Psychological Aspects of Erectile Dysfunction

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Introduction

While penile erection is often thought of as being a primarily physical event, there are myriad psychological factors that contribute to both attaining and maintaining penile tumescence. A complete understanding of the processes of erectile function and dysfunction requires not only an understanding of the physical and psychological factors that contribute to erection but how these factors interact and combine to produce the male erectile response. This chapter will focus on the psychological factors that often interfere with the ability to achieve and/or maintain penile erection suitable for a satisfactory sexual experience for both the man and his partner. While the mental health clinician may wish to consult the latest edition of the Diagnostic and Statistical Manual of Mental Disorders [1] for diagnostic criteria, this chapter is primarily focused on increasing the medical practitioner's awareness of the psychosocial factors to be considered in order to provide a more successful and satisfying treatment experience for the man and his partner suffering with this sexual dysfunction.

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The Psychological Assessment

Assessment begins with the recognition that men often want a discussion to take place with their physician about their sexual issues. Yet, it is often extraordinarily difficult for a man suffering from ED to initiate it [2]. Not only might a man be embarrassed about admitting to such difficulty, he may fear a judgmental or dismissive reaction from his healthcare provider. In fact, these men may often feel quite "broken" and often report feeling as if they are not a "real man" [3]. Whether the cause of a man's erectile problems is physical or psychological, their ED will have a psychogenic component, even if the ED was initially the result of constitution, illness, surgery, or other therapy. Minimally almost all of these men will experience some degree of secondary psychological distress [4]. Many of these men have lost confidence in their ability to function sexually and have become sexually avoidant. Sexual avoidance often leads to avoidance of affection as well. This will likely have led to significant relationship problems as partners often worry that they have become unattractive to the man, the man has fallen out of love with them or is interested in another partner, etc. Clearly, the man

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sitting in front of his physician has a complicated story to tell. As a result, the physician must realize that taking the time to allow the man to completely tell his story is of the utmost importance. Yet, this can be quite challenging in this day and age of medical practice (at least in the United States) where office visits have become more rushed and time limited, and medical/sexual history taking may suffer.

The psychological assessment of erectile dysfunction encompasses both individual and relationship factors. Mental health professionals will look at the man's sexual history, as well as the presence of any comorbid psychiatric conditions. While the typical medical office visit may not allow for a thorough discussion of the multiple factors involved in a complete assessment, there are some specific questions the medical practitioner may find particularly useful to ask [5, 6]. As with any other chief complaint, the physician will want to inquire as to the duration and the circumstances of the man's erectile difficulties. For example, it would be important to know if the ED was lifelong or acquired (i.e., when did the patient first begin to notice his erectile difficulties). Also important is whether the ED is generalized or situational (i.e., does this occur in all situations, only with a particular partner, or only with intercourse but not other types of sexual activity, etc.). Perhaps one of the greatest indicators of a predominantly psychologically based case of ED is the timing of the erectile loss. It is not uncommon for the man experiencing ED to describe a pattern of good erectile functioning until, or shortly after, the point of penetration. These men report ease of penile tumescence followed by extended periods of foreplay. However, as penetration looms, the man's erection begins to fade. This is a hallmark presentation of psychological conflict and may be a function of any combination of the following: performance anxiety, concerns about the relationship, commitment, loss of autonomy, or numerous other psychological concerns. Additionally, some questions about the timing of the onset of the difficulty can also be of great diagnostic value. Many men report good erectile functioning until the occurrence of some "relationship-deepening event." These men often present with histories suggesting, "The sex was great until…". "Until" may mean moving in together, getting engaged, getting married, the birth of the first child, etc. All of these experiences could be considered a "relationship-deepening event." The following is an overview of the most important areas for consideration by the practicing physician.

Individual Factors

While it is difficult to isolate a singular causative agent in the assessment of ED, there are several areas of inquiry that may yield insight into the sexual psychology of the man the physician is evaluating. Sex researchers have determined that the following are frequently relevant psychological issues independently or in combination: performance anxiety (the level of anxiety experienced by the man regarding his ability, or lack thereof, to function sexually), past sexual trauma (i.e., sexual abuse), a history of negative sexual messages (i.e., as a result of familial or religious training that may induce guilt about sexual function/preferences), lack of adequate information of sexual skill, lack of adequate arousal to sexual stimuli, conflicts about gender identity/sexual orientation/or paraphilic interests, unrealistic expectations, other sexual dysfunctions (i.e., premature/delayed ejaculation), and/or other comorbid psychiatric disorders (i.e., depression, anxiety/panic disorder, bipolar illness, attention-deficit disorder, autism spectrum disorders, etc.) [7, 8].

While the abovementioned factors are often noted during a standard examination, equally often a psychologically based ED is *interpersonal rather* than *intrapersonal in its etiology.* For most of the men who are treated for ED, it is not the sex they have on their own that is problematic (i.e., masturbation). Rather it is the sex they have with a partner that, when problematic, may spur the desire for medical/psychological consultation. While the man may initiate this consult himself, it is very often his distressed partner who has urged him to do so [9]. Interpersonal factors that may result in

psychogenic ED include, but are not limited to, relationship conflict (i.e., anger), fear or avoidance of intimacy (i.e., fears of loss of autonomy and/or rejection), nonsexual relationship problems (i.e., problems with children and/or finances), and partner sexual dysfunction.

Impact of ED on the Man's Sexual Partner

One of the most overlooked factors in the assessment and treatment of ED is the impact that ED has on the man's sexual partner and their relationship [10]. Whether we are discussing heterosexual, homosexual, or bisexual relationships, healthcare professionals often neglect to include an adequate consideration of the man's partner in the assessment/treatment process.

ED within the context of a relationship affects all involved parties, not just the man experiencing the ED. Partners often wonder/worry about their potential contribution to the problem. Am I not attractive enough? Am I not a good-enough sex partner? Does may partner no longer love/desire me? Is he interested in someone else? Is he having an affair? Often, problems in the relationship occur because many men withdraw all affection from their partners when they are experiencing erectile difficulties. Many men in our offices have often commented that they hold back on affectionate gestures that might imply an interest in sexual activity for fear that they will be "unable to finish what I've started." As a result, a pattern of sexual avoidance becomes a pattern of affectionate avoidance as well. Regardless of the etiology of the ED, restoration of a satisfying sexual life for men in relationships will require repair of any relationship damage resulting from the disruption in their sexual/affectionate life.

Psychological Treatments

While there is no single psychological treatment for ED, many approaches have proven to be quite helpful. Often, the greatest determining factor for treatment choice is ascertained by an identification of the etiological factor(s) resulting in the erectile difficulties. For example, if the sexual problem is the result of depression, or another mood disorder, that condition will need to be targeted. Cognitive behavioral therapy (CBT), often combined with medication, is the treatment of choice for many. Similarly, if the ED is the result of anxiety (i.e., performance anxiety), relaxation exercises such as Masters and Johnson's *Sensate Focus* may be of particular use [11], as well as a variety of mindfulness exercises [12]. For the deeper-rooted problems of fear of abandonment, loss of autonomy, ambivalence about relationship commitment, in-depth psychodynamically oriented therapies may be most appropriate. When the primary issues appear to be a conflict between the couple, couple's therapy is often most indicated. Of course, as alluded to earlier, couple's therapy is likely to be indicated regardless of etiology since the ED has impacted the couple and their relationship, and repair of the relational damage will need to be addressed.

At the current time, there is a great deal of emphasis on therapies that combine both medical and psychological interventions. Many sex therapists today rely on a more "biopsychosocial" approach to treatment that recognizes the complex interaction of physiology, psychology, and relationship factors in the formation of both sexual health and dysfunction [12, 13]. Perelman [14] and Rosen [15] have both commented on the importance of combined therapies in which physicians and mental health professionals work collaboratively in an effort to provide comprehensive and efficient treatments. In fact, Perelman [16] has taken this a step further by advocating for a *transdisciplinary* perspective in the treatment of sexual difficulties in which the focus expands from combining the efforts of different practitioners, to one in which practitioners transcend the biases of their individual professions and integrate knowledge from other clinical and academic traditions.

While this chapter is focused on the psychological causes and treatments of ED, there is no reason to believe a single pathogenetic pathway to erectile dysfunction exists, and the benefits of the combination therapies mentioned are obvious. Besides the common sense appeal of such

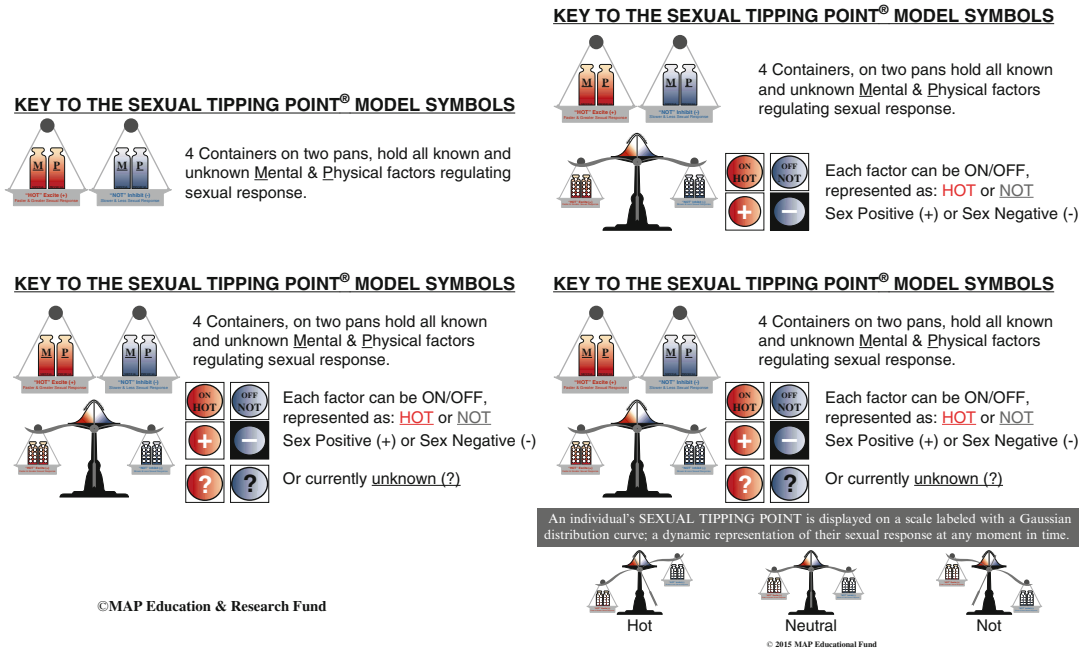

Fig. 3.1 How the STP explains sexual function and dysfunction: a sequential key to the STP model (Copyright © 2015 MAP Educational Fund. Used with permission)

models, there is as noted above an ever-expanding body of empirically based quantitative and qualitative evidence supporting a multidimensional conceptualization, especially in the areas of treatment optimization, treatment adherence, and continuation of recommended therapies [17–33].

The practicing physician may choose from a variety of biopsychosocial-behavioral and cultural models when contemplating erectile dysfunction, but sexual medicine and sex therapy have recently been most influenced by various "dual-control models" [34–39]. Bancroft and colleagues [34] remain the best known and researched of the various dual-control models. Yet, from our perspective when contemplating the clinical need for understanding etiology, diagnosis, and treatment, we find the Sexual Tipping Point® (STP) (Fig. 3.1) dual-control model particularly useful in its ability to illustrate both intra- and interindividual variability that characterizes erectile response and its impact on both men and their partners.[1] [30]

The Sexual Tipping Point® model easily illuminates the mind-body concept that mental factors can "turn you on" as well as "turn you off"; the same is true of the physical factors. The Sexual Tipping Point® is the characteristic threshold for an expression of a given sexual response. Therefore, an individual's Sexual Tipping Point® represents the cumulative impact of the interaction of a constitutionally established capacity to express a sexual response elicited by different types of stimulation as dynamically impacted by various psychosocial-behavioral and cultural factors. An individual's threshold will vary somewhat from one sexual experience to another, based on the proportional effect of all the different factors that determine that tipping point at a particular moment in time. For instance, the cartoon in Fig. 3.2 illustrates an individual suffering from a diminished erectile response [30].

Besides illustrating all etiological permutations, including normal *sexual balance*, the Sexual Tipping Point® concept is particularly useful for modeling treatment and can easily be used to explain risks and benefits for patients with erectile disorders. The STP model can be

[1] The Sexual Tipping Point model is the registered trademark of the MAP Education & Research Fund, a (501)(C3) public charity.

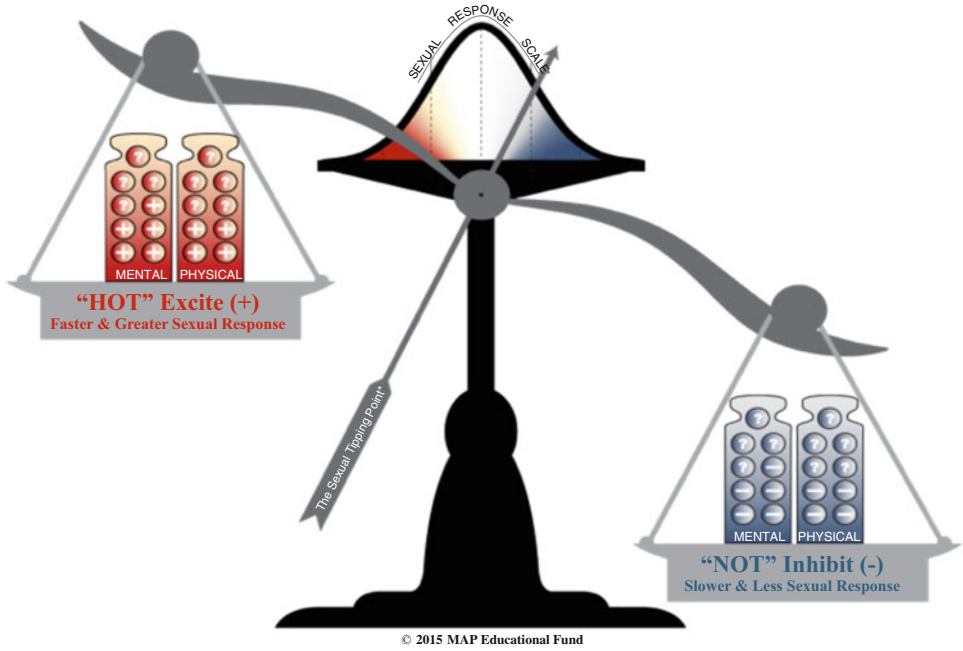

Fig. 3.2 STP illustrates diminished erectile response (Copyright ©2015 MAP Educational Fund. Used with permission)

used to teach patients where different treatment targets should be focused,depending on diagnosis of their etiological determinants. Typically expressed erroneous binary beliefs can be politely disabused, and the patient can be reassured that "no it is not all in your head" nor "all a physical problem." Reciprocally, their partner can be assured it is "not all their fault!" Teaching the STP model to the patient and partner can reduce patient and partner despair and anger, while providing hope through a simple explanation of how the problem's causes can be diagnosed, parsed, and "fixed." In fact, the Sexual Tipping Point® also allows for modeling of a variety of future treatments, including medical or surgical interventions not yet discovered or proven such as novel pharmacotherapy, genetic engineering, or nanotechnology [38]. This is illustrated in Fig. 3.3.

For those interested, mapedfund.org provides a video explanation of the STP model as well as continuously updated images and other resources which are all available for free download by healthcare professionals.

Talking to Patients About Sexual Issues

While there is no one way to best address these issues in medical practice, it is clear that patients will be receptive to talking to their physicians about their sexual problems [40] particularly if the physician initiates the conversation [2]. Indeed, most mental health professionals will report that the majority of their sex therapy referrals come directly from physicians. Consistent with current pharmaceutical advertising, many men consider their physician to be the primary source of assistance when confronting sexual problems such as erectile dysfunction [41]. This is especially so in the age of PDE-5 inhibitors since many men are hopeful that a simple prescription will alleviate their sexual distress. Yet

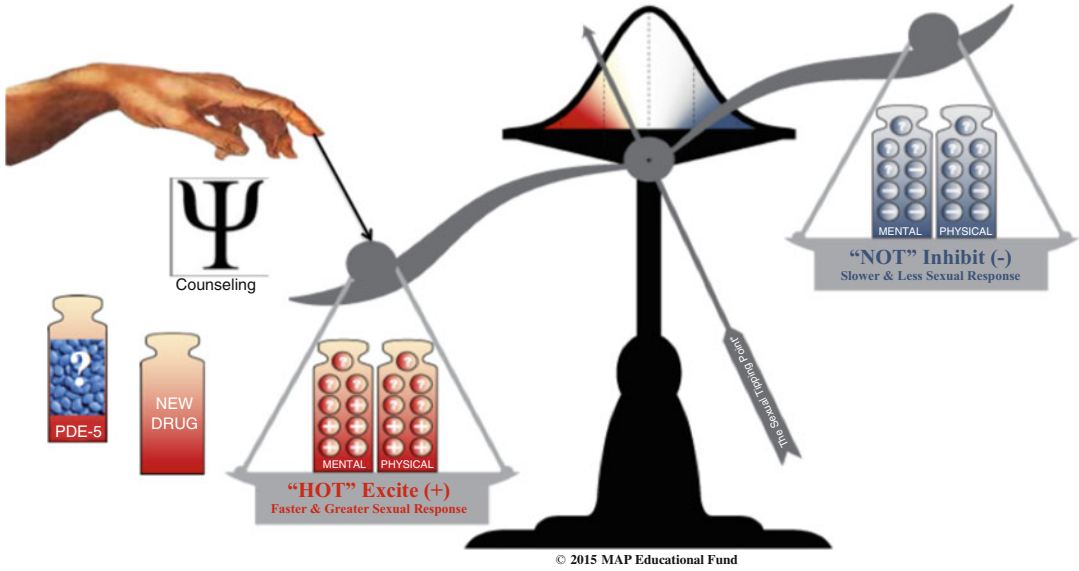

Fig. 3.3 Illustrating the elegant solution: STP depicts integrated treatment with a future medical therapy that is unknown today. For the metabolic syndrome patient. The ideal solution to balance risk/benefit (Copyright © 2015 MAP Educational Fund. Used with permission)

many physicians are still uncomfortable discussing sexual matters with their patients and often do not spend the necessary time to either inquire or address sexual concerns. This is quite unfortunate inasmuch as sex therapist Candace Risen [42] reminds us, "They [patients] dread being asked, but they long to be asked." Despite having had little training in medical school in the particulars of how to discuss sex with patients, physicians can still play a vital role in assisting ED patients to get the help they so desperately want. It is important to note that there are many possible levels of intervention for the practicing physician that do not require a large investment of time or specialized training in sexual medicine.

A physician might find another popular and user-friendly model helpful that was developed by psychologist, Jack Annon [43]. Annon termed his model the PLISSIT model in which he described several levels of intervention at which physicians can choose to respond to patients' sexual concerns. In this model, the letter "P" stands for *permission*, *which* involves the physician giving the patient permission to speak and voice their concerns about sex. This level is especially important, as patients often are unsure of whether or not their physician will be receptive to their concerns and may find discussing sexual difficulties such as ED embarrassing. Simply opening the door for the patient to feel welcome asking for advice and assistance can be highly therapeutic. The second level of intervention in the PLISSIT model is "LI" or *limited information.* Limited information may be some brief education about the physiology of erectile response, the "normalizing" of occasional erectile difficulties for most men, or some brief information about treatment options. "SS" stands for *specific instructions* in which the physician may make a specific suggestion for treatment such as oral medications, penile injections, penile prostheses, etc. These first three levels of intervention can be easily communicated to patients using the STP framework. Finally, the "IT" refers to *intensive therapy* in which the physician may believe that either the medical options alone have not been successful or the patient requires treatment for a detected comorbid mental health issue and makes a referral to a sex therapist or other mental health specialist.

Oftentimes, physicians report discomfort bringing up sexual issues with their patients. This

may be, in large part, because discussing sexual issues has historically been absent from the training of healthcare professionals [2]. However, as mentioned previously patients often want to discuss their sexual difficulties with their physicians; indeed that is the reason that many will seek out medical attention in the first place. According to Carroll [8], assuming the patient does not bring up sexual difficulties themselves, the physician can begin with an open-ended inquiry as to whether the patient has any sexual concerns. Something as simple as "How is your sexual life going?" or "Do you have any sexual concerns?" will go a long way in helping the patient to feel comfortable in bringing up their concerns. This type of question gives the patient permission to discuss such sensitive topics (recall the "P" from the PLISSIT model) and frames the issue in a nonjudgmental manner. Presenting with a nonjudgmental attitude is essential in assisting the patient to feel comfortable in opening up to his physician. Again, it is important to remember that patients want to discuss these matters with their physicians. When the physician is sensitive enough to this reality, the rest of the helping process will likely flow smoothly.

Psychological Issues in the Post-Viagra Era

There is little doubt that the advent of oral medications for the treatment of ED has created a tremendous paradigm shift in the way we think about the evaluation and treatment of this disorder. According to Rosen et al. [7], since the introduction of PDE-5 inhibitors in 1998, well over 100 million men worldwide have sought treatment for ED, and these drugs have become a first-line treatment. This has occurred for several reasons and has had both advantages and problems.

Sildenafil, tadalafil, and vardenafil (Viagra, Cialis, and Levitra) have become the ED treatment of choice for both physicians and patients for a variety of reasons. On the positive side, they have offered the hope and promise of effective treatment for ED that has encouraged more patients to seek treatment than ever before. Earlier medical treatments such as the vacuum constriction device, penile injections, and penile prostheses all had significant drawbacks in the eyes of many patients and their partners. The sheer simplicity of being able to quickly and easily "swallow a pill" has obvious appeal. And for many patients, these medications have been highly effective and easy to tolerate. The possibility of an effective treatment that is easy to use and is relatively safe has allowed many men and their partners to resume having sexual intercourse for the first time in many years. This has also made office practice easier for many physicians as it has allowed them to offer treatment quickly and easily without the need for an extensive and expensive evaluation process.

However, despite these seeming advantages, the use of oral medications has not been without its problems and critics. Marino [44] reminds us that all progress paves over some bit of knowledge or washes away some valuable aspect of practice. That is, with any new technological advance, a field inevitably loses some of the art attached to its craft [45]. Indeed, many physicians have lamented the fact that "quick and easy solutions" can easily overlook important medical and psychological factors that otherwise would have been attended to. For example, while time consuming and expensive, the work-ups patients used to receive would, on occasion, turn up evidence of cardiovascular and other diseases that now go undetected until they become highly problematic. In addition, the ease of obtaining oral medications for ED has led some physicians, and many patients, to erroneously assume that the treatment of ED will be simple, yet this is often not the case. Despite the ease of availability, the dropout rate for oral medication therapies for ED is still very high. This may be due to the price (these medications can be quite expensive and often not covered by health insurance, at least in the United States). While side effects and expense play a part, psychosocial, behavioral, and cultural obstacles can frequently be significant barriers to successful treatment. Unfortunately, this is exacerbated by the fact that many physicians are spending less time discuss-

ing sexual concerns with their patients and may dismiss them subsequent to a hastily obtained sex history and quickly written prescription. This may have the effect of making the man feel his physician has neither the time nor the interest to fully address his sexual concerns. While he may accept the suggestion of medication, if it does not adequately resolve his ED, the man will be much less likely to return for follow-up care than he would be if he left the office visit with the feeling that he was being heard and well attended to. As a result, the underlying psychological issues are left unresolved (i.e., relationship problems as an example), and at times even when the man's erections improve with medication, his sexual relationship may not [33].

The availability of oral medications as a treatment for ED has also led some sexuality professionals to express significant apprehension that sexuality and sexual function that will come be increasingly seen as a purely mechanical process that is easily amenable to a simple, "quick-fix" type of resolution [45–48]. This concern, which is also sometimes referred to as the *medicalization* of sexuality, may lead many physicians and their patients to ignore the complexity of the sexual/relational experience that is so central to the human condition. For many years, sex therapists have attempted to shift patients (especially their male patients) away from a limited one-dimensional view of sex as an exclusively goal-directed genital experience. All healthcare professionals and patients are best served when avoiding such an overly reductionist viewpoint.

It has been argued [45] that the recent excitement about the possibility of successful restoration of erectile dysfunction via the use oral medications has led to some unfortunately unrealistic expectations on the part of many male patients. It is well known among physicians that the aging process will lead to inevitable changes in male sexual response and function. Specifically, erectile difficulties and inconsistencies will become increasingly common as a man ages. While some patients may have experienced disappointment, when informed of this normal effect of aging, they had been generally accepting of this reality. However, in the post-Viagra age, many men now have the promise of not only restored erectile function but the illusion of a restored youth, as well. While some may not initially see the potential harm in a treatment that may allow a man to feel more youthful, physicians and other healthcare professionals must consider the possibility that we are offering an unrealistic (and perhaps unfair) picture to patients that reinforces the notion that youth is "good" and aging is "bad." Rather than supporting our patients in the acceptance of natural and healthy aging, we may inadvertently be doing them a disservice as they struggle to come to terms with normal bodily changes [49].

A similar concern relates to our treatment of men with prostate cancer. Many men enter surgical treatment for prostate cancer with the high (perhaps unrealistic) expectation that their erectile function will be completely restored. In this day and age of surgical advances and "nerve-sparing" prostatectomy, many men assume that following radical prostatectomy, they will be able to resume their sexual lives as before. Unfortunately, too few physicians do enough to correct this mistaken assumption. Even with advanced surgical technique, penile rehabilitation protocols, and oral medications to treat ED, fewer men then one would hope regain complete erectile function, and controversy over the most efficacious postsurgical protocols continues to this day [49]. Most prostate cancer surgical patients will experience a long healing process (perhaps years), weaker, or less rigid erections, and the loss of "erections on demand." Many men feel unprepared for these changes, sometimes because they chose to be overly optimistic regarding surgical outcome. However, it is also likely that many men feel unprepared because their physicians were unwilling, or unable, to have the conversation with these men that assist them in having a more realistic assessment of their post-surgical sexual lives. As mentioned earlier, many physicians often feel uncomfortable discussing sexual matters with patients, and some may fear that having such a conversation may deter men from having a surgical treatment that might be medically in the patients' best interests. Whatever the reason, many men enter mental health treatment feeling angry, depressed, frustrated, and "broken." Sometimes, these men feel that they

are no longer a "real man" [51]. Physicians taking more time to have these important conversations with these men and their partners prior to surgery would do so much good in minimizing the distress over this surgical sequela.

One of the strongest voices for a more realistic mental health model for men (especially aging men or physically compromised men) is Barry McCarthy, Ph.D., and his frequent collaborator, Michael Metz, Ph.D. McCarthy and Metz [52] were strong advocates for what they refer to as the *Good-Enough Sex model.* According to McCarthy and Metz, the focus of sexual activity should be less about performance and more about pleasure. Their Good-Enough Sex model has 12 essential principles:

1. Sex is a good element in life, an invaluable part of the man's and couple's comfort, intimacy, pleasure, and confidence.
2. Relationship and sexual satisfaction are the ultimate developmental focus. The couple is an intimate team.
3. Realistic age-appropriate sexual expectations are essential for couple sexual satisfaction.
4. Good physical health and healthy behavioral habits are vital for sexual health. The man values his own and his partner's sexual body.
5. Relaxation is the foundation for pleasure and function.
6. Pleasure is as important as function.
7. Valuing variable, flexible sexual experiences and abandoning the "need" for perfect performance inoculate the man and couple against sexual dysfunction by overcoming performance pressure, fears of failure, and rejection.
8. The five purposes for sex are integrated into the couple's sexual relationship (shared pleasure and enjoyment, a means to deepen and reinforce intimacy and satisfaction, a tension reducer to deal with the stresses of a shared life, a means to reinforce self-esteem and confidence, and the traditional biological function of procreation).
9. The couple integrates and flexibly uses the three sexual arousal styles (partner interaction, self-entrancement, and role enactment).
10. Gender differences and similarities are respectfully valued and mutually accepted.
11. Sex is integrated into the couple's real life and real life is integrated into their sexual relationship. Sexuality is developing, growing, and evolving throughout life.
12. Sexuality is personalized. Sex can be playful, spiritual, and special.

While each of these points has great potential utility in improving the sex life of the man and his partner, numbers 3, 6, and 7 have particular relevance for the aging man and the prostate cancer surgical patients.

Some Thoughts on Sexual and Cultural Diversity

Hall and Graham [53] suggest that much of what we know about sexual problems and sexual medicine comes from Western societies (the United States, Canada, Britain, and Western Europe), where sex research was first established. As a result, there is a dearth of research on sexual problems in non-Western cultures. They further remind us that the ED treatment dropout rate for ethnic minorities is extraordinarily high. It is important for the practicing physician to be mindful of the fact what is regarded as "problematic" sexual functioning may be normative in a different cultural context. It is extremely difficult to be aware of all of our cultural biases and assumptions. This, again, highlights the need for physicians to take the time to actively listen to what their patient's complaints are, as well as clearly ascertain the solution they are seeking. The sexual goal of a Western physician may not be the same as the sexual goal of a non-Western patient and his partner. Oftentimes, treatment suggestions we make may be seen as culturally or religiously unacceptable to the man we are treating. Ensuring that we have the "buy-in" and cooperation of our patients is essential to good treatment outcome, especially with regard to sexual problems such as ED.

Sensitivity to psychological needs of sexual minorities is also necessary for physicians treating ED. Nichols [54] asserts that since the early days of the AIDS epidemic, research on the sexuality of gay males has focused almost exclusively on HIV transmission and prevention. Male sexual dysfunction has received relatively little attention. Sandfort and de Keizer [55] actually found that reports of ED were higher for gay men than straight men, and Hart, Wolitski, and Purcell [56] also found high ED rates in gay men. Moser [57] reports that while medicine has recently begun to address the sexual concerns of gay and bisexual men, other sexual minorities (transgender, kink) have received little or no attention. According to Moser, many men suffering with ED are fearful of being judged negatively by their physicians due to their sexual lifestyles and thus are often likely to postpone seeking treatment for their ED, or may forego treatment altogether. Clearly, this is an unfortunate situation and one that future training of physicians needs to address. For the practicing physician, suffice to say that it is highly likely that you will come across members of cultural and sexual minorities who are suffering with ED and desirous of treatment. It is imperative that the practicing physician makes no assumptions about the sexuality of the man he or she is seeing for consultation. In order to adequately address the medical and psychological sexual needs of such patients, a nonjudgmental attitude, a welcoming office environment, and a willingness to take the time to truly listen to the patient's story are essential. Below some case histories illustrate many of the principles described within this chapter.

Case Examples

Case #1: Bob: A Case of Misunderstanding

Bob was a 25-year-old heterosexual male who was referred for sex therapy by his urologist. Bob reported being unable to complete sexual intercourse because he was unable to sustain penile erection until the point of orgasm/ejaculation. Bob's physician briefly listened to his complaints, did a cursory physical examination, and prescribed a trial of a PDE-5 inhibitor. Bob had seen another urologist about a year before and received the same treatment recommendation. After approximately 2 months, Bob returned to his urologist saying that the medication did not resolve his problem. As a result, Bob received a referral for sex therapy and called to arrange a consultation.

At Bob's initial sex therapy visit, he gave a detailed description of his symptoms. It soon became clear that Bob's dysfunction was not ED, but rather delayed ejaculation. What Bob was unable to successfully convey to his urologist was the fact that while he was unable to maintain his erection until the completion of sexual intercourse, he would routinely engage in intercourse for up to 60 min! He would eventually be unable to continue and would stop intercourse before orgasm/ejaculation would occur. The recommendation of the PDE-5 inhibitor obviously was not going to effectively address Bob's difficulties. Sex therapy then proceeded to treat the DE condition, and Bob was eventually able to have sexual intercourse in a much more satisfying manner.

Comment: This case highlights two very important factors in the assessment and treatment of male sexual dysfunction. The most obvious is the importance of carefully listening to the patient's complaint and taking the time to obtain a detailed history and description of the problem. If Bob's physician had done this, it would have likely led Bob to an effective course of treatment much sooner. Bob was fortunate that he did not give up his search for assistance. Many patients would have become frustrated with the process and lack of success and as a result, would continue to suffer needlessly. The second notable feature of this case is how difficult it is for many patients to accurately articulate their symptoms. Many patients lack the vocabulary to effectively convey the details of their situation. Bob had never heard of DE, and truly believed he suffered from ED. His lack of clinical sophistication highlights even more so the need for physicians to take careful, comprehensive sex histories and to educate patients.

Case #2: Jim: An Example of Combination Treatment

Jim was a 44-year-old, heterosexual, married man who was referred for sex therapy by his urologist. Jim had been experiencing intermittent erectile dysfunction for approximately 2 years, but the frequency of erectile difficulties was increasing. Jim's urologist did a history and examination and was unable to identify a medical explanation for his ED. However, he wisely recommended a course of sex therapy to see if that would improve Jim's sexual difficulties.

Jim reported being happily married for 15 years. In describing his symptoms, he reported easily achieving penile erection, but would lose penile rigidity while attempting to begin sexual intercourse. This situation was distressing to both Jim and his wife, as she feared he no longer found her physically attractive and/or was no longer in love with her. Jim assured us both that this was far from the case.

By way of history, Jim's parents had a difficult marriage. Jim's mother left the family when he was 5 years old complaining that Jim's father was a business failure and she wanted better for herself. In retrospect, Jim believes his mother was frustrated in her own life as she became pregnant, married very young, and had no opportunity to pursue the career of her dreams. Still, as a young boy, Jim deeply felt the pain of abandonment.

Jim reports his erectile difficulties began during a down period in his business. Both he and his wife were concerned about this, but Jim found himself especially agitated. He had assumed that his erectile difficulties were the result of the stress of business complications, but even as business improved his erectile functioning remained problematic. During psychotherapy, Jim was able to see how his business setbacks and wife's concerns triggered in him fears of abandonment, and he reported oftentimes feeling panicked that his wife would leave him. Of course, she had never expressed any such sentiments, but Jim recalled feeling that his mother's abandonment seemed to come without notice and was fearful that his wife would one day simply not be home when he arrived. In psychotherapy we were able to work through the unresolved pain of Jim's abandonment as a child, and much of his anxiety subsided. However, his sexual difficulties improved only slightly. Jim now had lost confidence in his ability to function sexually and found himself experiencing high degrees of performance anxiety. In addition, since Jim's erectile problems persisted, his wife felt more convinced than ever that he had lost her attraction to her. We began to engage in several sessions of couple's therapy in an effort to repair the damage that had been done to the relationship and to alleviate some of Jim's performance fears. In addition, we worked with Jim's urologist who prescribed a PDE-5 inhibitor and Jim found that to be helpful with erections. As Jim's confidence returned, we gradually reduced the dosage of the PDE-5 inhibitor until Jim was able to function well without any medication. Individual and couple's therapy continued for several more months until both Jim and his wife felt comfortable that the situation had been successfully resolved.

Comment: This case is a good illustration of the importance of both combined therapy and couple's therapy in the successful resolution of many cases of ED. In addition to working through Jim's conflicts in individual therapy, this case demonstrates the benefits of the cooperative interaction between the urologist and the sex therapist. As mentioned earlier in this chapter, combined treatments often have the greatest efficacy in addressing the needs of the man struggling with ED. In addition, this case clearly illustrates the importance of considering the partner in the treatment process. Jim and his wife were struggling to understand and repair the damage done to their relationship. Jim's wife needed to discuss and resolve her fears and concerns that she was no longer attractive to him. Beyond her concerns, the fractures that had occurred in their relationship due to the fighting and resultant distancing between them had to be therapeutically corrected. It is unlikely that this case would have had a successful outcome without attention to these additional factors. It was to the physician's credit that subsequent to careful

diagnosis, an appropriate referral sex therapy was both given which resulted in a successful treatment.

Case #3: Andrew: A Case of Kinky Desire

Andrew was a 37-year-old single male who had never successfully completed sexual intercourse. He reported that his early attempts at sexual intercourse resulted in erectile loss, and as a result he had avoided sexual opportunities for the past several years. Recently, he had met a new woman with whom he believed he wanted to have an intimate relationship. He had been able to avoid sex for several months, but she eventually sensed something was amiss. He had told her he had ED and she was kind and sympathetic. She encouraged him to engage sexually with her, but he experienced the same sexual frustration with erectile insufficiency. He would achieve only a partial erection, and that erection would fade even further as sex progressed. His new girlfriend encouraged him to seek medical help, hoping that a PDE-5 inhibitor would be helpful to Andrew.

Andrew met with a urologist who did a history and examination. He found no evidence of organic dysfunction and suggested Andrew try a PDE-5 inhibitor. Andrew took some samples and a prescription, but he never used them saying he was not a "medication" type of person. As frustration mounted for both Andrew and his girlfriend, Andrew became increasingly distressed at the possibility she would leave him. Fortunately his urologist was able to elicit this information from him during the 1-month follow-up session that had been previously scheduled for Andrew, which allowed the urologist to make an opportune referral for sex therapy.

Andrew presented for therapy as a highly anxious and agitated man. His distress was palpable. Careful questioning about his sexual history encouraged Andrew to finally reveal to his therapist the details that he did not reveal to his urologist, namely, that his sexual interests did not include the more "vanilla" types of sex. Andrew was aroused by fantasies of bondage and discipline. His sexuality was stirred by what is often referred to as BDSM (bondage and discipline, dominance and submission, sadomasochism). Unfortunately, Andrew was very conflicted about his sexual interests believing that others would see them as unacceptable; indeed he often felt they were unacceptable to him as well. Andrew was concerned that he was somehow a sexual "freak" and could never reveal his secret desires to anyone. Interestingly, when masturbating to BDSM fantasies, Andrew experienced good, solid erections and satisfying orgasms.

Much of Andrew's psychotherapy focused on helping him to better accept himself and his sexual interests. In addition, Andrew was helped to take some risks in revealing himself to his new girlfriend. Obviously, Andrew was quite tentative and initially resistant to moving in this direction, but as the relationship progressed, he began to gently introduce the topic of kinky sex into their discussions. Much to his surprise, his girlfriend was quite receptive to sexual experimentation, and they began to explore the type of sex Andrew found most erotic and arousing. This led to his first successful sexual intercourse, and the couple was able to integrate some BDSM into their lovemaking. Interestingly, this also allowed Andrew to learn to enjoy non-kinky sex as well, although his primary sexual interests remain of the kink variety.

Comment: This case illustrates the difficulty many patients experience in fully revealing their sexual interests to their physicians and the importance for the physician to identify when to refer. Andrew felt great shame and embarrassment regarding his interest in kinky sex and feared he would be judged negatively for his proclivities. As a result, he was unwilling to reveal himself to his urologist, who was naturally unable to effectively intervene as he was without adequate information. As mentioned previously, many patients with nonstandard sexual interests delay, or avoid, seeking medical assistance for their ED. Regrettably, there may have been little Andrew's urologist could have done differently, yet Andrew's case illuminates the importance of physicians being nonjudgmental and accepting of their patients' sexuality. It also highlights the

value for physicians to provide follow-up care to patients following office visits in an effort to verify if medical suggestions were taken, and if not, why they may have been resisted. Finally, when a patient is unwilling to disclose important information regarding their sexuality, often a referral to a sex therapist may unlock that seeming conundrum.

Case #4: Stanley: A Case of ED Following Radical Prostatectomy

Stanley was a 66-year-old married heterosexual male who had undergone a radical prostatectomy 3 years prior to sex therapy consultation. Stanley reported being happily married to his wife of 38 years, and they had a mutually satisfying sex life prior to his treatment for prostate cancer. Despite a nerve-sparing procedure having been performed at a major medical center, 3-year postsurgery, Stanley's erectile functioning was still problematic and he was becoming increasingly frustrated and angry. He had been taking a PDE-5 inhibitor daily for over a year, with no improvement. In consultation with his urologist, both agreed that a referral for sex therapy might be overdue.

Stanley and his wife presented for sex therapy as a couple in distress. While Stanley was upset about his continued erectile difficulties, his wife was more concerned about his level of anger and distancing from her. Stanley's wife was focused on her relief that he was a cancer survivor, and said that she didn't care if they were able to resume having a sexual relationship. She was thankful to still have Stanley alive and couldn't understand why he was not similarly grateful. Stanley, on the other hand, felt betrayed by his urologist. Despite evidence to the contrary suggested to him presurgically, Stanley believed that his postsurgical erectile functioning adjustment would be better than it was, and he now doubted his decision to having gone forward with surgery. Stanley reported feeling "broken" and like "half of a man." Much of Stanley's psychotherapy focused on dealing with his anger and coming to terms with the fact that his sexuality would likely be quite different than he had expected.

Both Stanley and his wife did well with couple's therapy. Stanley's anger eventually receded, and his wife was a willing participant in exploring a new version of what their sexual life would be. Both eventually embraced McCarthy and Metz' idea of a Good-Enough Sex model of sexual functioning [52], and they began to reexperience the intimacy they had lost. After several months of psychotherapy, Stanley and his wife reported rediscovering the happiness they had feared was forever lost.

Comment: This case highlights several important concepts for the practicing physician. The psychological challenges that accompany ED following treatment for prostate cancer cannot be underestimated. So many men experience postsurgical disillusionment and feel misled about the prospects for postsurgical erectile functioning. Even those men who are able to regain erectile function that is suitable for sexual intercourse experience some distress over the fact that their erections, while perhaps sufficient for penetration, are not of the same quality as they were in presurgery. This case exemplifies the difficulty and challenges surgeons experience when a patient facing a life-threatening disease does not fully absorb the educational messages imbedded in the standard informed consent that is typically provided presurgically. It is a sobering reminder of the importance for explicit discussion that sets appropriate sexual expectations for prostate cancer patients and their partners prior to their treatment making decision. In addition, increased sensitivity to the psychological sequelae that often accompany even "successful" surgical outcomes is warranted.

Conclusions

Clearly, men experiencing ED will often present with myriad psychological concerns and issues. When these issues are properly explored by the practicing physician, greater treatment success and satisfaction will result for the patient, his partner, and the physician. The biopsychosocial-behavioral and cultural models of sexual dysfunction provide a compelling argument for

sexual medicine treatments that integrate sex counseling and medical and/or surgical treatments [13, 14]. The goal is not just to alleviate our patient's ED, but when possible to improve intimacy and relationships. This chapter has attempted to highlight the need for physicians to be on the alert for psychological causation, psychological complication, and an increased sensitivity to the importance of including the partner in treatment (when possible) in order to make treatment outcomes more positive for these patients. We hope this chapter has helped to make clear that whether ED is caused by psychological factors or not, most every man experiencing ED will have psychological issues that require attention. The healthcare professional who provides an integrated treatment will offer the most optimized approach and the most elegant solution [16]. We hope such a transdisciplinary perspective becomes the prevalent teaching model for all healthcare practitioners early in their training. Optimally, all healthcare practitioners will utilize a patient-centered holistic view of healing that integrates a variety of treatment approaches as needed for ED or other sexual dysfunction.

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