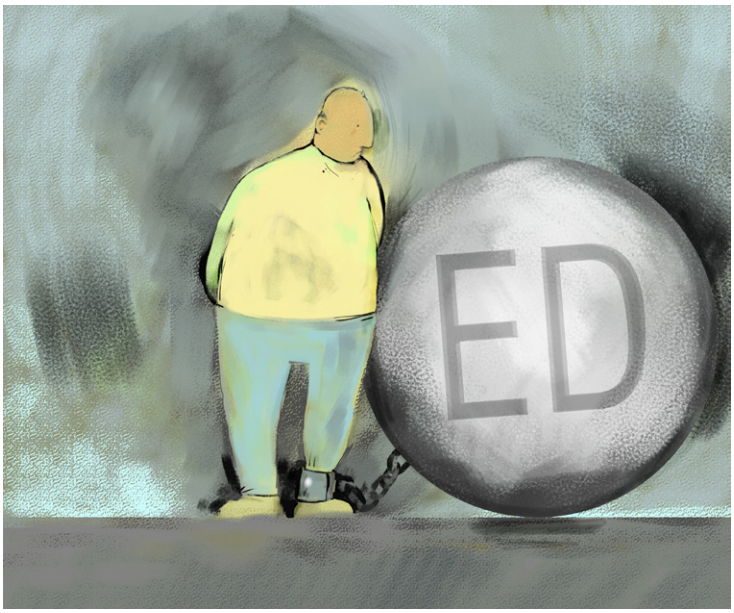
Erectile Dysfunction: Entering the conversation



by Luke Devlin.

A Problem!

No, she's seductive: squandered so many kisses on me:
urged me on with every one of her powers!
She could have moved heavy oak-trees,
stirred hard adamant, or the deafest stones.
She'd have moved all men, all living things for sure:
but I was neither man nor living, as once before.
What joy can deaf ears have when Phemis sings?
What joy can blind Thamyras have in painted things?
But what silent delights my mind invented!
What did I not imagine, all the various ways!
But still my sex lay there prematurely dead,
shamefully, limper than a rose picked yesterday –
Look, now, he's lively at the wrong time, able,
now he's demanding work and service.
Why can't you lie down modestly, worst part of me?
You've caught me like this with your promises before.
You failed your master: I was left weaponless, through you,
enduring sad hurt and great embarrassment.

(Ovid, The Amores. 16BC.)

Introduction

Erectile Dysfunction (ED) is not a condition that is specific to the modern world we live in. The extract above from the poem, "A Problem" was written by the Roman lyric poet Ovid in 16 BC, and although it is wonderfully artistic in its articulation of the experience of ED, its importance and inclusion in this article serves to demonstrate the timeless nature of the condition. Today it is estimated that ED affects up to 25% of males globally and yet it seems to be a condition that is largely suffered in silence. At the time of writing, no statistics are available on the prevalence of ED in Ireland but there is nothing to suggest that we might differ from the rest of the world. With a reported ratio of 1:4 men experiencing ED at some stage in their lives the chances are that we, as counsellors, will have to be prepared, professionally and personally, to deal with it. Sex and sexually related issues has long been a taboo subject in Ireland. Thankfully, that is changing although it is a slow process of change. As agents of change (such as the counselling process is) we have a duty to challenge ourselves and our thinking on all issues including sex and sexuality. We can only bring our clients as far as we are willing to go ourselves so we must continue to push our boundaries in a safe but courageous way. This article will seek to provide a brief overview of the aetiological understanding of ED and also discuss the implications this may have on the therapeutic interventions that are adopted in a counselling and psychotherapy context. It is hoped that if we can become more comfortable in our own conversation around ED, this might help us to initiate (if necessary) and become part of the conversation with our clients.

Sexual dysfunction

Erectile dysfunction is classed as a sexual dysfunction. Reber et al (1985) define sexual dysfunction as being "marked by

inhibition of arousal or of the psychophysiological aspects of the sexual response cycle" (p.734). The DSM V describes sexual dysfunctions as "a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (p.423). To understand this better though perhaps we need to understand the concept of normal, healthy sexual functioning. In 1966, Masters and Johnston proposed that the human sexual response cycle proceeded through four clearly defined stages of (1) Excitement (2) Plateau (3) Orgasm (4) Resolution but something was missing from this neatly constructed cycle. What if a person was unable to get to stage one of "excitement"? Clearly the element of desire was missing and Wincze and Carey (2001) have documented that "most sexologists agree that healthy sexual functioning comprises three primary stages: desire, arousal, and orgasm" (p.4). At the risk of being crude but to address the stages from a non-professional and, for the purpose of this article, male viewpoint, desire can be described as being "horny" or "turned on", arousal is often reflected or understood in the ability to get an erection or "hard on" and orgasm describes the sensation or ability to ejaculate or "come". If this is the accepted view of healthy sexual functioning then it should naturally follow that sexual dysfunction should also fall into these three categories. Erectile dysfunction (ED), previously known as "the ambiguous and pejorative term impotence" (Burnett, 2006. p101), is described by Schumacher et al as "constant or frequent difficulty in obtaining or maintaining an erection" (1981, p.40) and as such is classed as an arousal disorder.

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The erection

An erection occurs when blood flows into the penis. There is "increased arterial inflow to the penis, penile blood engorgement, and decreased venous outflow" Saenz de Tejada et al., 2004). Glands in the penis swell and harden with this increased blood flow and the penis becomes erect. Erectile difficulties arise when there is decreased or insufficient blood flow to the penis.

Erectile dysfunction (ED) and DSM V

The current Diagnostic and Statistical Manual of Mental Disorders (DSM V) uses the term "Erectile Disorder" and classifies the diagnostic criteria as follows:

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 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 Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as 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. (DSM V. p.426)

In order to bolster these diagnostic criteria, the practitioner is asked to specify whether the condition is: Lifelong: The disturbance has been present since the individual became sexually active or, Acquired: The disturbance began after a period of relatively normal sexual function. And also to clarify if the condition is either Generalized: Not limited to certain types of stimulation, situations, or partners or, Situational: Only occurs with certain types of stimulation, situations, or partners. This author feels that although it is useful to have an understanding of the current diagnostic criteria for ED, it is not the job of the counsellor to diagnose any client but what should be taken from this is the necessity to ask two clear questions each time we are presented with a sexual dysfunction in therapy. (1) Is the condition lifelong or acquired? (2) Is it generalized or situational? and to explore these comprehensively. These alone might uncover any precipitating or causal factors in the client's experience of ED.

The causes of ED

Early understandings and attitudes towards impotence and ED seemed to suggest that 90% of cases were psychogenic, the cause being psychological as opposed to physiological in nature (Schumacher et al. 1981), but we have come a long way in our understanding of the aetiological understanding of ED since then. Jern et al (2012) contend that "ED

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is proposed to have a multifactorial etiology, with organic and/or psychogenic causal factors" and The National Health Service (NHS) in Britain provide a comprehensive guide to these causes and describe three main areas:

- **Physical causes**

  Vasculogenic: Affecting blood flow to the penis.

  Neurogenic: Affecting the nervous system.

  Hormonal: Affecting hormone levels.

  Anatomical: Affecting the physicality of the penis.

- **Medicinal causes**
  There are certain medications that can cause ED and many of these are taken/ prescribed routinely. They include medications to treat: High blood pressure, Cholesterol, Depression, Stomach ulcers, Epilepsy, Hayfever as well as medications that are used for chemotherapy, mental health and steroid replacement.

  (http://www.nhs.uk/Conditions/Erectiledysfunction/Pages/Causes.aspx)

- **Psychological causes**
  The psychological well-being of an individual can have a huge impact on the incidence and severity of ED. Any of the following factors can have a contributing factor to ED: Depression, Anxiety, Stress, Relationship difficulties and pressures to conform/ achieve perceived sexual norms

- **Other causes**
  Alcohol misuse or abuse can seriously affect the ability to achieve an erection as can drug or other substance misuse. Tiredness and fatigue can also play a significant part in the experience of ED. It should be noted that any of these causes may not happen in isolation and quite often will overlap. For example, a person experiencing ED who may be depressed might be prescribed an anti-depressant, which might in turn make the ED even worse.

ED and the pathways into therapy

Regardless of any moral or ethical viewpoints on the medicalisation of male sexual dysfunction and particularly ED, the advent of PDE5i drugs such as Viagra, (sildenafil), Cialis (tadalafil) and Levitra (vardenafil) have, at the very least, "normalised" the experience of ED. Clever marketing ensured that worldwide sporting icon Pele made it alright to have ED and that this could be cured with this new, wonderful magic bullet. The term "erectile dysfunction" is now a part of our vocabulary and conversation and although most middle-aged men with ED are routinely prescribed a PDE5i without any psychological evaluation (Leiblum, 2007) there is a growing awareness in the medical profession of the need for "an integrated medical-psychological approach to treatment...because of the importance of the psychological/ interpersonal factors that may have caused, contributed to, or arisen as a result of ED" (Aubin et al. 2009, p.123). Rosen et al (2006) describe how "partner concerns are a potentially motivating factor in encouraging men with ED to seek treatment and may be a critical factor in the decision whether to initiate or to maintain therapy" (p.217). Perhaps we need to be both perceptive and brave enough in our practices to acknowledge that ED might well be an unspoken element in clients presenting issues such as depression, anxiety, stress and relationship difficulties. Berry (2013) contends that men's reluctance to engage in psychotherapy for sexual issues is rooted in particular scripts of masculinity (p.32) so maybe we need to challenge this particular script and start inquiring about sexual and erectile functioning as a matter of course. Interestingly, a study has shown that 80% of men with ED who had not consulted a medical professional stated that they would have been open to discussing ED if a physician had initiated it. (Wylie, 2003). This surely has implications for the need for counsellors to, at least, ask the question or open a discussion.

Diagnosis / measurement

One of the most commonly used diagnostic tools for ED is the International Index of Erectile Function or IIEF. This is a 15-point, self-reporting instrument, which is based on five specific questions that have a choice of five standard answers for each. Normally though, "diagnosis of ED has historically been based on the self-reported ability of the man to achieve and maintain erection sufficient for sexual performance" (Leiblum, 2007, p.283) and this highlights the necessity to ask the key questions around Lifelong Vs. Acquired / Generalised Vs. Situational as this will give a clear insight into the context of the problem but also, and just as importantly, the clients subjective understanding of normal sexual functioning.

The implications for therapy

"Before the advent of modern therapies, erectile dysfunction was often treated through psychoanalysis, when treated at

all." Melman, (1999). Now that our understanding of ED has improved significantly it is possible to have the root or cause of the ED issue treated by a specialist in that field. If the cause of ED is a physical one such as cardiovascular disease, this can be treated by a cardiovascular specialist, if the problem is being caused by a prescribed medication, this can be altered or at least understood by the health care professional prescribing the medication but what are the therapy implications for counsellors and psychotherapists?

Clients presenting with or who disclose ED

It is the opinion of this author that one of the first responsibilities the counsellor has with a client presenting with ED is to encourage them to liaise with their GP. Given the knowledge that is available regarding the causes of ED (such as cardiovascular disease etc.) this would seem to be the safest and most pragmatic thing to do. ED is a very complex issue and there is a danger that more harm than good could be done in the counselling space by a professional who does not understand not only the causes of the condition but also the distress it can create in a client's life. A lot of men see getting an erection as a statement of how masculine they are and the counsellor needs to have a real empathy and understanding of the possible embarrassment, upset, anxiety and destabilising effect this perceived change in masculinity can have. Neukrug et al (2012) explain that these feelings alone can "prevent clients from discussing their concerns and can result in poor or even lack of treatment," and so a successful treatment outcome will rely heavily on the skill and knowledge of the counsellor.

In researching this work, the author has noted that the preferred or at least, most written about form of therapy for ED is with a specialist sex therapist. One of the most successful treatment models is the Sensate Focus model which was developed by Masters and Johnston in the 1970's and focuses on sensation rather than performance and encourages partners to approach intimate physical and emotional involvement in a gradual, non-threatening manner (Leiblum, 2007. p.124). This can be an expensive and unrealistic option for most though and so it is quite probable that a counsellor in general practice will come across a client, or quite possibly a couple, affected by ED at some stage. Stevenson (2010) talks about "developing a curious, positive, affirmative, comfortable, non-judgemental and integrated approach" (p.35) as a basis for working with clients who present with any sexual difficulties or issues and this approach can be very beneficial in working with ED. This somewhat "Rogerian" stance may allow the client to feel accepted and give space to discuss feelings of loss, embarrassment or anxiety but it also needs to be carried out from a place of understanding and with a comprehensive knowledge of ED from the counsellor's perspective. Popovic (2007) describes how the initial therapeutic work should centre on information giving and psychosexual education about erectile dysfunction, disclosure, spectatoring (attention is focussed on the act of sex and not erotic stimulation) and performance anxieties and these are all aimed at normalising the condition. To do this authentically and effectively though requires the counsellor to be confident and clear about his or her own understanding of ED and to know their own place in the conversation. Perhaps even knowing what books, articles and websites to recommend can be as effective as the therapeutic approach that is adopted. There should also be an investigative and information-gathering element to these initial sessions and this will require the counsellor to be comfortable discussing issues around masturbation and masturbation fantasies, sexual practices and orientations and perhaps being honest enough to ask for clarification around sexual terminology that they may not be familiar with.

Sex therapy in counselling and vice versa

Sex therapy, although a specialised area of practice, has many similarities to the counselling work that is undertaken every day in this country. In reality, perhaps we as counsellors will be the first person with whom someone who lives with ED will be able to talk to about their experience. We should be confident in our core skills to work effectively with ED and indeed any sexual dysfunction and it is not coincidental that the traditional sex therapy approaches as listed by Leiblum (2007) of Anxiety Reduction, Cognitive Behaviour Interventions, Increased Sexual Stimulation (exploring sexual scripts and boundaries), Interpersonal Assertiveness and Couples Communication Training, Relapse Prevention /Planning bear more than a passing resemblance

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to the work we carry out, and approaches we utilise for any other client presenting issue. At first glance it might seem that this type of work might be best suited to a CBT approach as it will "directly target symptoms, reduce distress, re-evaluate thinking and promote helpful behavioural responses (Leichsenring et al, 2006. p234) and the time limited structure of CBT may be preferred as many men who seek help for sexual dysfunction are looking for a quick fix (Hawton, 1998). However, this author argues for an integrated approach possibly combining elements of Person Centred Therapy (PCT) and CBT. PCT can be just as effective as CBT in reducing stress, re-evaluating thinking and promoting behavioural responses and Tursi and Cochran (2006) explain that by allowing a client to struggle with beliefs and attitudes and by expressing empathy and acceptance with their struggle, we allow them to take responsibility for the decisions and actions they take, and beliefs that they may hold, and this will empower them to take ownership of any changes they wish to make.

Conclusion

Starting a conversation can sometimes be a daunting challenge, especially if we are not sure of our knowledge, status or credibility. There is always the risk that we might be proved wrong or that somebody disagrees with our world view. This was the experience of the author throughout the process of researching and writing this article on ED but there was always a strong motivation to at least start the conversation. This article has given a very brief overview on the aetiological understanding of ED and explained some implications for therapy. For a more detailed understanding the author recommends the texts of Masters and Johnston, Wincze and Carey and Sandra Leiblum.

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