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When an erection alone is not enough: biopsychosocial obstacles to lovemaking

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Giving men firm erections is relatively straightforward these days; getting them to make use of it regularly in lovemaking is more complicated. Discontinuation rates for any of the available medical treatments for erectile dysfunction, including sildenafil, have been found to range from 50% to 60%. Thus, there is a disproportionately high number of individuals who fail to continue using medical interventions compared to those for whom treatment is efficacious. If not efficacy, then what factors contribute to this puzzling dropout phenomenon? This article discusses the psychological resistances of men, women, and couples that contribute to their stopping treatment for erectile dysfunction. Some of the factors that may be responsible include: (1) the length of time the couple was asexual before seeking treatment; (2) the man's approach to resuming a sexual life with his partner; (3) the man's expectations of how sildenafil will change his life; (4) the partner's physical and emotional readiness to resume lovemaking; (5) the meaning for each partner of using a medical intervention to restore lovemaking; (6) the quality of the nonsexual relationship; and (7) unconventional sexual arousal patterns in the man. To be effective, clinicians must go beyond the simple restoration of erectile function to help patients become active lovemakers again.
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Introduction

Giving men firm erections is relatively straightforward these days; getting them to make use of it regularly in lovemaking is more complicated. Today several different medical options for restoring erectile function are available, including sildenafil, intracavernosal injections, intraurethral therapy, vacuum pumps, and penile prosthesis. These diverse treatment options have efficacy rates between 44% and 91% but also have equally impressive discontinuation rates ranging from 20% to 50% (Pfizer Inc, oral communication, 2001).[1,2] How do we explain this phenomenon?

Obviously, no treatment works for everyone, and some of the disparity between efficacy and discontinuation may be accounted for by inadequate patient education, fear of serious adverse events such as sudden death, or an unacceptable ratio of benefit to adverse effect. For instance, we know that patients are sometimes not advised that sildenafil works best when taken on an empty stomach, that best results are achieved 45–60 minutes after taking the drug, and that efficacy improves from the first dose through to the eighth.[3] In addition, despite substantial efforts to allay safety concerns, some physicians and patients continue to consider sildenafil an unsafe drug. However, discontinuing treatment may be best explained from a biopsychosocial perspective that considers a broader view than simply efficacy, education, or adverse event profiles.

The broader context

Discontinuation of treatment may be considered the end result of an extended process that began months before the patient, with or without partner, presented for evaluation. Too often clinicians take a limited, organ-focused perspective: the man presents with erectile dysfunction and a reliable and safe remedy is prescribed to treat the malfunction. This outlook omits the following: (1) patient variables, such as performance anxiety, depression, unrealistic expectations, or unconventional sexual arousal patterns (for example, transvestism, sadomasochism, voyeurism, pedophilia); (2) partner

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variables, such as health status or disinterest in or inability to resume lovemaking; (3) interpersonal nonsexual variables, such as the quality of the couple's overall relationship; (4) interpersonal sexual variables, such as interval of sexual abstinence or sexual scripts; and (5) contextual variables, such as current life stresses with finances, children, parents, or occupation.

To illustrate, the typical patient who presents for treatment of erectile dysfunction at our clinic is a 54-y-old married man who has waited 2 y to seek help. During that time he may have developed feelings of inadequacy, performance anxiety, resentment, and possibly depression. Also, a pernicious pattern has evolved. He has begun to go to sleep earlier or later than his partner; he offers plausible excuses to his wife for being too tired or too busy to make love; he cites age as a convenient cover-up: 'Look dear, I'm not 25 anymore.' His goal is to avoid embarrassment or outright failure. The couple's frequency of attempts at lovemaking has slowly dwindled to once a month, then once every several months, and then it has mysteriously disappeared. He has no desire and has become overly involved with work, television, volunteer efforts, or the children. Not just intercourse has disappeared, but also affectionate touch. Everything is avoided that might remotely be perceived by the partner to be a suggestion for sexual play.

For her part, the wife begins to wonder, 'Does he still love me?' 'Is he having an affair?' 'Is he still attracted to me with the weight I've gained over the years?' 'Is that part of our relationship over?' Some women may collude with their partner to avoid sex play to lessen either the pain of feeling rejected or the pressure to have sex. For many women, the relationship feels emptier with no lovemaking or affectionate touch. She may experience her husband as somewhat down, irritable, preoccupied, or defensive.

Some men come for evaluation at the behest of their partner. Others, however, seek treatment without telling their partner. In the latter case, after obtaining sildenafil from the primary care physician or urologist, the husband may come home and display, without prior discussion, his newfound erection to his wife. Surprised, because she was unaware of his visit to the physician, she may feel an amalgam of amazement, anger, dismay, and certainly anxiety: 'Can I get ready for this again?' 'Will this erection last?' 'I was hoping we were past this.' He, too, is anxious about his performance. Sometimes, when the wife discovers that he has taken sildenafil, she feels betrayed, believing that his arousal is due to the medication and not to her. Even when prepared for his new erectile ability, the woman may discover that because of menopause, lubrication and arousal may have become more difficult, resulting in uncomfortable or painful intercourse. Between them, the experience is less than memorable, and somehow his desire to try again wanes.

In reaction to this situation, the man may simply tell the physician that sildenafil 'did not work'. A careful inquiry by the physician may uncover the formidable barriers of fear and anxiety that had grown during the years of avoidance and failure that were too difficult to surmount. To enable sildenafil to 'work', the couple now needs help overcoming these unrecognized, intransigent blocks to their lovemaking.

This common scenario illustrates five causes of psychological resistance that may contribute to discontinuing treatment for erectile dysfunction: (1) the length of time the couple was asexual before seeking treatment; (2) the man's approach to resuming a sexual life with his partner; (3) the female partner's physical and emotional readiness to resume lovemaking; (4) the meaning for each partner of using a medical intervention to enable intercourse; and (5) the quality of the nonsexual aspects of the relationship.

The scenario does not illustrate the situation when the man's unconventional pattern of sexual arousal or lack of desire for his partner is the culprit. Too often men disguise their unconventional patterns of sexual arousal out of fear of humiliation or embarrassment. Oral agents require that the man be aroused by his partner. If his sexual preference is for something other than conventional lovemaking (for example, a sadomasochistic encounter), he is not likely to generate an erection with his partner under conventional circumstances. Similarly, if he finds his partner unattractive, sildenafil will not induce a genital response.

Review of the literature

In psychiatry, integrated treatment approaches that blend pharmacological and psychological therapies have proven to be superior to either approach alone. This is especially noteworthy in the treatment of depression.[4] To date, however, no controlled studies of erectile dysfunction therapy have examined whether such an integrated method would be more successful than either a medical or psychological treatment alone. Common sense suggests that this would be the case, but designing and testing the elements of a combined treatment with matched treatment and control groups are challenging.[5]

Recently, a report of an uncontrolled, combined treatment study of 57 patients who were given both sildenafil and psychotherapy was published.[6] These patients ranged in age from 21 to 75 y, with a mean age of 53 y. The duration of their erectile dysfunction ranged from 1 month to 38 y, with a mean duration of 8 y. Seventy-eight percent of this sample had been in psychotherapy with one of four

clinicians from 1 to 16 y, the average being 2 y. Clinicians' assessment of the etiology of the men's erectile dysfunction was 52% psychogenic, 22% organic, 22% mixed, and 3% unclear.

All patients received sildenafil and continued in psychotherapy. Some men were seen weekly, others every 2 months. The dose of sildenafil was adjusted as necessary to optimize the possibility that the patients could successfully accomplish intercourse. Patients were evaluated twice at approximately 5 weeks and again at 10 weeks after receiving the first sildenafil prescription.

Qualitative data characterizing patients' responses were gathered and classified into 1 of 7 categories: four variants of success and three variants of failure.

The first success category, *maximum* success (S1), applied to patients who, after taking the drug one or more times, no longer needed it to accomplish intercourse. Performance anxiety was diminished enough that the man's biological capacities were again sufficient. There were no partner complaints.

The next best success category, *drug-dependent success* (S2), typified the case where sildenafil was always necessary to consummate a satisfying intercourse experience. Without sildenafil, the sexual experience was labeled as unsuccessful by one or both partners.

The third category, *drug-dependent success with the development of a new sexual symptom* (S3), is self-descriptive. Although intercourse occurred, either the man or woman developed a desire, arousal, orgasmic, or pain symptom.

Minimum success, *improvement but no intercourse* (S4), described the man who had an erection firm enough to engage in sexual intercourse, but who also had psychological resistances that prevented intercourse from occurring.

The first category of failure, *transient unsustainable improvement* (F1), identified patients for whom sildenafil reliably generated a firm erection and intercourse occurred on occasion; however, the erection was not used by the couple, the ability to achieve an erection was not valued enough by them to behave sexually, or one partner developed a crippling sexual symptom such as aversion.

The second failure category, *resistance* failure (F2), was given to patients or couples who were unable to overcome their reluctance to taking a drug.

Finally, *pharmacologic failure* (F3) described the group who, after dose adjustments and assurances that the drug was being properly taken, did not have any improvement in erectile ability.

At the first follow-up visit, sildenafil combined with psychotherapy was found to improve *erections* for 67% of the men (the four success categories, S1–S4, plus the first failure category, F1). Fifty-five percent of the sample was able to have successful *intercourse* (S1–S3). Fifty-two percent had ideal outcomes (S1 and S2); that is, intercourse occurred regularly without new sexual symptoms. At the 10-week follow-up, 64% of men continued to have improved erections, 50% were having successful intercourse, and 43% were considered to have ideal outcomes. Data were not available at follow-up for 21% of the original sample.

Of the 30 men diagnosed as having pure or primarily psychogenic etiologies, 73% responded with improved erections (S1–S4 and F1) by the second follow-up visit, 53% were having successful intercourse (S1–S3), and 47% had ideal outcomes (S1–S2). The data from the psychogenic men, however, were indistinguishable from the entire sample.

What this study demonstrates is that the difference between improved erections (67% and 64% at the first and second follow-ups, respectively) and an ideal follow-up (52% and 43% at the first and second follow-ups, respectively) is the degree to which we can assume that biopsychosocial factors contribute to discontinuation of the relatively effective and safe treatment.

Sildenafil as a therapeutic probe

Sensate focus was a therapeutic technique championed by Masters and Johnson to help men and women overcome sexual performance anxiety.[6] Initially, sensate focus was given to all patients as a treatment strategy. Similar to the sildenafil experience, patients often did not respond as expected. Psychological resistances interfered with the effectiveness of the intervention. Clinicians then changed their strategy and used sensate focus as a therapeutic probe. Instead of conceptualizing the intervention as a treatment, clinicians now employed the method to flush out unrecognized resistances. Once identified, these resistances were usually amenable to psychotherapeutic intervention.

As treatments, sildenafil and sensate focus have much in common. Sildenafil may enable an erection but not enable intercourse. Therefore, in practice sildenafil actually functions as a therapeutic probe to illuminate the hidden reasons why a man, woman, or couple do not make use of an effective treatment. In this treatment paradigm, the physician, having previously prescribed sildenafil, now inquires how well it worked to create an erection and what the couple learned from the experience of using it. Depending on the answers, the clinician and patient can explore whether the man understands the reasons for his reluctance to use the erection for intercourse, whether the man or woman is depressed, whether she is not prepared physically or psychologically to resume lovemaking, whether there is a high degree of anger or disappointment in

the relationship, whether one of them prefers an asexual equilibrium, or whether she perceives he is responding to the drug and not to her. Physicians then have the choice of deciding whether to attempt to minimize the resistances themselves by continuing the discussion or whether to involve a mental health clinician to achieve this goal with the man or couple.

Such clinicians are well suited to work with the couple or the man to illuminate and reduce the resistances to lovemaking. The therapist helps the couple cultivate a romantic ambiance and engage in conversations that physically and psychologically prepare them to become lovers again. The therapist also assists them in accepting the changes that have occurred in their lives, such as menopause, disability, illness, or other life stresses, or helps the man minimize his unconventional arousal requirements. In some cases, the recognized psychological issues can be addressed simultaneously with drug treatment.[7] If not confronted, these powerful psychological impediments to making love will render the best-intentioned and most appropriate medical treatment efforts ineffectual.

The future: combined treatment approaches

To be effective in enabling patients to achieve their goal of making love, clinicians need a means of assessing what the man or couple requires to attain their goal. Success can no longer be defined as a rapid, sustained genital response.

In simple cases, oral agents most likely will restore men's genital adequacy; nothing more than a medical prescription and advice regarding how to best use the drug are necessary. However, many situations are not so straightforward. In more complicated cases, sexual competence and/or gratification is not ensured with medication alone. In these instances, sildenafil functions as a therapeutic probe, uncovering patient, partner, interpersonal, and contextual issues that can conspire to interfere with the stated goal of resuming lovemaking.

For example, when relationships are problematic, any of the following motives by one or both partners will interfere with the successful resumption of lovemaking: poorly managed or unresolved anger, power and control issues, and contempt and disappointment. These concerns, complicated by prolonged sexual abstinence, need to be addressed before or during the pharmacological treatment intervention to achieve the stated goal.

Similarly, when unrealistic expectations, such as 'with my restored erection, lovemaking will be more frequent' or 'I will feel more lovable/successful in life', fail to be realized, the treatment will be characterized as 'sildenafil didn't work' not that 'I had unrealistic expectations'.

Finally, disguised or hidden (conventional and unconventional) sexual arousal patterns may be the cause of sildenafil failure. Sildenafil requires the man to desire his partner; lack of sexual arousal for his partner prevents any erectile response. It is noteworthy that requirement for sexual arousal by the partner is not necessary for intracavernosal injection, vacuum pump therapy, or a penile prosthesis. Injections and pumps induce erection, but sildenafil facilitates erection only when the man is aroused by his partner.

Examples of disguised or hidden conventional and unconventional arousal patterns can include the married man who is secretly attracted to men, the man who has no sexual desire for his wife, and the man who cannot acknowledge his unconventional patterns of arousal, such as to young children or in sadomasochistic situations. Any of these arousal patterns are likely to interfere with the man achieving or sustaining his genital response to his conventional partner. Sildenafil cannot be expected to overcome these psychosocial obstacles or a couple's psychological impasse.

It would be ideal if every man brought his partner for evaluation and if both were seen simultaneously by a physician and mental health clinician. However, this is usually not possible for practical reasons. Nonetheless, before concluding that treatment has failed, the clinician must consider the myriad biopsychosocial reasons that could collude to prevent the couple from attaining their stated goal.

In the future, I believe combined treatments will be the rule rather than the exception. Algorithms need to be developed to determine when a patient or couple requires no intervention, intervention first, or simultaneous interventions and what the form of such interventions should look like.[8] This requires a new role for mental health clinicians.[9] They need to not only make themselves available to their medical colleagues but also develop methods to evaluate whether the notion that combined treatments for erectile dysfunction, such as treating depression simultaneously, are indeed superior to treating erectile dysfunction and associated biopsychosocial conditions separately.

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Appendix

Open discussion following Dr Althof's presentation

Dr Nehra: Is there an instrument that we as physicians can use that can possibly increase our referral pattern to our psychologist colleagues?
Dr Althof: I think you're the instrument. You can go beyond asking whether this treatment worked and express a curiosity as to why it did not work. Of course, you'll check whether the patient followed the treatment protocol properly, but then you can go one step further and wonder with the patient, 'how come you're having difficulty using this?' I know there are time issues, but if we want to help our patients, we are the tool.
Dr Porst: A major issue is the female partner. From my comprehensive experience, many of the female partners are reluctant to accept any treatment because they are not counseled regarding the fact that males have many organic factors. The females have in mind that they become unattractive to their partners, and, therefore, they are reluctant to accept any treatment in this field because they always have in mind, he now needs a drug to get sexually engaged with me. We have no educational material for the females. We have a lot of educational material for the males.
Dr Althof: The interesting thing with the PDE-5 drugs is that you can stress to the woman that he needs to be aroused for the medication to work.
Dr Porst: Yes, but she has in mind that he needs a drug to become aroused.
Dr Althof: That's why a combined treatment is going to be necessary to help her overcome her resistance to accepting his taking a drug.
Dr Meuleman: How essential is it that the partner is in the office?
Dr Althof: It's preferable. It's not essential. In the real world, I think you go with what you have in front of you. You say it would be useful if your partner could come with you. When it doesn't happen, you go with what you have.
Dr Montorsi: In my practice, it is not unusual for the patients to ask me, 'Do I need to tell my partner that I have had a pill before sex?' I don't know how to answer them.
Dr Althof: I try to answer that question with a general guideline about secrets in relationships; that is, I think that secrets in relationships are ultimately destructive. Now if the person is single, I have a different answer. However, if they're in an ongoing relationship, I tell them these things are often discovered. What are you going to do, hide it for the next 5 y? What happens then is you have the sequelae of the person feeling betrayed. They discover the medicine maybe 3 months later and get angry. So generally, I talk with people about the destructiveness of secrets and about what they think the problem will be; that is, what is the reluctance to discuss this with the partner; how do you think she might react or feel? I try to help them think it through.
Dr Nehra: Are there some psychological profiles or parameters that may be evolving within those couples that are allowing them to not go for therapy after that period?
Dr Althof: I think that most people stop using the drugs in the beginning. If you look at the discontinuation studies, most people just don't continue to use it. Then you have a group of people that use it for a long time. I think the issue is to catch it early and to have more follow-up in the beginning and then taper it off. Just be curious and ask what the difficulty is. Ask questions beyond 'Does it work?'
Dr Porst: I think the highest dropout rate is within the first 2 months after prescription. The patients are not coming back or they have tried it once or twice and they are stopping because they have communication problems in the partnership about this topic.
Dr Pryor: We're talking about the same sort of issues. It's not just the erection, it's the relationship that you have to look at as well.
Dr Giuliano: What kind of counseling do you provide to a patient who is alone? He is 50 y old, no longer has a partner, and is afraid of a new relationship. He has experienced erectile dysfunction in the past few years, and he is afraid with a new relationship that he will fail.
Dr Althof: I feel like I become a coach. You explain to people about the idea of performance anxiety and how it escalates. I tell people that they need to take it slow, that they need to get comfortable, and that, if they expect to be able to surmount this in one

evening, it's not going to happen. I try to give them realistic expectations of what will happen. I tell them the penis is connected to the heart and that what's in their heart will help them to overcome their anxieties. Often men have a mechanical view of the penis, believing it should work anywhere, any time, with anybody, under any circumstances. That's just not going to happen, especially as the man ages. So I become a coach to try to get them to slow down, to appreciate the context of what's going on, to become comfortable, to recognize that biology is in some way less important, and to realize that emotions will interfere or enhance their sexual response.