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Psychotherapy for Erectile Dysfunction

Now More Relevant Than Ever

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The introduction of sildenafil in 1998 dramatically altered the treatment landscape for erectile dysfunction (ED). Although physicians now have a simple, efficacious, and safe treatment for ED, psychosocial barriers interfere with patients making effective use of these interventions. The role of psychotherapy is clearer than ever before in optimizing therapeutic outcome. The four goals of psychotherapy for ED are to identify and work through the resistances to medical intervention that lead to premature discontinuation; to reduce or eliminate performance anxiety; to understand the context in which men make love; and to implement psychoeducation and modification of sexual scripts. This article discusses three factors that make psychotherapy effective as well as outcome studies evaluating psychotherapy. By providing patients with an integrated medical/psychologic treatment, clinicians are likely to increase significantly the effectiveness of their treatment interventions for ED.

Key Words: Sildenafil; psychosocial barriers; psychotherapy; erectile dysfunction; lovemaking.

Introduction

The introduction of sildenafil in 1998 dramatically altered the treatment landscape for erectile dysfunction (ED). Physicians now have a simple, efficacious, and safe intervention that restores potency in approx 50–70% of men with ED *(1,2)*. Given the efficacy of phosphodiesterase 5 (PDE5) inhibitors, one might conclude that psychotherapy for ED is an obsolete and antiquated intervention. On the contrary, we believe psychotherapy is now more relevant than ever.

Our goal in writing this article is to argue that in the new age of PDE5 inhibitors, psychotherapy is essential to help patients/couples make better use of medical interventions and to lessen the high discontinuation rates owing to psychosocial factors. Helping men to achieve firm erections is relatively straightforward these days; getting them to engage in regular lovemaking is more complicated *(3–6)*.

Psychotherapy is useful either in its traditional form as the sole intervention for men or couples in whom the etiology of the ED is primarily psychogenic or, in an updated rendering, where it is an integral aspect of a combined or integrated biopsychosocial intervention *(7)*. Psychotherapy in the context of an integrated treatment is often short term, targeted at helping couples overcome their resistances to making use of a medical intervention such as a PDE5 inhibitor. Such brief interventions consist of advice giving, coaching, and focused problem solving.

Goals of Psychotherapy

In either the traditional or integrated form of psychotherapy, the therapist and patient or couple work toward four goals, which are discussed next.

I. Identifying and Working Through the Resistances to Medical Interventions That Lead to Premature Discontinuation

It is clear that there is a significant disparity between efficacy and continuation rates. Clinicians underestimate the degree to which psychosocial forces sabotage their well-intended and effective medical interventions. Such psychosocial factors include the length of time a couple was asexual before seeking treatment, the man's approach to resuming sexual life with his partner, the man having no or low sexual desire for his partner, the partner's lack of physical and emotional readiness to resume lovemaking, the meaning for each partner of using a medical intervention to restore lovemaking, the quality of the nonsexual relationship, and the couple's expectations regarding treatment outcome. These factors alone and together often prove to be formidable obstacles for effective treatment. Except in ideal circumstances when these psychosocial forces are not present, dispensing a tablet to reverse these powerful forces is not likely to succeed.

When couples are unable to make use of impressive medical interventions, they need psychotherapy to overcome unseen, intransigent blocks to much or all of their lovemaking.

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The therapist can help the couple cultivate a romantic ambiance and engage in conversations that will physically and psychologically prepare them to be lovers again. The therapist can also assist them in accepting the changes that have occurred in their lives, such as menopause, disability, illness, or other life stressors. Sometimes these resistances need to be worked through prior to beginning a medical intervention; usually they can be simultaneously addressed.

II. Seeking to Reduce or Eliminate Performance Anxiety

Performance anxiety is the final common pathway for all sexual dysfunctions. It is a pernicious process that stems from the man or partner's response to the initial erectile failure. The loss of reliable erectile function causes the man to question his sexual confidence and to worry that he will again lose his erection during subsequent attempts at lovemaking. His worry and preoccupation interfere with sexual arousal and cause him to be overly focused on his performance, leading to the anticipated sexual failure and further erosion of sexual confidence. Ultimately, performance anxiety causes men to avoid lovemaking and is difficult to overcome without treatment.

III. Understanding the Context in Which Men/Couples Make Love

The quality of the nonsexual relationship, the man's depressive symptomatology, worries about work or finances, and concerns about the health of his spouse are some examples of contextual elements that impact sexual life. A sexual problem, such as ED, can be the symptom of an unresolved relationship problem that is or is not expressed more directly. In therapy such a dysfunction can serve as a window into the quality of the couple's relationship. Relationships in which partners feel disconnected, resentful, or angry, where power struggles occur, love is dead, trust broken, or hurtful, disrespectful behavior is displayed are just some of the relationship dynamics that impede good sexual functioning. While some couples are able to compartmentalize their sexual relationship and function well sexually despite problematic relationship dynamics, this is not true for most. How one feels about his or her partner affects how that person will feel and function with the partner sexually. Psychotherapy may help the man surmount the barriers to psychologic intimacy or learn communication skills that will enable better understanding, conflict resolution, anger management, and management of disappointments in one's life.

Similarly, other contextual factors may play a role in the development and maintenance of erectile problems. For example, disappointments at work, fertility concerns, financial worries, problems with one's parents or children can all negatively impact sexual life.

We know that between 20 and 50% of men with ED have symptoms of depression; this is often an expression of the unresolved dilemmas in their lives and sometimes a psychologic response to the ED *(8)*. Shabsigh et al. *(9)* reported that depressed men are more likely to prematurely terminate ED treatment than nondepressed men. This further supports the notion of combined medical/psychologic treatments to heighten the effectiveness of treatment for ED.

IV. Implementing Psychoeducation and Modification of Sexual Scripts

Myths abound regarding sexual life and influence attitudes and behaviors. Examples of such myths include the following:

1. It is the responsibility of the man to satisfy the woman.
2. Size and firmness of the erect penis are necessary determinants of the female partner's satisfaction.
3. A woman's favorite part of sex is intercourse.
4. A man always wants and is always ready to have sex.
5. Once a woman learns to like sex, she will become insatiable.
6. With age, all men lose their ability to achieve erections *(10,11)*.

The myth most often held by partners of impotent men is that the failure to achieve erection indicates a diminution of affection for them or their loss of attractiveness and suggests the man's involvement with another woman.

Rosen et al. *(12)* list eight forms of cognitive distortion that may interfere with erectile function:

1. All or nothing thinking—e.g., "I am a complete failure because my erection was not 100% rigid."
2. Overgeneralization—e.g., "If I had trouble getting an erection last night, I won't have one this morning."
3. Disqualifying the positive—e.g., "My partner says I have a good erection because she doesn't want to hurt my feelings."
4. Mind reading—e.g., "I don't need to ask. I know how she felt about last night."
5. Fortune telling—e.g., "I am sure things will go badly tonight."
6. Emotional reasoning—e.g., "Because a man feels something is true, it must be."
7. Categorical imperatives—that is, "shoulds," "ought to," and "musts" dominate the man's cognitive processes.
8. Catastrophizing—e.g., "If I fail tonight, my girlfriend will dump me."

Psychoeducational interventions also aim to rework the behavioral repertoire of the man or couple, referred to as their sexual script *(13)*. These scripts may be broad and include a wide range of sexual activities or narrowly focused on one activity performed with little or no variation. An example of a narrow script would be the couple who never have foreplay and begin lovemaking with missionary style intercourse. By having such a narrow range of sexual expression, when dysfunction sets in there are no alternative outlets for the couple to adopt. Often dysfunctions signal the end to sexual life. By modifying rigid and narrow scripts,

therapists may help couples overcome a dormant sexual life or bypass various forms of dysfunction.

What Makes Therapy Work

Donahey and Miller *(14)* report that regardless of the therapeutic modality (individual, couples, or group therapy) or the specific therapy goals, there are several common factors that make psychotherapy effective:

1. Psychotherapy empowers the patient to experience himself as having the ability to create change and impact contextual factors.
2. Because the patient/therapist relationship is critical to successful therapeutic outcome, the therapist knows that he or she must assess and accommodate the patient's readiness for change and provide a safe and empathic environment in which the patient can explore obstacles, choices, and meanings of his psychologic and behavioral dilemmas.
3. The role of hopefulness and realistic expectancy is provided.

Outcome Studies

There are no published randomized, double-blind, placebo-controlled clinical trials of psychotherapy with men/couples with ED. The majority of psychotherapy treatment outcome studies can be characterized as uncontrolled, unblinded trials.

Given this important caveat, the outcome literature demonstrates that men with lifelong and acquired EDs achieved significant gains both initially and over the long term following participation in sex therapy. Men with acquired disorders tended to fare better than those with lifelong problems. Masters and Johnson *(15)* reported initial failure rates of 41 and 26% for lifelong (primary) and acquired (secondary) ED, respectively. The 2- to 5-yr follow-up of this cohort indicated that the men had sustained their gains.

Masters and Johnson's work remains unparalleled; no other clinical center has been able to rival the magnitude of their success, or report on as extensive a cohort with such an extended follow-up interval. There are, however, other investigations that report on the efficacy of psychologic interventions for ED *(16–20)*. In an excellent review of the studies of treatment for ED, Mohr and Beutler *(21)* wrote, "Averaging across studies, it appears that approximately two-thirds of the men suffering from erectile failure will be satisfied with their improvement at follow-up ranging from six months to six years" (p. 123).

All studies with long-term follow-up noted a tendency for men to suffer relapses. In writing about the problem of relapse in treating all forms of sexual dysfunction, Hawton et al. *(22)* reported that recurrence of or continuing difficulty with the presenting sexual problem was commonly being reported by 75% of couples; this caused little to no concern for 34%. These unconcerned patients indicated that they discussed the difficulty with the partner, practiced the techniques learned during therapy, accepted that difficulties were likely to recur, and read books about sexuality.

The concept of relapse prevention has only recently been incorporated into sex therapy. McCarthy *(23)* in discussing relapse prevention suggests that therapists schedule periodic "booster or maintenance" sessions following termination. Patients remark that knowing that they will be seen again in 6 mo keeps them on target because they know they will have to "report" on their progress. The follow-up sessions can also be used to work out any "glitches" that have interfered with their progress.

The reported successful sex therapy outcome studies reported on multimodal treatments consisting of interventions such as systematic desensitization, sensate focus, interpersonal therapy, behavioral assignments, sex education, communications and sexual skills training, and masturbation exercises. It has not been possible to statistically analyze the precise contribution of any of these treatment techniques to the success of the integrated multimodal treatment outcome.

Conclusion

To be effective in enabling patients to make love, clinicians need to broaden their perspective from genital function to appreciating the context in which couples live. Outcomes conceived solely in terms of erectile rigidity are far too narrow and mechanistic criteria for success. Successful sexuality outcomes require attending to the complex interplay among the biologic, psychologic, and relational components of individuals' and couples' lives.

Although clinicians now have safe, effective pharmaceutical interventions available to restore sexual function, couples' formidable psychosocial barriers may diminish the treatment outcome. By providing patients with an integrated medical/psychologic treatment aimed at overcoming these barriers, clinicians are likely to increase significantly the effectiveness of their treatment interventions.

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