a Predictor of Treatment Response During Cognitive Behavioral Sex Therapy. *Archives of Sexual Behavior, 42(1),* 143-152.

Thirty-one women with sexual dysfunction receiving cognitive- behavioral sex therapy (with or without ginkgo biloba), were assessed pre- and post-treatment for sexual satisfaction, sexual distress, sexual functioning, and relationship satisfaction. Women with higher relationship satisfaction at intake experienced larger gains in sexual satisfaction and distress over the course of treatment. Improved sexual functioning was associated with decreased sexual distress only for women entering therapy with high relationship satisfaction.

II. Multivariate Factors Contributing to Women's Sexual Problems

A. Sexual Attitudes

8) Mitchell, K. R., Mercer, C. H., Ploubidis, G. B., Jones, K. G., Datta, J., Field, N., ... & Wellings, K. (2013). Sexual function in Britain: Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet*, *382(9907),* 1817-1829.

We undertook a probability sample survey [Natsal-3] in Britain and obtained data for 4913 men and 6777 women. For men and women, low sexual function was associated with increased age, and, after age-adjustment, with depression and self-reported poor health status, experiencing the end of a relationship, inability to talk easily about sex with a partner and not being happy in the relationship. Low sexual function was associated with numerous other factors including sexual frequency, same sex history, experience of non-volitional sex and STI diagnosis. Among individuals reporting sex in the past year, **problems with sexual response were common (42% of men and 51% of women reported one or more problem) but self-reported distress about sex lives was much less common (10%).** For individuals in a sexual relationship for the past year, 23% of men and 27% of women reported an imbalance in level of interest in sex between partners, and appr. 20% said that their partner had had sexual difficulties. **Most participants who did not have sex in the past year were not dissatisfied, distressed, or avoiding sex because of sexual difficulties.**

9) Santos-Iglesias, P., Sierra, J.C., Vallejo-Medina, P. (2012). Predictors of sexual assertiveness: The role of sexual desire, arousal, attitudes, and partner abuse. *Archives of Sexual Behavior, 42,* 1043-1052.

This study assessed interpersonal, attitudinal, and sexual predictors of sexual assertiveness in a Spanish sample of 1,619 men and 1,755 women aged 18–87. In men, higher sexual assertiveness was predicted by more positive attitudes toward sexual fantasies and erotophilia, higher dyadic desire, and higher sexual arousal. **In women, higher sexual assertiveness was predicted by less non-physical abuse, less solitary sexual desire and higher dyadic sexual desire, erotophilia, and positive attitudes towards sexual fantasies.**

10) Herbenick, D., Reece, M., Schick, V., Jozkowski, K.N., Middelstadt, S.E., Sanders, S.A.,…& Fortenberry, J.D. (2011). Beliefs about women's vibrator use: Results from a nationally representative probability survey in the United States. *Journal of Sex & Marital Therapy, 37(5),* 329-345.

Surveys and interviews informed the development of a 10-item scale, the Beliefs About Women's Vibrator Use Scale, which was administered online. **Most women and men held high positive and low negative beliefs about women's vibrator use. Women with positive beliefs reported higher questionnaire scores related to higher arousal, lubrication, orgasm, and satisfaction, and less pain.**

B. Body Image

11) Woertman, L., & van den Brink, F. (2012). Body image and female sexual functioning and behavior: A review. *The Journal of Sex Research, 49(2-3),* 184-211.

In this review, 57 empirical studies were reviewed regarding the association between sexuality and body image among healthy women. Cognitions and self-consciousness are key factors operating between women's body image and sexuality. **Body evaluations and cognitions not only interfere with sexual responses and experiences during sexual activity, but also with sexual behavior, sexual avoidance, and risky sexual behavior.**

12) Pazmany, E., Bergeron, S., Oudenhove, L.V., Verhaeghe, J. & Enzlin, P. (2013). Body Image and Genital Self-image in Pre-menopausal Women with Dyspareunia. *Archives of Sexual Behavior, 42,* 999-1010.

With a prevalence of 15–21 %, dyspareunia is one of the most commonly reported sexual dysfunctions in pre-menopausal women under the age of 40. The present, controlled study investigated body image and genital self-image in a community sample of 330 pre- menopausal women with self-reported dyspareunia and 138 pain-free controls. Women with dyspareunia reported significantly more distress about their body image and a more negative genital self-image. When trait anxiety was controlled for, **a more negative genital self-image was strongly and independently associated with an increased likelihood of reporting dyspareunia**.

13) Weaver, A. D., & Byers, E. S. (2013). Eye of the beholder? Sociocultural factors in the body image and sexual well-being of heterosexual women. *International Journal of Sexual Health*, *25*(2), 128-147.

Studying 124 women, we **supported a proposed perception-of-partner pathway** in that greater DISC (discrepancy between perceptions of actual and ideal figure) was associated with poorer body image, which in turn was associated with poorer sexual well-being.. **Heterosexual women's beliefs about how their partners view them are important to their sexual well-being.**

14) Zhaoyang, R. & Cooper, M.L., (2013). Body Satisfaction and Couple's Daily Sexual Experience: A Dyadic Perspective. *Archives of Sexual Behavior, 42,* 985-998.

The current study used 1,598 daily sex reports completed by 144 couples over an average of 3 weeks. Results indicated that **an individual's satisfaction with his or her own body was not as important to the overall quality of sexual experience as one's satisfaction with the partner's body or as the partner's satisfaction with the individual's body**. Women's sexual outcomes were more strongly shaped by partner satisfaction with her body than the reverse**.**

C. Social Identity

15) Fahs, B. & Swank, E. (2010). Social identities as predictors of women's sexual satisfaction and sexual activity. *Archives of Sexual Behavior, 40(5), 903-914.*

This study utilized secondary analysis of 1,473 women from the National Health and Social Life Survey. Lower status women (women of color, working-class, younger, less educated, women who worked full-time) reported low sexual satisfaction and high levels of sexual activity. Women who reported high satisfaction and low activity represented the largest cluster of women, indicating that **more women**

reported a disjuncture between satisfaction and activity than reported a match between satisfaction and activity..

D. Illness

16. de Lucena, B. B., & Abdo, C. H. N. (2014). Personal factors that contribute to or impair women's ability to achieve orgasm. *International Journal of Impotence Research,* 26, 177-181.

This work compared women in a stable relationship that, after a normal arousal phase, do not have an orgasm (OD) with those who do (OA). Significant differences were found with regard to level of education, sex education during childhood and/or adolescence, masturbation, sexual satisfaction, anxiety, and sexual desire. Women who masturbate and/or have completed high school are considerably more likely to reach orgasm during sexual activity.

17) McClelland, S.I., Holland, K.J., & Griggs, J.J. (2014). Vaginal dryness and beyond: The sexual health needs of women diagnosed with metastatic breast cancer. *The Journal of Sex Research. Online first August 11:1-13.*

Semistructured interviews were conducted with 32 women diagnosed with metastatic breast cancer (ages 35 to 77) about questions they had concerning their sexual health and intimate relationships. **Findings indicated that sexual activities with partners were important; however, participants worried about their own physical limitations and reported frequent physical (e.g., bone pains) and vaginal pain associated with intercourse. When women raised concerns about these issues in clinical settings, medical providers often focused exclusively on vaginal lubricants, which did not address the entirety of women's problems or concerns**. In addition, women diagnosed with metastatic breast cancer reported needing additional resources about specialized vaginal lubricants, nonpenetrative and nongenitally focused sex, and sexual positions that did not compromise their physical health yet still provided pleasure.

18) Salisbury, C. M., & Fisher, W. A. (2013). “Did You Come?”: A qualitative exploration of gender differences in beliefs, experiences, and concerns regarding female orgasm occurrence during heterosexual sexual interactions. *The Journal of Sex Research*, (ahead-of-print), 1-16.

Qualitative reports were obtained from five female and five male focus groups with three to five participants per group. For both men and women, the most common concern regarding lack of female orgasm in a partnered context focused on the

negative impact this might have on the male partner's ego. Male and female participants also agreed that men have the physical responsibility to stimulate their female partner to orgasm, while women have the psychological responsibility of being mentally prepared to experience the orgasm. **Men and women tended to maintain different beliefs, however, regarding clitoral stimulation during intercourse, as well as the importance of female orgasm for a woman's sexual satisfaction in a partnered context.**

E. Stress

19) Hamilton, L.D. & Julian, A.M. (2010). The Relationship Between Daily Hassles and Sexual Function in Men and Women. *Archives of Sexual Behavior, 39,* 221-239.

Participants completed online questionnaires on daily stressors, anxiety, depression, and sexual function. Daily stressors predicted lower scores on sexual satisfaction. Daily stressors, depression, and anxiety were highly correlated. Financial stressors and stressors related to low socioeconomic status were related to lower scores on all aspects of sexual functioning for women but not for men. Women's sexual functioning scores were more strongly related to stress and depression than men's scores.

III. Theorizing sexual function and desire

20) Bogaert, A.F. & Brotto, L.A. (2014). Object of Desire Self-Consciousness Theory. *Journal of Sex & Marital Therapy, 40,* 323-338.

The construct of *object of desire self-consciousness* is the perception that one is romantically and sexually desirable in another's eyes. The authors discuss the nature of the construct, variations in its expression, possible sources, and how it may function as part of a script related to romance and sexuality. The authors review literature on fantasies, sexual activity preferences, sexual dysfunctions, and language that suggest that **object of desire self-consciousness plays a particularly important role in heterosexual women's sexual/romantic functioning and desires.**

21) Carvalheira, A. A., Brotto, L. A., & Leal, I. (2010). Women's motivations for sex: Exploring the diagnostic and statistical manual, text revision criteria for hypoactive sexual desire and female sexual arousal disorders. *The Journal of Sexual Medicine*, *7*, 1454-1463.

There are problems with the existing definition of hypoactive sexual desire disorder (HSDD). 3687 women completed a web-based survey. Desire for sex and sexual

fantasy are not universal experiences. Among women who easily became aroused, 16% reported only engaging in sex if they felt sexual desire at the outset whereas 31% typically or always accessed desire only once they were aroused. **Women in longer-term relationships engaged in sex with no sexual desire more often (42%) than women in short-term relationships** (**23%).** After controlling for age, **relationship duration was negatively associated with frequency of initiating sex**, **women's satisfaction with their own sexuality and sexual satisfaction with the partner**. Relationship duration should be recognized in any future diagnostic framework of dysfunction.

22) Cuntim, M., & Nobre, P. (2011). The role of cognitive distraction on female orgasm. *Sexologies*, *20*, 212-214.

A total of 191 women from the general population completed questionnaires assessing orgasm function, automatic thoughts during sexual activity and cognitive distraction. Findings indicated that lack of erotic thoughts during sexual activity was the best predictor of women's sexual difficulties. **Sexual abuse thoughts, failure and disengagement thoughts, partner's lack of affection, sexual passivity and control, and lack of erotic thoughts were significantly higher in women with orgasm difficulties compared to sexually healthy women**.

23) Ferreira, L.C., Narciso, I., & Noo, R.F. (2012). Intimacy, Sexual Desire and Differentiation in Couplehood: A Theoretical and Methodological Review. *Journal of Sex & Marital Therapy, 38,* 263-280.

Although **some dimensions associated with intimacy tend to increase during the relationship, sexual desire and related constructs tend to decrease.** Some researchers have recently suggested that couples' relationships with high degrees of sharing and fusion might be particularly detrimental for the sustenance of sexual desire. **This article explores the concept of differentiation as a possible influencing variable between intimacy and desire.**

24) McCabe, M. P., & Goldhammer, D. L. (2012). Demographic and psychological factors related to sexual desire among heterosexual women in a relationship. *Journal of Sex Research*,*49*, 78-87.

This study examined demographic, psychological, and relationship factors associated with the experience of sexual desire in women. Participants were 741 partnered heterosexual women who completed questionnaires online. For each of six aspects of sexual desire, the number and frequency of problems in other aspects of women's sexual functioning were the most common predictors,

indicating a strong interrelationship among aspects of sexual response. S**exual desire was lower among older, postmenopausal women, those who had been in their current relationship for a longer period of time, and if their partner experienced a sexual dysfunction.**

25) Oliveira, C., & Nobre, P. J. (2013). Cognitive structures in women with sexual dysfunction: The role of early maladaptive schemas. *Journal of Sexual Medicine*, *10*, 1755-1763.

The aim of this study was to evaluate the presence and importance of early maladaptive cognitive schemas on women's sexual functioning. The study had a control sample of 167 women without sexual problems, a subclinical sample of 37 women with low sexual functioning, and a clinical sample of 24 women with sexual dysfunction. Participants completed several questionnaires. W**omen with sexual dysfunction acknowledged significantly more early maladaptive cognitive schemas** having to do with failure, dependence/incompetence, and vulnerability to danger. These negative thought patterns were especially noteworthy in response to negative sexual events.

26) Mitchell, K.R. & Wellings, K.A. (2014). How Do Men and Women Define Sexual Desire and Sexual Arousal? *Journal of Sex & Marital Therapy, 40(1),* 17-32.

The purpose of this study was to understand how men and women define and distinguish *sexual desire* and *sexual arousal*. The authors conducted 32 semi-structured interviews in South East England. **Participants generally used 3 criteria: the sequence in which** the d**esire and arousal occurred; whether the mind or the body (or both) were engaged; and the extent to which feelings of desire or arousal were responsive (in response to person or stimulus) and motivational (oriented toward a goal**). However, there were numerous times when these distinctions were reversed or blurred. **The results support recent proposals to merge the diagnostic categories of female sexual arousal disorder and hyposexual desire disorder into a single diagnostic category.**

27) Fahs, B. & Frank, E. (2014). Notes from the back room: Gender, power, and (in)visibility in women's experiences of masturbation. *The Journal of Sex Research, 51(3),* 241-252.

Masturbation research that emphasizes frequency, health correlates, and couples' issues has dominated research, largely neglecting social and subjective

perspectives. This study drew upon qualitative interviews with 20 women that illuminated political and experiential themes in women's experiences with masturbation that revealed the internalization of stereotypically masculine scripts: a) assumptions that most women self-penetrate during masturbation even when primarily focused on clitoral stimulation; b) masturbation as sexual labor; c) masturbation as a threat to male dominance; d) masturbation as routine tension release; and e) masturbation as a source of joy, fun, and pleasure.

IV. Contentions in DSM Diagnostic Critera

28) Brotto, L.A. (2010). The DSM diagnostic criteria for hypoactive sexual desire disorder in women. *Archives of Sexual Behavior, 39(2),* 221-239.

This article reviews the diagnosis of Hypoactive Sexual Desire Disorder (HSDD) in prior and current (DSM-IV-TR) editions of the DSM, critiques the existing criteria, and proposes criteria for consideration in DSM-5. The main problems are: **no clear operational definition of desire, the fact that sexual activity often occurs without desire, confusions over untriggered versus responsive desire, the relative infrequency of unprovoked sexual fantasies, and the significant overlap between desire and arousal**. The article concludes with the recommendation that desire and arousal be combined into one disorder.

29) Graham, C., Brotto, L., & Zucker, K. (2014). Response to Balon and Clayton (2014): Female Sexual Interest/Arousal Disorder is a diagnosis more on firm ground than thin air. *Archives of Sexual Behavior, 43(7),* 1231-1234.

In their commentary on the DSM-5, Balon and Clayton (2014) claimed that the creation of the new DSM-5 diagnosis of Female Sexual Interest/ Arousal Disorder (FSIAD) ‘‘creates havoc in the entire area of sexual dysfunction.’’ This is just one of many hyperbolic (and, as we will argue, unsupported) statements made in their commentary which we will analyze.

V. Lessons from male sexual pharmaceuticals

A. Recreational use

30) Harte, C.B. & Meston, C.M. (2011). Recreational use of erectile dysfunction medications in undergraduate men in the United States: Characteristics and associated risk factors. *Archives of sexual behavior, 40,* 597-606. DOI 10.1007/s10508-010-9619-y

Erectile dysfunction medications (EDMs) are often used as a sexual enhancement

aid by men without a medical reason. Recreational EDM use has been associated with various sexual risk behaviors. In the present study, a sample of 1,944 men was recruited from U.S. undergraduate institutions between 2006 and 2007. Four percent of participants had recreationally used an EDM at some point in their lives, with 1.4% reporting current use. **The majority of recreational college EDM users reported mixing EDMs with illicit drugs, particularly during risky sexual behaviors. Recreational EDM use was independently associated with increased age, gay, or bisexual sexual orientation, drug abuse, lifetime number of sex partners, and lifetime number of "one-night stands."** Recreational EDM users reported twice the rate of erectile difficulties compared to nonusers**.** A sizable portion of recreational EDM users are heterosexual men whose use does not solely occur within venues that cater to men having sex with men.

B. PDE5 Discontinuation

31) Carvalheira, A.A., Pereira, N.M., Maroco, J., and Forjaz, V. (2012). Dropout in the treatment of erectile dysfunction with PDE5: A study on predictors and a qualitative analysis of reasons for discontinuation. *Journal of Sexual Medicine, 9,* 2361-2369.

A total of 327 men with clinical ED who had been treated with PDE5 were interviewed by telephone. Of the total sample, 160 men (48.9%) had discontinued PDE5 treatment. The discontinuation rate was higher among men with diabetes (73%) and in iatrogenic group (65%), and lower in venogenic etiology (38.7%) Qualitative analyses revealed diverse reasons for discontinuation: non-effectiveness of PDE5 (36.8%), psychological factors (e.g., anxiety, negative emotions, fears, concerns, dysfunctional beliefs) (17.5%), erection recovery (14.4%), and concerns about the cardiovascular safety of PDE5 (8.7%). Older men and men whose partners were involved in the treatment, were less likely to discontinue treatment.

32) Carvalheira, A., Forjaz, V., and Pereira, N.M. (2014). Adherence to phosphodiesterase type 5 inhibitors in the treatment of erectile dysfunction in long-term users: How do men use the inhibitors? *Journal of Sexual Medicine, 2,* 96-102.

A total of 148 men with clinical ED who maintained the treatment with PDE5-i for over 3 years were interviewed. 75% claimed not to use PDE5-i in every intercourse. **Analyzing men's narratives revealed a combination of factors that influence the adherence to PDE5-i, with psychological and medication-related factors most prevalent.**

33) Conaglen, H.M. & Conaglen, J.V. (2012). Sexual medicine: Why stop a good thing? Discontinuing PDE5 inhibitors. *Nature Reviews Urology 9,* 483-485.

Most studies investigating reasons for discontinuation of successful treatments for erectile dysfunction (ED) have been published relatively soon after each type of therapy has been introduced. **The time has come to further investigate discontinuation from a multidisciplinary perspective.**

34) Conaglen, H.M. & Conaglen, J.V. (2012). Couples' reasons for adherence to, or discontinuation of, PDE Type 5 inhibitors for men with erectile dysfunction at 12 to 24 month follow-up after a 6 month free trial. *Journal of Sexual Medicine, 9,* 857-865.

155 interviews were conducted. 71% were using PDE5 at 18 months. Most men interviewed were using the oral medications either 1–2x/week or 1–2x/month. 44% of men who had decreased their use reported less need for them. 34 men said the main reason they used less medication was cost. “Partner issues” from the men's perspective were seldom reported in this study. However, **for a number of women, “partner issues” meant a range of problems from separation to alcohol abuse, lack of communication, and lack of confidence, or fear of failure.** This is the first study to ask couples why they decided to continue or stop using PDE5 when followed up. Female partners provided a different perspective on “partner issues” often cited as reasons for discontinuing PDE5 use. It was also clear that discontinuation did not mean couples were no longer sexually active.