PSYCHOSEXUAL ISSUES AND ERECTILE DYSFUNCTION (ED)

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Presentation Aims

- To provide a broad overview of Psychogenic causes of ED and the links between Organic and Psychogenic ED
- To provide an overview of Psychosexual Therapy for ED

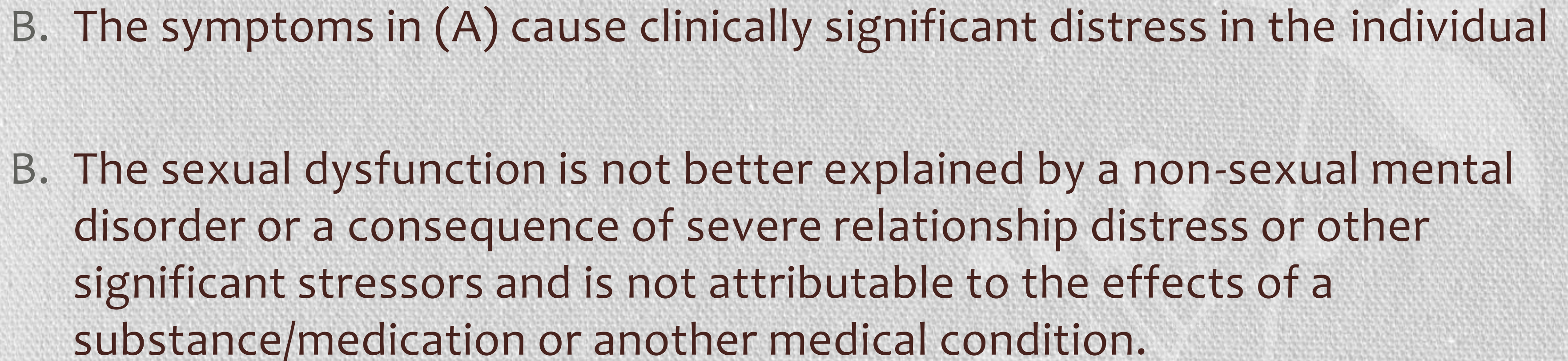
Presentation Objectives

- Consider some of the psychogenic causes of ED
- Consider ways to differentiate between Psychogenic and Organic ED
- Explore some of the relational effects of ED on couples and individuals
- Explain the role of psychosexual therapy in addressing ED – including making referrals to Psychosexual Counselling

Erectile Disorder (Dysfunction) – DSM5

A. One of the three following symptoms must be experienced on almost all or all (75-100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts);
   1. Marked difficulty in obtaining an erection during sexual activity
   2. Marked difficulty in maintaining an erection until the completion of sexual activity
   3. Marked decrease in erectile rigidity

B. The symptoms in (A) have persisted for a minimum duration of approx 6 months



B. The symptoms in (A) cause clinically significant distress in the individual

B. The sexual dysfunction is not better explained by a non-sexual mental disorder or a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Erectile disorder can be

- Lifelong – present since the individual became sexually active
- Acquired – started after a period of normal sexual functioning

- Generalised – not limited to certain types of situation, stimulation, or partners
- Situational – only occurs with certain types of stimulation, situation or partners

Can cause;

- Mild Distress
- Moderate Distress
- Severe Distress

Psychogenic or Organic?

- Lizza and Rosen (1999) – Psychogenic Erectile dysfunction is due predominantly and exclusively to psychological or interpersonal factors.

- Gambescia et al. (2009) "even in clearly organic ED cases, secondary psychogenic problems frequently develop".

Psychogenic ED

- Rosen (2001) Main causes fall within three groups
  1. Immediate factors – e.g. perfomance anxiety
  2. Recent prior life events
  3. Developmental factors from childhood and adolescence

Gambescia et al. (2009) suggests three categories for identifying the psychological etiology of ED

1. Individual factors - Current personality and mental health factors, including performance anxiety and mental illness
2. Interpersonal factors between partners
3. Intergenerational conditions, developmental vulnerabilities, and socio-economic factors.

Psychological Factors

- Early Psychoanalytical Ideas – Unresolved Oedipal desires

- Contemporary Ideas
  - Masters and Johnson (1970) – Anxiety at the root of sexual difficulty. The fear of not being able to gain or sustain an erection and fears about sexual performance creates a 'Spectatoring role'. This role causes the individual to become an observer of their sexual encounters and prevents them from directly experiencing their own arousal.

- Cognitive affective models – rather than experiencing a positive ‘affect’ (emotional/psychological state) from a sexual encounter the individual becomes pre-occupied with concern about the sexual encounter which interferes with their ability to experience and process the erotic aspects of the sexual experience (See Barlow, 1986; Sbrocco and Barlow, 1996; Nobre, 2010).

- Schema (core beliefs) – based on CBT theory, individuals hold maladaptive schema (collections of beliefs about self, others, the world) which inhibit processing of erotic stimuli as the persons attention shifts to the emotional consequences of inadequate sexual performance. Zilbergeld (1992) identifies some of these scheme as ‘male myths’.

- Clarke, et al. (2014) “dysfunctional sexual beliefs and sexual attitudes in males are closely linked to perceptions of the male gender role and normative masculinity… participants exposed to traditional male role conditions reported significantly greater endorsement of dysfunctional sexual beliefs”
- Nobre (2010) Cognitive-emotive model of sexual dysfunction suggests that dysfunctional sexual beliefs may have a heightening or maintaining effect on sexual dysfunction.
- Further research is needed….

Case Examples;

- Case 1: 50yr old male, has not been in a sexual relationship for 8 years. His last relationship ended in divorce and a custody battle for his children. He has avoided relationships as his children are now grown up he has met and is dating a new partner. He is finding it difficult to gain an erection for sexual intercourse but is having no difficulties during masturbation. Medical check find no physical cause for his difficulties.

- Case 2: A 20yr old male reports erectile difficulties with his girlfriend. He has no difficulties with masturbation but reports he only masturbates to pornography. His girlfriend feels that he does not find her attractive and this is the cause of his erectile difficulties. Medical check find no physical cause for his difficulties.

- Case 3: A 32 year old male reports erectile difficulties for masturbation and with his partner. He has a history of depression and has previously had low-intensity CBT as well as being prescribed anti-depressant medication. He has low self esteem and poor social skills. He reports relationship difficulties as the result of his erectile problems. Medical checks have ruled out a physical cause for his erectile difficulties.

- Case 4: A 63 year old male reports erectile difficulties that have been present for the last 10 years in his relationship and has been prescribed Sildenafil by his GP with a positive effect. His sexual relationship with his wife is infrequent and he worries about what the future holds for his sexual relationships as he describe having a strong libido.

- Case study 5: A 45 year old male presents with erections which he reports are “not as firm as they used to be” although are still usable for penetration. He reports a lack of confidence sexually. He is divorced and is currently casually dating but ends relationships before they become sexual.

- Case study 6: A 30 year old male presents with erectile difficulties with partners. He reports no difficulties with erections for masturbation and cannot gain an erection with partners. After several sessions he reveals that he has not been honest in therapy and that his partners are male, he states that his reason for not disclosing his partners sex was that he feels guilty and ashamed of his attraction.

- Case study 7: A 37 year old male presents with erectile difficulties. He is diabetic and has been prescribed Tadalafil by his GP. He worries about his sexual performance and avoids sex with his partner. He states he feels he should not need to take medication to get an erection.

Impact of ED

- Couple Relationships
  - A sexual problem can be a symptom of or can provoke couple conflict. Determining which is which can help decide whether Couple or Psychosexual Therapy is appropriate.
  - Whilst one partner might suffer from the sexual dysfunction it is often helpful to think of the problem in relational terms. One person has the problem but both are affected by it, by working together they are much more likely to find a successful resolution.
- Individuals
  - Can create issues in forming and maintaining relationship.
  - May heighten unrealistic expectations on sexual performance which contribute to avoidance.
  - The desire to enter into a couple relationship can prompt individuals to seek help.

Psychosexual Treatment

- Integrative Psychodynamic, Systemic and CBT approach

- Focus on;
  - Cognitive restructuring, exploring realistic expectations for sexual functioning and challenging sexual myths and self-defeating negative thoughts
  - Enhancing communication skills – clarifying colloquialisms and euphemisms and promoting communication that is clear. The aim is to support clients to be able to talk openly about their sexual needs.
  - Promoting full body – reciprocal sexual pleasure beyond a focus on intercourse
  - Provide strategies to manage anxiety and reduce ‘spectatoring’
  - Assign specific behavioural exercises (sensate focus, masturbatory programmes etc).
  - Focus on long-term management and relapse prevention

Referring to Psychosexual Therapy

- Useful if patient has been through appropriate medical checks in line with British Society for Sexual Medicine (BSSM) Guidelines for management of ED (2013) before referral to Psychosexual Therapy.

- Practitioners also could make use of the PLISSIT model when working with patients presenting with sexual difficulties.

- BSSM paper Hackett, et al. (2008) British Society for Sexual Medicine Guidelines on the management of Erectile Dysfunction. *Journal of Sexual Medicine - useful to contextualise some of the medical issues in managing patients presenting with ED.*

Psychosexual Therapy - Typical Treatment Process

- Initial Assessment
- History Take
- Formulation (Predisposing, Precipitating, Maintaining Factors)
- Education and Information giving
- Sensate Focus
- Specific Treatment Exercises for Sexual Dysfunction
- Review and Discharge

Criteria for working with couples;

- The Disorder is definable in accordance with DSM IV (DSM 5) and has persisted for at least a few months.
- The couple's general relationship is reasonably harmonious (sufficient for the partners to have a reasonable chance of working collaboratively on tasks), and the couple committed to each other and to maintenance of the relationship.
- The couple both perceive the difficulties as being sexual and accept mutuality of responsibility for their resolution.
- Both partners want change and are motivated to work for it.
- The problem is likely to be caused or maintained by psychological factors and any organic cause for the Disorder(s) is taken into account.

- The Disorder(s) is not a side effect of medical treatment which would render treatment ineffective.
- Neither partner has a current active major psychiatric disorder, and substance abuse is not a feature of the relationship.
- The couple are prepared to give the time to treatment which it requires:-
  - Regular visits to therapist
  - Time spent together at home on tasks.
- The Therapist must be satisfied that secrets between the couple will not impede treatment.

(Ref: Hawton, K. (1995) Treatment of Sexual Disorders by Sex Therapy and Other Approaches. British Journal of Psychiatry: 167.)

Closing Thoughts

- Treatment for Erectile Disorder can result in enhanced sexual satisfaction and relationship well-being, regardless of erectile capacity (Tiefer, 2006)

- Gambescia et al. (2009) "even in clearly organic ED cases, secondary psychogenic problems frequently develop".

References and further reading

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- Zilbergeld, B. (1992) *The New male Sexuality.* New York: Bantam Books.

- College of Sexual and Relationship Therapists www.cosrt.co.uk

- British Society for Sexual Medicine (BSSM) http://www.bssm.org.uk/

- Questions?