

The Psychosocial Context of Sexual Dysfunction

Based on a presentation by David L. Rowland, PhD

Presentation Summary

The emotions and expectations that arise in the context of a sexual relationship have a strong impact on sexual response. Furthermore, sexual response does not exist independent of one's sexual history, which itself is embedded in a cultural context that molds the attitudes, expectations, and sex roles of the partners. In examining erectile dysfunction (ED), factors in the domains of cultural context, sexual histories, sexual dyadic actors,

and individual personalities must be taken into account. The outcomes of treatment for sexual dysfunction must address not only the physical problem but the nuances of psychological and interpersonal issues as well, because the relationship between psychosocial factors and genital response is an interactive one. Therefore, improved genital functioning, better sexual satisfaction, and an enhanced sexual relationship should be the explicit and implicit goals of treating ED.

In a departure from the approach taken by the clinicians who preceded him, David L. Rowland, PhD, indicated that his psychological/behavioral perspective on sexual dysfunction would address the broader issues that surround it, including those that emanate from the man's own personality and from his relationship with his partner.

"Although I don't have any answers that satisfactorily address whether sexual dysfunction should or should not be covered by health insurance, I hope to raise questions that are worth considering when dealing with patient treatment and satisfaction," Dr. Rowland said.

Multidimensional Sexual Response

"Even though ED [erectile dysfunction] has been the focus of this discussion, most of it, intentional or not, has looked at the genital area as the source of the problem," Dr. Rowland continued. "However, there is a need to integrate the genital response with the other dimensions of the person, including his cognitions, affects, and motivations, because these all play important roles in sexual response and dysfunction.

"Although the presumed endpoint of sexual response in the male is erection and orgasm," Dr. Rowland said, "these physiological responses do not occur in isolation from the emotions

and expectations that a man brings to the sexual situation.” Such emotions and expectations also occur in the context of a sexual relationship, he explained, observing that as a result of this sexual dyad, many other factors bear on a man’s sexual response, including the quality of the dyadic relationship, the attractiveness of the partner, and the partner’s own expectations and emotions.

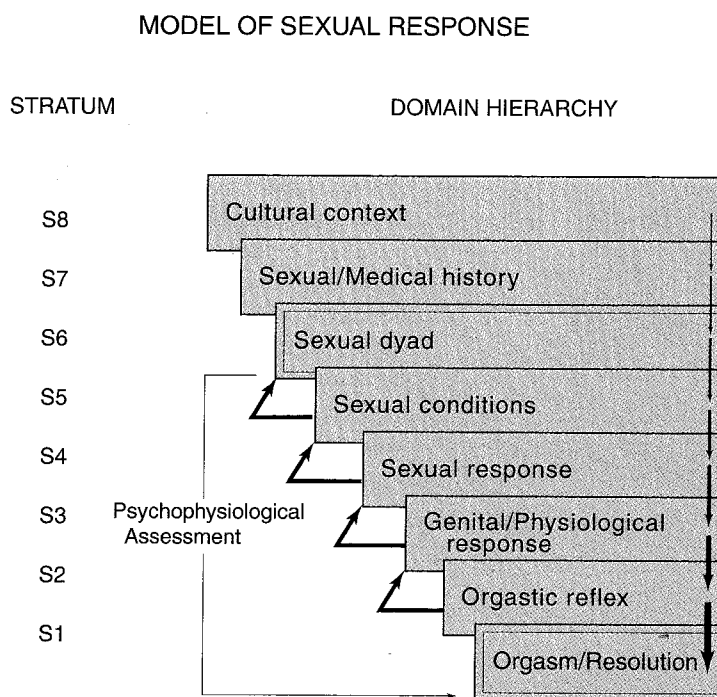
However, just as a person’s sexual response is not independent of his or her sexual relationship, Dr. Rowland said, that sexual relationship does not exist independent of his or her sexual history; that is, a person’s current sexual relationship (and all that it entails) represents only the most recent phase of an overall sexual history that continues to affect the current sexual relationship and that itself has been embedded in a cultural context which has molded the attitudes, expectations, and sexual roles of each person in the dyad.

“When we discuss sexual dysfunction, we may want to avoid a simple reference to the physiological endpoints of erection or ejaculation without giving credence to the important role that these other domains—cultural context, sexual histories, sexual dyadic factors, and individual personalities—play in the expression of a person’s sexuality,” Dr. Rowland said, noting that as a dysfunctional sexual response is examined, it must be realized that factors in any or all these domains may contribute to the sexual problem; therefore, the same factors may be important to the solution¹; that is, even when a sexual problem is primarily organogenic, these other factors may maintain or exacerbate the dysfunction (Figure).

ED Affects the Relationship

“Accumulating evidence suggests that when an erectile problem occurs, whether it is organogenic or psychogenic, it is not confined to the genital area. The inability to respond

Figure. Hierarchical model of the various domains that affect ejaculation latency.



Source: Adapted from Rowland DL. A psychophysiological approach to assessing premature ejaculation. *International Journal of Impotence Research* 1998;10 (Suppl 2):S44-S48. Used with permission.

adequately in a physically sexual way significantly alters the man’s psychological response to the sexual situation,” Dr. Rowland said, adding that a man with an erection problem typically sees himself as a failure, because he is unable to satisfy not only himself but his partner.

Such a sense of failure evokes a strong negative emotional response, which in turn can have detrimental effects on the sexual relationship, so the relationship between psychosocial factors and genital response is an interactive one. Not only does the man’s psychological makeup and his relationship with his partner influ-

ence his sexual response, but the sexual response itself (including whether it is functional or dysfunctional) is likely to influence the man's self-perceptions and emotions and to affect the relationship.

More Than Just Treating the Penis

Men typically seek treatment for sexual problems because they view their penises as "not working properly." One of the major goals of treatment is to return normal penile functioning to the man, Dr. Rowland said, noting that "men often focus heavily on genital issues at the expense of neglecting more subtle but no less important psychological and interpersonal issues that may affect the sexual response."

Such a focus is not unexpected, Dr. Rowland said, because the problem stems from a nonfunctional penis, and the solution is typically identified by the patient as one that involves making the penis functional again. In reality, Dr. Rowland continued, an improved genital response constitutes only the most tangible aspect of the broader and often only implied outcome desired by the patient: achievement of better erections that lead to greater sexual satisfaction. And such sexual satisfaction is usually desired within the context of a sexual relationship, he added.

Three outcomes—improved genital functioning, improved sexual satisfaction, and an improved sexual relationship—constitute the explicit and implicit goals of ED treatment, according to Dr. Rowland, who said these goals are typically interrelated. For example, improvement of erectile function may improve sexual satisfaction, which in turn may improve the overall sexual relationship.

However, Dr. Rowland cautioned, "it is a mistake for the clinician or physician to assume that this simple course of events will necessarily occur if only the genital problem has been treated, because an erection

problem will often change the dynamics of the sexual relationship, and such a change may not be easily reversed when only the genital component of the problem is treated."

Achieving Desired Outcomes

"Because we cannot assume that improved genital functioning will lead to greater sexual satisfaction and a better sexual relationship," Dr. Rowland said, "it is worthwhile to consider treatment strategies that help ensure these less tangible but more important outcomes. Perhaps this is one area where the perspectives of the sex therapist and the urologist diverge."

Like urologists, Dr. Rowland explained, sex therapists are interested in using biological options to achieve such outcomes when they are appropriate, that is, when the dysfunction has a probable organogenic cause or even when the dysfunction, though not organogenic, can be alleviated by a biologically based treatment such as pharmacotherapy.

However, the sex therapist is interested in going beyond treatment of the genital problem to ensure the issues of sexual satisfaction and an improved relationship are addressed as part of the treatment strategy. To do so, Dr. Rowland said, the therapist must explore, at least minimally, the individual psychological factors that are likely to have an impact on sexual satisfaction and the interpersonal dynamics that are likely to affect the overall sexual relationship.

Individual Psychological Factors

"Psychological factors might be categorized as having emotional, cognitive, and motivational dimensions," Dr. Rowland said, "and each dimension can then be explored in relation to sexual response and dysfunction." For example, he continued, "evidence indicates that men with ED score higher on scales of depression than their sexually functional counter-

parts. Whereas for most men these scores do not fall in the clinical range, about 10% of such men show signs of significant clinical depression."²

Regarding the cognitive dimension, sexual failure leads to self-blame, Dr. Rowland said, noting that men are culturally conditioned to assume responsibility for their partner's sexual satisfaction, so their failure has a significant impact on their self-efficacy. He cautioned that the cognitive, emotional, and motivational dimensions should be seen as interrelated rather than independent entities, because changes in one are likely to bring about changes in the other.

Dr. Rowland explained that a man with an erection problem comes to expect (the cognitive aspect) frustration and failure in sexual situations, which generates negative feelings about sexual situations in general (the emotional component), and as a result his interest in sex begins to decline (the motivational component). A common reaction in men with ED is hypoactive sexual desire, he added, noting that a series of chain reactions involving expectation, emotion, and motivation is set in motion, so the normal psychological processes that support a healthy sexual response are disrupted. Simple medical solutions that are limited to addressing only the genital component of the problem may be effective in re-establishing erection, he said, but such situations may not be adequate to deal with the disrupted psychological "support" systems associated with a normal, healthy sexual response.

Relationship Dynamics

Erectile dysfunction can significantly alter the man's psychological functioning, which is likely to affect relationship dynamics, Dr. Rowland said, noting that a man with ED may choose to deal with the situation in part by avoiding intimacy with his partner. Such an action is likely to

cause a reaction in the partner, who because of the man's physical avoidance of her, may feel less attractive and desirable. Such reactions can lead to frustration and eventually anger on the part of the partner.

Whereas that is only one possible scenario of how an erection problem can alter the dyadic interaction, the idea that such complex interpersonal dynamics can be overcome simply by reinstating erectile capacity is overly simplistic, Dr. Rowland said, observing that in such a scenario, the man's revitalized erection is not going to make his partner's anger go away.

To deal adequately with ED, the clinician may need to explore the multiple dimensions of the individual—the biological, the psychological, and the relational—and based on this exploration determine an optimal therapeutic strategy.

—David L. Rowland, PhD

"Ultimately," Dr. Rowland said, "it must be concluded that dealing with sexual dysfunction often involves more than merely treating the 'genital mechanics.' To deal adequately with ED," he continued, "the clinician may need to explore the multiple dimensions of the individual—the biological, the psychological, and the relational—and based on this exploration determine an optimal therapeutic strategy."

These therapeutic options lie along a continuum extending from one endpoint—an exclusively biological approach that might entail medication to the other endpoint—an exclusively counseling approach that might entail a number of sessions with a therapist to explore psychological and relationship issues.

Somewhere in the middle of this continuum lies an approach that combines pharmacotherapy with counseling to address broader relationship issues, Dr. Rowland explained.

The Role of the Treatment Strategy

"Presumably, the healthcare provider chooses a treatment strategy that maximizes the likelihood of achieving the multiple outcomes of improved genital response, improved sexual satisfaction, and an improved sexual relationship," Dr. Rowland said, adding that this choice is guided by a thorough understanding of the sexual problem and its context.

"However," he continued, "another factor that arises at this point in the treatment process is one that can affect the likelihood of achieving the desired outcomes but is often neglected: the attitudes and values of the patient and his partner toward the treatment itself. These need to be explored as therapeutic options are considered."

Certain treatment strategies, although well suited to the problem, may have little appeal to the patient or his partner, Dr. Rowland explained, noting that when the treatment strategy is inconsistent with the values of the patient or when the patient and/or partner respond negatively to the therapeutic approach, there is likely to be resistance to the therapy, less compliance, and resultant low satisfaction.

Dr. Rowland cited the use of intracavernosal injection (ICI) to treat ED as a good example of this phenomenon.³ "Despite the introduction of oral medication to treat ED, ICI will continue to be the primary option for a sizable subset of men with cardiovascular problems for whom sildenafil is contraindicated," he said.

"Because of its association with pain and penile injection, the patient may react negatively to ICI," Dr. Rowland continued. "Furthermore,

because the man's erection was elicited by the injection of a vasoactive substance rather than by the female partner, she may respond negatively as well, feeling that her role in her partner's arousal has been minimized. Such factors undoubtedly contribute to the relatively high attrition rate in ICI use, despite its generally high efficacy."

On the other side of the issue, Dr. Rowland pointed out, men may resist treatment strategies that require an exploration of psychological and/or relationship changes that might have resulted from the sexual problem.

"Because they don't see these factors as being part of the cause of the erectile problem, they see them as being unrelated to the solution," he explained, noting that in many cases unless such relationships are made explicit, the patient is unaware that the changes in relational and psychological dynamics resulting from the ED may lessen the likelihood that sexual satisfaction will be achieved, even when highly effective pharmacological therapies are prescribed.

Predictors of Outcome Satisfaction

It is still too early to know which factors will predict outcome satisfaction in men who are taking oral medication for erection problems, Dr. Rowland said, however, substantial research has been carried out on outcome satisfaction after other biomedical and/or counseling techniques to treat sexual problems, and the findings from these studies have clear relevance to all treatment strategies.³

"Some of the factors that predict outcome satisfaction are obvious," Dr. Rowland said, "such as the efficacy of the treatment mode and adverse side effects. Others may be less obvious, but they are not necessarily beyond the reach of most clinical settings." However, he noted, these factors may require a more integrated approach that addresses both the biological and psychosocial realms of the problem.

"At the individual level, the man's affective response to both the dysfunctional condition and the treatment mode predicts his level of sexual satisfaction," Dr. Rowland said, explaining that a patient who maintains his usual positive feelings with regard to sex and does not let them be overshadowed by unrealistic expectations and/or previously conditioned anxiety and frustration typically reports greater overall satisfaction with treatment.

A man's motivation or interest in sex is also related to satisfaction, he continued, partly because higher motivation produces greater compliance, greater tolerance for unpleasant side effects, and a greater willingness to overcome the barriers of cost and time and to accept the risks of treatment.

"Not unexpectedly," Dr. Rowland observed, "motivation and acceptance levels are highest in situations where the treatment mode is consistent with the values and needs of the patient and his partner." At the relationship level, he explained, a number of factors are likely to result in greater satisfaction with the outcome. He indicated that higher overall satisfaction with the relationship before the dysfunction or even just prior to treatment is predictive of higher overall satisfaction with the treatment.

Dr. Rowland explained that such interpersonal relationships are typically characterized by a heightened awareness of the sexual needs of the partner, open communication about sexual issues and problems, and a willingness on the part of the couple to explore alternatives to coitus in their lovemaking. "Perhaps one of the most salient predictors of satisfaction is the degree to which the sexual partner is involved in the decision about the type of treatment. Generally, if the partner is brought into this decision-making process, the satisfaction is much greater for both parties," he concluded.

...DISCUSSION HIGHLIGHTS...

Dr. Rajfer: I want to lay some groundwork here. Dr. Parham, how do managed care organizations feel about counseling for ED? I know you can't speak for the whole industry, but what is your sense of it?

Benefits for Counseling

Dr. Parham: I have had very little experience with it, Dr. Rajfer, but I would guess benefits for counseling are probably very limited, at least that is the case for most counseling in any insurance setting.

Dr. Leider: I would agree. I'm not saying it is right or wrong, but as far as the standards in the industry are concerned, psychological counseling is not included among the benefits.

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Dr. Sadovsky: Even though it may not be covered, I would like to believe that doesn't mean that psychological counseling doesn't occur. Hopefully, some counseling will be done by the clinician who is providing medical treatment. I simply want to clarify that it isn't an all-or-nothing phenomenon.

Dr. Leider: The analogy keeps getting bigger. We started with the con-

sultation with —most likely— a primary care physician, about sildenafil. Then we said: “Well, maybe there should be a cardiac evaluation.” Now we’re saying a psychological assessment might also be appropriate. All those things may be appropriate when the goal is enhanced function and quality of life, but we circle back to the earlier discussion of who will pay.

Need for Psychosexual History

Dr. Carson: Dr. Sharlip made the point earlier about taking a careful psychosexual history. I feel trying to determine what is causing the ED is the responsibility of the physician to whom the man initially goes about the problem. If significant psychological or relationship issues exist, then in addition to a prescription for sildenafil, that physician should recommend counseling to that patient.

All of us as urologists see some patients who come in with ED and have significant depression as well. In that situation we should send the patient to a psychiatrist for management of his depression.

Dr. Sharlip: Remember that sildenafil can have a negative psychological impact on the partner in a small percentage of cases. I have had a few patients for whom marital discord has arisen when the newly sexually active husband makes demands that his wife does not want to satisfy.

ED and Depression

Dr. Jarow: How do we as a group feel about whether depression is really associated with ED? If it is, how severe is it? Does it have an overall impact on productivity? Finally, how can all of this be formally assessed to show employers whether this is a problem worth spending money on?

Dr. Sadovsky: I don’t see much evidence at the current time that ED has much to do with productivity.

Dr. Sharlip: Depression can be very subtle. Patients can be depressed in ways they may not even be aware. All of us who have treated patients with ED by whatever means available have seen men who have had complete changes in personality for the better.

I’m sure the urologists in the group who have done penile implants have heard a patient say: “I feel like a whole man again.” I hear that repeatedly, because the cultural and sexual expectation is based on being able to perform if the opportunity is there.

Emotional Well-Being and Productivity

Dr. Rowland: I don’t believe there is any question that emotional well-being is influenced by a man’s ability to perform sexually, and emotional well-being undoubtedly affects productivity. But if you are going to argue for the value of the treatment of ED it shouldn’t be on the basis of productivity because at this time it’s too easy to challenge arguments for ED treatment based on productivity outcomes. However, it might be valuable to base treatment on emotional well-being.

Dr. Leider: Emotional well-being as the goal is problematic, Dr. Rowland, because so many factors in our lives and the lives of our patients affect emotional well-being. I mean if you looked for the number-one factor, it would probably be socioeconomic status. People who have very little money have tremendous stresses that cause emotional problems and a lack of well-being.

If the goal of society is to produce emotional well-being as the ultimate state, we should be giving people more money, we should be doing cosmetic surgery, we should be counseling whoever needs it whenever they need it, and it should all be paid for. It’s a slippery slope if emotional

well-being becomes the state we're all trying to achieve.

Dr. Carson: There is also a question about which comes first, the depression or the ED? I believe some depression causes ED, but then ED can cause depression, and some antidepressants can cause more ED, especially ejaculatory dysfunction, which causes problems with the depression treatment. It can be difficult to identify the original problem.

Dr. Sadovsky: We also treat anxiety, and it is hard to document exactly how anxiety affects productivity. If anxiety just seems to be affecting someone's sense of self, there's no objection to that. It is a difficult problem.

Projecting a "Caring" Image

Dr. Chang: It comes down to the bottom line. Employers who are motivated to provide treatments for emotional and psychological problems are less motivated by the expectation that such treatment will improve an employee's productivity. They are propelled by their desire to project a very positive image so the company will be seen as a caring one, that is, a company that has a good working environment. It does this in the hope of recruiting better future employees. Companies don't know how to deal with problems.

Dr. Basskin: I think what you are saying is true today when we have an unemployment rate of 3% and there is a tremendous shortage of labor.

Under those circumstances companies do indeed want to be seen as friendly; however, as soon as a recession comes around, that attitude will change pretty quickly. It will be back to bare minimum healthcare plans and an attitude on the part of employers that: "If you don't like it here, then go elsewhere."

Depression has not always been so high on everybody's list, and mental health has not always been viewed as a real disease. But now depression is very often treated, and nobody has problems approving drugs for it.

Dr. Leider: Most good managed care plans that have Medicare HMOs are trying to find the high-risk seniors, the 10% who are at very high risk of becoming ill and being hospitalized. If there were data to show that ED has a high predictive value of leading to hospitalization, whether it is for depression or other problems, it would be a powerful argument for treatment. That's the kind of research we need.

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