MEDICAL ACUPUNCTURE
Volume 26, Number 3, 2014

DOI: 10.1089/acu.2014.1034

A Multidisciplinary Approach Using Auriculotherapy for Erectile Dysfunction: A Qualitative Case Study

Susanne Suenson, MPH

ABSTRACT

Background: In 2007, 19 men with erectile dysfunction (ED) were treated in the current author's clinic, using a multidisciplinary approach a duration of 20 weeks, with weekly interventions. This multidisciplinary approach included auriculotherapy with the VAS (Vascular Autonomic Signal), Traditional Chinese Medicine (TCM) acupuncture, motivational interpellation (meaning admonition, not discussion), and practical exercises for home use.
Objective: The aim of this study was to demonstrate that a multidisciplinary approach to treating ED can be useful.
Design: A case-study procedure was used. Data consisted of self-evaluation texts together with therapy records for the patients. A hermeneutical method was used to process data.
Results: It was concluded that a multidisciplinary approach to treating ED help achieve both improved erectile function and self-esteem. This approach also improved social relations, and this was demonstrated via the self-assessment data processed by interpretation. Eighteen men experienced improved erectile function.
Discussion: The problem of ED must be studied as a biologic, social, and psychologic phenomenon in context, and examined from the perspective of the patient who experiences ED. Such persons can render information that may be interpreted by a therapist and/or a hermeneutical researcher. A health condition may be described in terms of its position in a continuum. The multidisciplinary therapy, as was used in this study, may have a marked impact on a man's self-esteem, restoring his feeling of manhood, compared to single biomedical treatment of ED.
Conclusions: A multidisciplinary model that incorporates auriculotherapy, TCM, motivation, and exercises is a useful treatment for ED.

Key Words: Erectile Dysfunction; Auriculotherapy; Acupuncture; Motivation; Exercises; Self-Assessment; Case Study; Qualitative Research; Multidisciplinary

INTRODUCTION

Erectile dysfunction (ED) is a presenting disorder at the current author's clinic in Copenhagen, Denmark. In 2007, the current author and colleagues studied ED in 19 men in the clinic. Seven spouses or partners also made contributions to help improve understanding of this phenomenon based on scientific investigation. A case-study design was used, involving a multidisciplinary treatment procedure that included auriculotherapy with the Vascular Anatomic Signal (VAS), Traditional Chinese Medicine (TCM) acupuncture, motivational interpellation, and practical exercises for home use. The results were assessed based on participants' self-reported changes in their erectile function and the current

Noerreport.com Akupuntur Clinic, Copenhagen, Denmark.

author's therapy notes. These subjective interpretations revealed improvements in erectile function in 18 of 19 cases.

ED, as a phenomenon, should be viewed as existing on a continuum from function to dysfunction and as a field of relationships affecting self-esteem and social relationships to the same extent that ED manifests in the biologic–medical sphere. Accordingly, the concept of a multidisciplinary, biopsychosocial model for understanding and treating the disorder lent itself to the cases in the present study.

Prevalence and Association

A Danish multicenter study involving 4310 male patients in general practice was published in 2004.[1] Age is a known risk factor for ED; the prevalence of complete ED was estimated at 4.5% in people ages 40–45, 11.1% in people ages 50–55, and 52% people ages 75–80.

The Massachusetts Male Aging Study (MMAS)[2] of 1987–1989, was a prospective study on the prevalence of ED in 1709 male Americans between ages 40 and 70, and found that prevalence of every degree of severity was 52%. Complete ED was found in 5% of 40-year-old men and in 15% of 70-year-old men.

A sizeable part of even the younger population in Denmark is affected by this problem. In a study published in 2011,[3] the prevalence of ''erectile difficulties'' (less-severe cases of ED) varies between 18% and 30% of 16-year-old men to 49-year-old men. Regular dysfunction, together with ''difficulties,'' affected 40% of the 4415 Danish males participating in this study.

While morbidity is a risk factor for ED,[4] healthy men also experience it.[5] ED affects both patients' sexuality and outlook on life.[6]

To the extent that humans regard well-functioning sexual abilities as a quality-of-life (QoL) issue in the general population, a dysfunction such as ED threatens general QoL.[6–8] Recent research suggests that ED is a marker as well as a predictor for somatic morbidity, such as metabolic syndrome and coronary heart disease.[9,10] It is possible that, in patients who are chronically ill, ED functions as an indicator of lack of coping and motivation to be treated, and thus is associated with a poor prognosis.

ED and the Biopsychosocial Model

ED should be targeted with a holistic approach, using the World Health Organization (WHO) definition of sexual health.[11] Such an approach, the biopsychosocial model, was offered by Engels in 1977.[12] It outlines a consolidated physiologic (biomedical), psychologic, and social understanding of sexuality; this approach to ED may be used to guide methods of diagnosis and intervention, whether from a therapeutic or public health perspective.

Sexual activity obviously involves physiologic processes; in addition, it involves psychologic processing via a man's motivation and expectations, his reactions and interpretations of erotic impulses, and his mental makeup and fundamental assumptions. Finally, sexuality occurs in a setting of specific values and societal perceptions shared by the people involved.

Elements of Diagnostics and Therapy

According to the WHO international classification of diseases (ICD)–10,[13] ED is a mental or behavioral disorder under the label F-52.2: ''Failure of genital response. The principal problem in men is Erectile Dysfunction (difficulty in developing or maintaining an erection suitable for satisfactory intercourse).'' As noted by Deadman,[14] there are cases of ED that do not come under the psychogenic etiology but are contingent on the presence of somatic disease. Yet, these cases have psychosocial implications.

In Western practice, ED was treated using behavioral modification or ''talk therapy,'' if the condition was treated at all, until medical treatment of ED was introduced via the U.S. Food and Drug Administration's (FDA) approval of sildenafil for medical use in 1998, followed by the approval of tadalafil and vardenafil in 2003 (trade names Viagra,® Cialis,® and Levitra,® respectively).[15]

Since the approval of these agents, ED—whether psychogenic or contingent on somatic disease—has predominantly been treated with medication. This therapy works directly on the smooth-muscle fibers of the penile blood vessels, thus, it is possible to avoid searching for the etiology of ED in a patient. However that incurs the risk of ignoring psychologic and behavioral factors that are at the root of the ED as well as biological factors stemming from other somatic disease that could be causing the ED. As it is, medication is not curative; instead it must be used each time a patient engages in sexual intercourse.

In contrast, the combined biopsychosocial approach developed in the current author's clinic enabled each patient's self-experienced phenomenon to be used as the ''starting point.'' Based on this, an appropriate anamnesis (therapist's recording of relevant data pertinent to the patient) is a prerequisite for arriving at an accurate diagnosis and providing proper therapy, using a wide range of ''tools,'' including those that are biomedical.

Men come for treatment even if they have some erectile function. They describe themselves as being ''impotent,'' which denotes a lack of power to do as they wish, when they wish—this problem is manifestly centered on just one thing: penile flaccidity. Awareness of biopsychosocial aspects of the condition, as discussed above, however, makes the therapist capable of relating to the larger picture of an individual man's condition in order to help treat it.

ED, Neurophysiology, and Auriculotherapy

The physiology of erection involves a range of regulatory processes in the human body and mind.[16] This physiology is centered in the hypothalamus. This part of the brain is

influenced by both sensory information (visual, olfactory, and somatosensory) and psychologic factors mediated via the cerebral cortex[17] (remembering and imagining) and the amygdala (learning, association, and habituation). At the spinal level of the S2–S4 plexes, brain activity is coordinated with sensory information from the mechanoreceptors of the penis. Both the parasympathetic and the sympathetic divisions of the autonomous nervous system are involved in establishing the erection. The baseline, sympathetic stimulation, centered on the TH10–L4 plexus together with a decrease in parasympathetic stimulation, restores the flaccid state. Hormones, neurohormones, and chemical agents—such as adrenaline, testosterone, oxytocin, 3,4-dihydroxyphenylalanine (DOPA), phenylethylamine, and nitric oxide—are involved in these processes.

To manipulate the erection using auriculotherapy with the VAS, one needs knowledge of the neurology of the entire process to detect, select, and choose from the range of points available for addressing a patient's ED.

ED and TCM Acupuncture

Likewise, the use of TCM acupuncture for treating ED requires knowledge of the choices available within classical TCM acupuncture.

According to TCM,[14] there are four factors involved in obtaining an erection. *Shen* (Spirit) is needed in order to muster desire. Yin and Blood must be present to fill the penis (*Zong Jin*) with Blood; Qi and Yang are needed to raise the penis and generate Heat; and *Jing* must flow to the penis in order to enable ejaculation.

The *Zang-fu* (organs) primarily involved and their channels (or meridians) are Kidney and Liver, but Heart is also involved and, potentially, the Gallbladder and Spleen channels.

The Kidneys are at the root of sexual development and libido. Kidney Yang is necessary in order to provide warmth, because without warmth, ED and loss of libido will follow. When Kidney Yin is lacking, this can lead to the failure of the penis to fill with Blood, totally or partially.

The role of the Liver and Gallbladder channels is to connect various parts of the body involved in erection and libido. The nature of the penis itself is defined by its Chinese name as the *Zong Jin*, a ''sinew,'' which also lends importance to the Liver and Gallbladder sinew channels.

Liver Deficiency is associated with failure to fill the penis with Yin and Blood.

The Spleen is associated with energy and anxiety. Deficiency in this organ may result in lack of Blood and Qi to fill the penis. The Heart is not directly associated with ED in TCM; however, if there is shortage of Qi in the Heart, *Shen* will not prevail and the actions of the Kidney will not be sufficient alone to promote libido and an erection. This highlights the connection between the mental and physiologic aspects of male sexuality.

MATERIALS AND METHODS

The Multidisciplinary Method

The observations below regarding the elements of diagnosis and therapy explain the rationale of the case study at the current author's clinic. The aim of the case study was to demonstrate that the multidisciplinary approach was effective for addressing ED. To summarize, this approach involved three major facets:

- Using specifically targeted auriculotherapy with the VAS intervention, based on neurophysiologic parameters
- Applying TCM acupuncture designed to direct energy toward the parts of the body and mind that need such energy
- Addressing motivational–explanatory impact and providing physical exercise.

This would take into account the concerns of the biopsychosocial model, that biomedicine alone is not able to circumscribe nor to contain the disorder complex of which the actual erection is only one part of several facets. Addressing the biopsychosocial relation to practice, self-esteem, and social relations for each patient influences the amount of time until that patient's experience of ED converts into an experience of erectile function.

In other words, this study attempted prove that this multidisciplinary approach to treating ED can be used to achieve both improved erectile function and self-esteem. This treatment is also likely to ameliorate impaired social relations. The results can be demonstrated through analysis of self-assessment data.

The Case Study Method

The current author used the case study as a framework because this framework lends itself to understanding of complex issues. The case-study research method is an empirical inquiry that investigates a contemporary phenomenon within its real-life context and in which multiple sources of evidence are used.[18]

In this case study, participants were compelled to face their ED, placing it in an expanded context. The confrontation with needle therapies, exercises, questions and information was mirrored in the patients' self-evaluation texts, which, again, were mirrored in the current author's subsequent interpretation. This double phenomenology—(1) the participants who have ED and (2) the current author's medical records of the participants, their ED, and their self-assessment texts—comprised the elements that were being studied.

The texts contributed by the participants were read and evaluated according to phenomenological and textual critique procedures, primarily using Dewey's (as discussed in Thayer)[19] and Good's[20] approach. Antonovsky's concept of *sense of coherence*[21] was used, along with the sociomedical

researcher, Gannik's concept of *field of ailment-oriented action*.[22]

Materials

The original material was recorded from February through July 2007 at the current author's clinic and is comprised of the participants' notes about their experiences during the therapy and the current author's therapy records.

The participants were recruited through an article in a womens' magazine (because of the impact on candidates' wives and girlfriends). The criterion and only screening utilized was for participants to have imminent, manifest ED. The participants had to consent to not use erection-inducing medication during the study period. Twenty-three men applied to participate in the study, and 4 were excluded on the basis of the noted criteria. The 19 participants had previously visited their general practitioners and most of these patients had been treated with medication. None had previously been treated with any other therapy besides medication.

The participants' age distribution was as follows: 1 in age group 70–74; 1 in age group 65–69; 5 in age group 60–64; 3 in age group 55–59; 2 in age group 50–54; 2 in age group 45–49; 3 in age group 40–44; 1 in age group 35–39; and 1 in age group 20–24. The average age was 53.3 years.

An approval of the project was not mandatory according to the guidelines for Ethics Committees in Science, pursuant to the legislation of the Kingdom of Denmark (''Lov om videnskabsetiske Komiteer nr. 402 af 28. maj 2003,''; ''Act on Medical Ethics Committies, Number 402,'' May 28, 2003).[23] The Danish legislation is in accordance with the Declaration of Helsinki.

Participants were informed and had consented to their texts being used in a publication on ED. Names and personal data are changed.

The project consisted of 19 participants being given individualized therapies once weekly, for 60 minutes, free of charge, through 20 weeks starting in February, 2007. The therapies included the following weekly interventions:

- Instruction in how to understand the man's part in a sexual relationship
- Introduction to doing daily exercises at home to strengthen erectile function
- Treatment with auriculotherapy with VAS at the clinic
- Treatment with TCM acupuncture at the clinic
- Discussion at the clinic to assess participants' compliance
- Self-assessment via e-mail, submitted by participants, weekly or fortnightly.

All therapies were administered during every session for all participants. The sequence was auriculotherapy before TCM acupuncture with the other disciplines used according to what occurred during the session.

The choice and sequence of points to treat, whether auricular or TCM points, was decided, based on a therapy assessment made in each session and using the points described in some of the sections below.

A psychologist collected the self-assessment reports and conducted a final interview with each participant.

Treatment Protocols

Four disciplines were used for treatment as described in the sections below.

Auriculotherapy with VAS. Taking into account the neurophysiology of ED, an intervention was undertaken by way of a number of auriculotherapy points and using the VAS. The Nogier VAS pulse[24] is a tactile detection of changes in the arterial waveform following stimulation of the auricle and thereby constitutes a method for detecting ear points capable of influencing the appropriate mechanisms therapeutically.

Based on an assessment of the specific mechanism to be supported or suppressed, the aim of an intervention is to use what is most effective and most economically practical, in terms of the number of needles applied.

Semipermanent (Aiguilles Semi-Permanentes [ASP]–type) steel needles were used for auriculotherapy throughout the project. Typically, a session would involve two, occasionally three, needles in each ear, but not always bilaterally. The selection of points would be indicated by the VAS reaction (Table 1).

TCM acupuncture. The overall aim of TCM acupuncture is to support, mentally and physically, the patient's endeavors to master his predicament. The preferred combinations during the 20 sessions and 5 months of the study were:

- *Main variant*—HT 7, GV 24, CV 4, and CV 15
- *Additional points*—one might consider opening *Du Mai* (GV) with SI 3 (L) and BL 62 (R)
- *Secondary variant*— LR 8, SP 6, CV 3, GB 34, TE 6, LR 3, and KI-6.

In some cases, conditions not pertinent to the actual ED may require treatment before treating ED.

The needling choice was made according to the progress made by each patient.

The needles used for TCM acupuncture throughout the project were Carbo, FDA-approved, surgical-grade, U.S. stainless-steel needles, gauged by length in mm: 0.2×13, 0.25×25, and 0.3×40. The needling techniques were neutral (no stimulation), bilateral, and/or guided by De Qi; and the needling duration was 20–30 minutes.

The main variant of TCM points derives from Maciocia's concept, which emphasizes the interconnection between the Heart and ED.[25,26] In TCM, the Heart is the seat of mental and emotional activity. Maciocia used points on the Heart meridian to treat ED, because the disorder generally is caused by too little or too much Heart Fire rather than by a

Table 1. Auriculotherapy Points Used to Address Erectile Dysfunction

Point	*Therapeutic indication*
''Aggressivity'' Point	Used to address aggressiveness & sexuality being interrelated
Amygdala	Used to treat lack of desire; the amygdala and fear are interrelated; & may be used with caution to suppress prohibitive memory
Anterior Hypothalamus	Used to stimulate testosterone production via the Anterior Pituitary Gland; in cases when erection ends prematurely; & to increase libido
Anterior Pituitary Gland	Used to stimulate FSH to promote maturity in sperm cells in testes & to stimulate LH to signal testosterone to be produced
Bosch Point	Used to access the parasympathetic nervous system
Frontal Lobe	Used to treat lack of desire, if imagery- or fantasy-related
Omega 2	Used to increase blood circulation in the penis
Ovary/Testes	Used to influence testosterone production
Pelvic Parasympathetic Point	Used to treat insufficient erection
Pineal Gland	Used to treat inverted relationship between melatonin level and gonadotropin secretion
Posterior Hypothalamus	Used to treat erection not lasting (via sympathetic nervous system)
Posterior Pituitary Gland	Used to stimulate sexual assertiveness via secreting oxytocin
Relaxing Triangle:	
Cosmonaut Point	Used to reach sympathetic ganglia Th12–L1 that react to stress
Sensory Master Point	Used stimulate visual sense & represents associative area
Corpus Callosum	Used to effect laterality & harmonize left and right brain
Sympathetic Ganglion Th10–L4	Used to stimulate sensory pathways
Sympathetic Master Point	Used to extend erection time (by way of limiting excess of sympathetic nervous system activity)

FSH, follicle-stimulating hormone; LH, luteinizing hormone.

Kidney Deficiency. Even though fundamental Yang, which is crucial for sexual function, is stored in the Kidney, the Heart is more important. The Heart relates indirectly to the Kidney by way of the *Du Mai*, which rises in the region between the Kidneys. *Du Mai* holds sway over sexuality and sexual functions, such as desire, sexual arousal, achieving and maintaining erection, and ejaculation.

Emphasis is placed on the relationship between the mental and the emotional aspects of the patient, situated in the Heart, and the erectile function is consistent with the psychogenic etiology of the disorder in Western medicine, in which the connection between heart-related problems and ED is also recognized. ED is a marker for cardiovascular disease.[10]

A single-discipline study conducted at a hospital in Vienna, Austria,[27] used the following points to treat psychogenic ED: KI 6; KI 27; CV 4; CV 6; GV 4; SP 6; and BL 23. This acupuncture protocol had a curative effect in 68.4% of patients enrolled in that study. Another 21.05% reported having improved erections, and only 10.5% reported experiencing no effect. Placebo therapy yielded a success rate of 9%.

Motivational interpellation. Whereas in-depth knowledge of neurophysiology and TCM fundamentals is essential to the therapist, this knowledge is not needed by the patient. The motivational part and accompanying exercises are anchor points for his recovery. In order for him to become involved actively and eventually to master his own coping, the patient is given education instruction about the existential aspects of being a man in a specific relationship, which is crucial for taking on the challenge of handling his ED. Instruction on general facts about sexuality, anatomy, and physiology are added as needed.

Taoism is the parent of TCM acupuncture. Taoism is comprised of an extensive body of traditional learning, concerning principles and practicalities of sexual comportment and well-being, based on accumulated experience and a heritage as far back as the 2000-year-old ''Yellow Emperor's Canon'' on health and medicine.

Researchers such as Chang[29] and Chia[30,31] have promulgated Taoist views and practices in motivational teaching and books on how to become aware of the meaning and importance of sexuality and sexual practices. These publications were accompanied by self-study material with practical exercises on how to handle ED. This material is well-suited for instructing Western patients who may not be familiar with Oriental forms of expression. Because Taoism is not an integrated religious or philosophical system, no personal commitment to matters of faith is involved.

In the therapy performed in the current study, two main motivational points were made:

(1) Gender equality in sexual matters clashes with the principles of Yin–Yang. A man must learn what it means ''to be Yang'' and how to make use of it. Without a male comportment, a man will not elicit the right response in the woman to succeed in mating.

(2) The ejaculation shifts a man from the Yang phase to the Yin phase. A man can have an erection when he wants and for as long as he wants if he learns to control ejaculation and to keep the Yang that is needed to maintain sexual energy.

Exercises. Ten exercises were used in this study. Exercise means ''physical action.'' There are exercises that teach and drill ways of sensing and controlling an ejaculation; exercises that teach other ways of stimulating and storing Yang; exercises that teach ways of using the penis in different stages of erection; and checklists concerning to how arouse a woman (the list was also given out to patients' female partners, teaching the women how to arouse the men). All the participants in the study were heterosexual men.

Self-assessment. A final feature of the therapy was that the participants submitted self-assessment reports weekly or fortnightly by e-mail. This was intended to help the men to ascertain their progress, establish an overview of their situations, and internalize the motivational part of the therapy.

RESULTS

At the onset of the project, most participants experienced an immediate or almost immediate improvement of their conditions. The very experience that an amelioration could occur at all would trigger changes in outlook, self-respect, and social relations. When the better mood was perceived within the framework of the motivational interpellation, it contributed to the therapy by itself. The participants became more confident, active, problem-oriented, and solution-oriented, using time, resources, and commitments to influence their situations. This was most strikingly expressed by a newfound willlingness to engage sexually and emotionally with their partners in contrast to earlier denial and neglect.

Compared to the situations recorded by the participants prior to the start of the study, 18 of 19 participants experienced substantial recovery of erectile function, self-respect, and social relationships. One did achieve partial recovery of erectile function but relapsed; however, he benefited from an improvement in self-respect and social relationships.

''Substantial recovery'' with respect to erectile function means wholly restituted function or having regained the ability to undertake satisfactory sexual intercourse in line with the WHO ICD-10 classification criterion.[11] With respect to self-respect and social relationships, a number of accounts of better functionality in these two aspects had to present in the texts submitted in order to qualify for a patient being considered ''improved.''

These results were freely demonstrated by the participants' reports recounting their recovery. They did not just feel better, they felt good about their sexual function in all three dimensions—functionality, self-esteem, and social relationships.

An example of the change resulting from the multidisciplinary method was offered by Participant No.16, a 51-year-old chief executive officer at the time of the study. He had a history of ED for 8 years. He described his sentiment initially in this fashion:[32]

> *I eventually sensed a hopelessness and feeling of inadequacy, fearing every day that this would be the last day of our marriage. I had become quite difficult to deal with. We talked about the problem but usually ending up arguing and me getting cross and mad at myself.…The fear and my general state of mind were self-reinforcing and if something radical would not have happened—well, the fear would have been self-fulfilling and we should not have been a married couple this day. …*

This participant expresses, in a very clear fashion, how ED works on self-esteem and social relations. The downward spiral of failing performance—defeat–fear of insufficiency–yet again failing performance—is demonstrated in a person who was otherwise in possession of a rather well-developed *sense of coherence* and high self-esteem; however, with respect to his ED, he was shaken. He had tried medication in to get back in control of his sexual function, but medication did not work for him. In fact, the remaining strength in his social relationships was what started him on the road to recovery, because his spouse was the person who got him into multidisciplinary therapy.

This patient's erectile function, his ability to cope and his self-esteem were restored, as expressed in his own words:

> *My sense of guilt is all gone and I have a feeling that I fill out my duty as a husband.…The morning after the first therapy in the clinic I woke up with a sizeable hard on — something that I had not experienced for years—and I had spontaneous erections. In the beginning, the effect would be different from one week to the next with bouts of recovery and occasional remissions. But the impact of the first treatment had raised hopes. There were periods of a sex life almost like when we were first married and our daily life was taking form again. …*
>
> *I have now a properly functioning sex life and we are practically as newly-weds.…It is like having had one's life handed back. When those things function, everything gets better and the occasional marital argument does not evoke the feeling of a hidden agenda of not being good enough in bed.…When one is impotent, one is inclined to blame every ill on that thing. This is no longer [the case]. …*

DISCUSSION

Using theory and methodology allowed the current author to view the problem of ED as a broad biopsychosocial

phenomenon that would be ameliorated by multidisciplinary treatment. The present study supported the author's hypothesis.

The theory and methodology used in this study rested on the assumptions that a phenomenon must be studied in context; that a phenomenon (such as ED) cannot be seen apart from the person experiencing it; that such a person is actually capable of rendering valid information regarding that problem and its implications, even in the form of texts; that such texts can be interpreted by the author as a therapist and a hermeneutical researcher; that ''people'' actually have quite a developed sense of how to deal with their health problems; and, finally, that an appropriate way of describing a health condition is by referring to it as a position in a continuum spanning the ''OK–Not OK'' gap.

The case-study method does not offer reliability or generality of findings in the way that controlled randomized trials do. However, a case study is useful as an exploratory tool and as a vehicle for finding suggestions of causality.

The exploratory and explanatory potential of this study is to suggest possible outcomes of a certain configuration of therapy in the 19 cases that were studied. Any result realized in each of these cases is theoretically feasible in other cases. Questions of prevalence or distribution must be answered through trials in other designs.

Apart from the obvious need of catering to patients that present at the clinic with a dysfunction, whatever the nature of that dysfunction may be, there is good reason to try to detect and treat ED because it is a marker and predictor for coronary heart disease, diabetes, and other conditions that affect public health. Given that the study of sexuality is a scientific field of its own merit and is an important source of QoL for most people, again, there is good reason to detect and treat ED.

Multidisciplinary therapy, as applied in the current study had a marked impact on male self-esteem, restoring the feeling of manhood in the patients, compared to medical treatment of ED. Using of only medications tends to leave a patient with feelings of being ''less of a man'' in that he is aware that it is the pill, not he that achieves the erection.

Other configurations of methods than those by this author might be brought up for discussion, thus widening the scope of multidisciplinary treatment of ED. Clinical cases have a long tradition of spreading knowledge regarding new procedures. More than the 19 cases included in this study is called for. Every practitioner who has been consulted by a patient with ED ought to be able to record the case and make it known to the audience of informed and the interested clinicians and researchers. This should be done whenever possible.

CONCLUSIONS

In a series of case studies, auriculotherapy in conjunction with other therapeutic methods was effective for treating ED. The interpretation of the results indicate that a multidisciplinary approach enhances the effect.

ACKNOWLEDGMENTS

The results of this study were previously presented in an address to physicians at the Metropolitan Hospital of Bispebjerg in Copenhagen, Denmark.

DISCLOSURE STATEMENT

No competing financial interests exist.

REFERENCES

1. Lyngdorf P, Hemmingsen L. Epidemiology of erectile dysfunction and its risk factors: A practice-based study in Denmark. *Int J Impot Res*. 2004;16(2):105–11.
2. Feldman HA, Goldstein I, Hatzichristou DG, et al. Impotence and its medical and psychosocial correlates: Results of the Massachusetts Male Aging Study. *J Urol*. 1994; 151(1):54–61.
3. Christensen BS, Groenbaek M, Osler M, Pedersen BV, Graugaard C, Frisch M. Sexual dysfunctions and difficulties in Denmark: Prevalence and associated sociodemographic factors. *Arch Sex Behav*. 2011;40(1):121–132.
4. Johannes CB, Araujo AB, Feldman HA, Derby CA, Kleinman KP, McKinlay, JB. Incidence of erectile dysfunction in men 40 to 69 years old: Longitudinal results from the Massachusetts Male Aging Study. *J Urol*. 2000;163(2):460–463.
5. Nicolosi A, Glasser DB, Moreira ED, et al. Prevalence of erectile dysfunction and associated factors among men without concomitant diseases: A population study. *Int J Impot Res*. 2003;15(4):253–257.
6. Mulhall J, King R, Glina S, Hvidsten K. Importance of and satisfaction with sex among men and women worldwide: Results of the global better sex survey. *J Sex Med*. 2008;5(4): 788–795.
7. Christensen BS, Groenbaek M, Pedersen BV, Graugaard C, Frisch M. Associations of unhealthy lifestyle factors with sexual inactivity and sexual dysfunctions in Denmark. *J Sex Med.* 2011;8(7):1903–1916.
8. Ventegodt S. Sex and the quality of life in Denmark. *Arch Sex Behav*. 1998;27(3):295–307.
9. De Berardis G, Franciosi M, Belfiglio M, et al. Erectile dysfunction and quality of life in type 2 diabetic patients: A serious problem too often overlooked. *Diabetes Care*. 2002; 25(2):284–291.
10. Shin D, Pregenzer G Jr, Gardin JM. Erectile dysfunction: A disease marker for cardiovascular disease. *Cardiol Rev*. 2011;19(1):5–11.
11. World Health Organization (WHO). WHO Gender and Human Rights–Sexual Health. Geneva: WHO; 2002. Online document at: www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en Accessed February 1, 2014.

12. University of Rochester Medical Center. Biopsychosocial Tradition [Biopsychosocial-model-approach.pdf]. Rochester, NY: University of Rochester Medical Center; 2011. Online document at: www.urmc.rochester.edu/education/md/prospective-students/curriculum Accessed February 1, 2014.
13. World Health Organization (WHO). WHO International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Version for 2007. Geneva: WHO; 2007. Online document at: www.apps.who.int/classifications/apps/icd/icd10online Accessed February 1, 2014.
14. Deadman P. The treatment of erectile dysfunction by acupuncture. *J Chinese Med*. 2007;85(10):5–14.
15. Eardley I. New oral therapies for the treatment of erectile dysfunction. *Br J Urol*. 1998;81(1):122–127.
16. Bear MF, Barry W, Connors MP. *Neuroscience: Exploring the Brain, 3rd ed*. Baltimore: Lippincott William & Wilkins; 2007.
17. LeVay S, Valente SM. Sexual attraction and arousal. In: *Human Sexuality*. Sunderland, MA: Sinauer Associates, Inc.; 2003:220–221.
18. Yin RK. *Case Study Research: Design and Methods*. Newbury Park, CA: Sage Publications; 1984.
19. Thayer HS. *The Logic of Pragmatism: An Examination of John Dewey's Logic*. London: Routledge & Kegan Paul; 1952.
20. Good, BJ. *Medicine, Rationality and Experience*. Cambridge, UK: Cambridge University Press; 1994.
21. Antonovsky A. The salutogenic model as a theory to guide health promotion. *Health Promotion Intl*. 1996;11(1):11–18.
22. Gannik DE. *The Social Theory of Illness: A Situational Perspective* [in Danish]. Copenhagen–Frederiksberg: Forlaget Samfundslitteratur; 2005.
23. Selected rules for research with humans. In: Vallgarda S, Koch L, eds. *Research Methods in Public Health Science* [in Danish]. Copenhagen: Munksgaard Danmark; 2007:282–286.
24. Oleson T. *Auriculotherapy Manual, 4th ed.* Edinburgh: Churchill Livingstone Elsevier; 2014.
25. Maciocia G. Articles: The Heart Channel. Online document at: www.giovanni-maciocia.com/articles/heart.html Accessed January 3, 2014.
26. Maciocia G. The Treatment of Male Problems in Chinese Medicine. Online document at: www.maciociaonline.blogspot.dk/search?q=impotence Accessed January 4, 2014.
27. Engelhardt PF, Daha LK, Zils T, Simak R, Konig K, Pfluger H. Acupuncture in the treatment of psychogenic erectile dysfunction: First results of a prospective randomized placebo-controlled study. *Int J of Impot Res*. 2003;15:343–346.
28. *The Yellow Emperor's Classic of Internal Medicine* [in Danish]. Copenhagen: Forlaget Sphinx; 1997.
29. Chang ST *The Tao of Sexology: The Book of Infinite Wisdom*. San Francisco: Tao Publishing: 1986.
30. Chia M, Winn M. *Taoist Secrets of Love—Cultivating Male Sexual Energy*. Santa Fe, NM: Aurora Press; 1984.
31. Chia M, Arava DA. *The Multi-Orgasmic Man*. London: Thorsens Harper; 1996.
32. Suenson S: "I am dying to get my hard-on back": Erectile Dysfunction as a Public Health Issue—a Qualitative Study [dissertation; in Danish] University of Copenhagen, Copenhagen, 2012. Online document at: http://mph.ku.dk/uddannelsen/master/afhandlinger/mph_2012/ Accessed February 6, 2014.

Address correspondence to:
Susanne Suenson, MPH
Noerreport.com Akupunktur Clinic
Roemersgade 23
DK-1362 Copenhagen K
Denmark

E-mail: mail@noerreport.com