Psychosocial and Relationship Issues in Men with Erectile Dysfunction

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Erectile dysfunction (ED) can affect men of all ages. In a cohort study, 31% of men, ages 18 to 59, experienced sexual dysfunction, a term that includes eight different sexual problems including ED (Laumann, Paik, & Rosen, 1999). According to the Massachusetts Male Aging Study, the probability of men, ages 40 to 70, having ED was 52%; of which 17% was minimal, 25% moderate, and 10% complete. ED is not necessarily dependent on age but as a man gets older his risk of developing ED increases. Based upon these data, approximately 30 million American men may have some form of ED (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994; Laumann et al., 1999). Even though the number of men with some form of ED is significant, few go to their doctor for this issue. With the availability of sildenafil in 1998, the media attention has brought the awareness of ED to the public eye. Over 25 million prescriptions of sildenafil (Viagra®) have been written since 1998. When vardenafil (Levitra®) and tadalafil (Cialis®) were approved by the U.S. Food and Drug Administration in 2003, the surge of interest rose even further. The development of these medications demonstrates how the medical field is expanding knowledge to help men with this issue.

Functional Effects
Not being able to physically achieve or maintain an erection is important to the male and his sense of maleness. In the hierarchy of signs that confirm and confer manhood that correspond to sexual activity, men list having an erection at the top of their list, followed by penile penetration, sexual desire, and lastly, the ability to ejaculate (Pontin, Porter, & McDonagh, 2002). The inability to function sexually can impact the role a man plays in the world, thus taking away his identity. Therefore, the loss of erectile capability can have a profound effect on a man and how he is viewed by society (Dunsmuir, 1999). The ability to perform sexually is very important to a man. ED, resulting in the loss of sexual function, can lead to feelings of dissatisfaction with life and add to his stress (Jack, 2005).

Psychosocial Effects
Seeking professional health care for ED is a big step for many men. Generally, either the man or his partner has noticed an issue with his physical or mental well-being. Most men, however, do not seek help for a wide variety of reasons: (a) lack of support, (b) fear or denial of the issue, and (c) barriers that they put in front of themselves. Men do the “locker room” talk about their sexuality or sexual conquests and feel very embarrassed if they cannot even get an erection. Whether conscious or unconscious, this “locker room” talk is done to hide feelings of insecurity and inadequacies. Men do not want to change their behavior because of being “made fun of” by others (Pontin et al., 2002). Ego plays a huge role in a man’s life and, when threatened, it can alter his mindset and actions. In one study, about one-third of the men felt that other people were “quite a lot or a great deal happier” because they are sexually fulfilled while a little over one-third felt “quite a lot or a great deal less desirable” as a result of their...
erectile difficulties (Meyer, Gilling, Lockyer, & MacDonagh, 2003, p. 930).

**Emotional Effects: Anxiety, Depression, and Low Self-Esteem**

Men who experience ED can suffer the effects of anxiety, depression, low self-esteem, and decrease in quality of life (QoL) (Feldman et al., 1994). Men who have ED are not just affected physically but emotionally as well. In general, men are more introverted and keep their feelings to themselves without expressing how they truly feel. This has led them to become emotionally distant from the people in their lives. Men with erectile difficulties tend to emotionally and physically withdraw from their partners. They fear that any physical affection will precipitate a request or desire for intercourse from their partners and remind them of their inability to achieve an erection. Men who are more prone to have a decrease in their sexual response are more at risk to lose their sexual interest and erectile responsiveness when anxious or depressed (Bancroft & Janssen, 2001). It is believed that negative thinking about sexual behaviors may lead to increased performance anxiety, poorer sexual function, and perhaps, avoiding sexual activity (Fichten et al., 1998).

Men who judge themselves solely on sexual performance may think of themselves as failures. This problem causes a lapse of confidence and a drop in self-esteem. Men commonly report that sexual performance occupies a lot of their mental energy.

There is a documented association between ED and depression. Successful treatment of ED can critically improve depression scale scores in men (Shabsigh et al., 1998). In a Columbia University study, 152 men with mild-to-moderate depression were enrolled. None of the men were taking any antidepressant medications. All of these men had ED for at least 6 months, with a mean of 6 years. Half of the men were given a PDE5 inhibitor and the other half a placebo. The results showed the PDE5 group had better results in restoring erectile function than the placebo group. Seventy-six percent of the men treated successfully for ED also had better erectile function and experienced an improvement in their overall QoL and depressive symptoms (Harvard Medical School, 2004).

**The Effects of ED On Relationships**

An intimate relationship between two people is very personal and private. When a man has ED, it may affect and/or change his relationship with himself and his partner(s). The man may be embarrassed and even feel guilty, making it difficult to talk to his partner about this issue. ED has a direct impact on how it affects a man’s life and marriage. It is suggested that ED is involved in one in five failed marriages (Wespes et al., 2002). ED not only affects the man but his partner as well. Table 1 lists quotes from men in the author’s clinical experience when describing how ED was affecting their lives. These quotes cannot be quantified but the impact is tremendous.

<table>
<thead>
<tr>
<th>Table 1. Quotes of Men During an Office Visit – Relationship Effects</th>
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<tbody>
<tr>
<td>“My woman is thinking about leaving me because of this issue. You have to do something to help me.”</td>
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<tr>
<td>“By having ED, it has affected my marriage because our sex life was really good. Now, there is none and it is not the same. I am not into cuddling and that stuff.”</td>
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<tr>
<td>“I am here because of my wife. This really doesn’t bother me but it does her and I love her. Just because I can’t get an erection doesn’t mean she should be deprived.”</td>
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<tr>
<td>“Let’s be completely honest. Men state that they do this because of their wives, but I am doing this because of me! I need to be able to get erections and have sex with my wife.”</td>
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**Partner relationship.** A common issue among couples dealing with ED starts with failures of sexual advances. This can have an effect on issues of trust, intimacy, and closeness. The man withdraws emotionally and physically because of fear of failure. The partner starts to believe that the man is losing interest in her, thereby impacting self-esteem and feelings of attractiveness. In reality, the man is not losing interest but may be manifesting signs of frustration and humiliation of not being able to complete the sex act. Many men think it is inappropriate to need nurturance, admit that he needs a hug, or seek affection. So, they frequently do without the comfort and emotional support often more available for women. When a man cannot perform intercourse and satisfy his own and his partner’s sexual needs, he can feel devastated and very much alone. From this cascade of events, the couple starts to alienate themselves emotionally and physically (Roy & Allen, 2004).

Partners who measure their self-esteem, femininity, and desirability by how men respond to their sexuality are particularly vulnerable to fears of abandonment and rejection. Men’s emotional detachment feeds into
these fears. Partners may worry that their mates may be impotent with them, but potent with another person, leaving them with fantasies of betrayal and infidelity. This issue can drive a couple apart because of fears and misconceptions when in reality the couple needs to communicate (LoPiccolo, 1999).

When a man or a woman loses a loving sexual relationship due to ED, either or both individuals may choose to withhold their partner from any other type of sexual experience. After experiencing the pain associated with rejection and lack of empathy from their partner, men and women will divert their attention to other matters in order to compensate for the loss of their sexual partner. Sometimes potency problems are a screen for more serious emotional or relationship issues. At this point, there may be other relationship issues between the couple that take priority before focusing on ED issues. This is an appropriate time for a man or the couple to be referred to a marriage counselor or sex therapist. Even the most sophisticated couples can benefit from opening lines of communication about sex and learning how best to utilize their functional capabilities (Padma-Nathan et al., 1997). Counseling may be able to rekindle the romance and redirect energies into the relationship.

Social/Work relationships. ED affects not only the relationship with his partner but may also affect how the man interacts with friends and co-workers. A man may lose his confidence, his enjoyment in life, and morale. Outwardly, a man might project a macho image but inside may not feel like he measures up (Tomlinson & Wright, 2004).

Productivity at work can also decrease because of lack of self-esteem and confidence. The co-worker/social relationship can change based upon the attitude of each person and how each deals with the issue. Because ED is not discussed openly, a man may feel isolated and alone.

From another perspective, difficulties at work can factor into problems with ED. Most men view their careers as the center of their lives. When an unfavorable or difficult situation affects their careers, a man may see himself as a failure. Not moving up the chain of command, becoming financially sound, or getting the respect of peers can affect a man’s sex life. Any monetary setback can affect a man’s self-worth because today’s society views that as a measure of success. If a man is not performing well at work, he may find it difficult to perform well in the bedroom (Jack, 2005).

Nursing Responsibilities

Clinic visit. ED is a topic that neither the patient nor clinician tends to bring up in the clinic setting. Feelings of embarrassment and uncomfortableness are two of the reasons cited (Baldwin, Ginsberg, & Harkaway, 2000). Health care clinicians need to establish an atmosphere of comfortableness and openness for the patient. Clinicians also need to encourage a patient to involve his partner in the clinic visit and treatment decision process. In that way, discussion of mutual fears and anxieties can be addressed. Once communication channels are opened, then they can make the best decision for them as a couple. This gives them the greatest chance of treatment success (Roy & Allen, 2004). In our clinic, we use the following outlined practices to involve the patient and partner to make them feel comfortable at their visit.

Medical history. The room set-up should be conducive to the situation so that the patient does not feel inferior but as an equal participate in the clinician-patient interaction. The clinician needs to introduce him or herself to the patient/partner and explain that a medical, sexual, and psychosocial history will be taken. Based upon that information, treatment options will be discussed. Explaining your medical background to the patient/partner can be helpful and possibly put them more at ease.

A thorough medical history (see Table 2), including medications, drug allergies, and any alternative therapies is an essential first step. This will help and guide the clinician on identifying and recognizing the problem (Albaugh & Lewis, 2005). The role of nonprescription drugs and over-the-counter (OTC) drugs may factor into the patient’s self-treatment of ED. Obtaining a thorough history of these medications is vital in the medical assessment. This part of

<table>
<thead>
<tr>
<th>Table 2. Medical History: Key Topics for Assessment</th>
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<tbody>
<tr>
<td>• Chronic conditions – Diabetes, anemia, renal failure</td>
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<tr>
<td>• Vascular risk factors – Diabetes, hypercholesterolemia, hypertension, heart disease, familial background</td>
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<tr>
<td>• Pelvic/perineal/penile trauma – Penile fracture, bicycling</td>
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<tr>
<td>• Previous surgery – Prostate cancer, laminectomy, cardiac related</td>
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<tr>
<td>• Neurological illness – Spinal cord injury, head trauma</td>
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<tr>
<td>• Psychiatric illness – Depression, anxiety, schizophrenia, bipolar</td>
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<tr>
<td>• Radiotherapy – Brachytherapy, external beam therapy</td>
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<tr>
<td>• Prescription drugs</td>
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<tr>
<td>• Smoking, alcohol, and recreational drug use</td>
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<tr>
<td>• Sedentary lifestyle</td>
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<tr>
<td>• OTC medications</td>
</tr>
<tr>
<td>• Nonprescription medications</td>
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the visit can be more comfortable for the patient because the topic may be less threatening. If agreeable to the patient, the partner may be able to add additional information on the patient’s past medical history.

**Sexual/Psychosocial history.** When obtaining a sexual/psychosocial history, it is imperative that the clinician make the patient feel relaxed, welcomed, and not rushed in the conversation. Gaining the patient’s trust and projecting an open and honest approach may minimize possible embarrassment or discomfort during the visit. Some

Table 3.
Sexual – Psychosocial History

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<tbody>
<tr>
<td>1.</td>
<td>Are you married, single, divorced, or widowed?</td>
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<tr>
<td>2.</td>
<td>If not married, are you in a relationship? Yes or No</td>
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<tr>
<td>3.</td>
<td>How long in your relationship?</td>
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<tr>
<td>4.</td>
<td>Is your relationship good, fair, poor?</td>
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<tr>
<td>5.</td>
<td>Do you have more than one (1) partner? Yes or No</td>
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<tr>
<td>6.</td>
<td>Is your partner interested in you receiving treatment? Yes or No</td>
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<td>7.</td>
<td>Is your partner aware of your visit? Yes or No</td>
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<td>8.</td>
<td>Is your partner understanding of your condition? Yes or No</td>
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<tr>
<td>9.</td>
<td>Does your partner’s reaction worsen your condition?</td>
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<tr>
<td>10.</td>
<td>How would you rate your sexual desire? High, average, low</td>
</tr>
<tr>
<td>11.</td>
<td>How would you rate your partner’s sexual desire? High, average, low</td>
</tr>
<tr>
<td>12.</td>
<td>If your desire is low, for how long? Did anything trigger it?</td>
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<tr>
<td>13.</td>
<td>How long have you noticed having ED?</td>
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<tr>
<td>14.</td>
<td>Did this happen suddenly or gradually?</td>
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</table>

Table 4.
Questions on Quality and Frequency of Erections

Which of the following five statements about the quality of erections pertains to you?

1. Limp penis.
2. Full penis, no hardness or penetration.
3. Occasional penetration, no maintaining hardness.
4. Sufficient penetration, no maintaining hardness.
5. Able to penetrate easily and maintain to orgasm.

- Do you notice any type of an erection during the middle of the night or early morning?
- Do you notice any spontaneous erections throughout the day?
- Are you able to achieve any type of erection through masturbation or stimulation?
- Are your erections straight or curved?
- Are you able to have an orgasm or ejaculate?
- Do you notice that your erections vary based upon positioning?

the partner relationship can play a pivotal role in how the patient copes with his ED. The trust level that the patient has and develops with the clinician will determine the openness of his answers and what he is willing to discuss. The clinician needs to be sensitive and respectful of the patient’s situation and offer encouragement as the patient relates his concerns. Health care clinicians have a knack of reading what is happening with patients because of the skill set that has been acquired with experience. Letting the patient know that he is not alone in this situation and informing him of some statistics is helpful in a man’s mindset. Discussing with the patient some of the medical reasons he is experiencing ED or how a relationship issue, home, or work is affecting him can put him more at ease.

As the visit proceeds, the patient will be asked specific questions about the quality and frequency of his erections (see Table 4). In our clinical practice, these questions are effective as part of the assessment. If the clinician-patient trust level has been established, patient embarrassment is generally not an issue at this point.

**Education**

Even though there is an abundance of information, many patients and partners still do not have a grasp of the proper understanding of sexual functioning and dysfunction (Albaugh et al., 2002). Once the assessment is completed, the clinician can pinpoint specific educational needs of the patient/partner. Misconceptions can be corrected. If there are medical reasons for the man’s ED, this information is presented and discussed. It is important for the clinician to review pertinent risk factors that the patient can control to improve his overall health (see Table 5). Referrals for smoking cessation classes, workout facilities, and booklets of recipes of proper diet can be offered.
**Table 5.**  
**Key Points: Decreasing the Risk for ED**

- Follow a low-fat, low-cholesterol, and heart-healthy diet.
- Exercise regularly.
- Avoid tobacco products and excessive alcohol use.
- Avoid activities prone to cause penile or groin pain.
- Ensure proper evaluation and management of concomitant problems such as diabetes and hypertension.

**Source:** Albaugh & Lewis, 2005.

**Table 6.**  
**Sexual Foreplay Activities**

- Try not to have sexual intercourse as the goal.
- Talk about what is inhibiting touching each other.
- Explore each other avoiding touching the genitals.
- Pretend that you are dating again.
- Over time, partners can spend more time touching genitals until an orgasm occurs through stroking with a hand or oral sex.
- Talk about what each other wants.
- Once both people are comfortable, then sexual intercourse can occur.

**Source:** The American Cancer Society, 2005.

The clinician then discusses the possible treatment options in-depth and reviews the pros, cons, and side effects of the treatments with the patient/partner. With the proper information, they can process the information and start to feel better about themselves and their options.

Health care clinicians should encourage couples to communicate and ask questions so they know what each other is thinking. It is beneficial for the clinician to provide booklets or pamphlets about issues that can cause ED. Review this information in lay language so that they can fully understand. The clinician may need to intervene and inform the patient/partner of some sexual foreplay activities that could be helpful for them. This will depend on the treatment option(s) chosen (see Table 6). These foreplay activities can assist the couple to gradually become more intimate and enhance the treatment options.

It is important to stress to the patient/partner the need to practice and develop a comfort level with any of the clinical recommendations provided. However, if these recommendations are not effective, than a referral to a sex therapist or marriage counselor may be indicated.

**Conclusion**

Erectile dysfunction affects men physically and psychosocially. With the demographic shift of men living longer, the issue of ED will become even more prominent. Clinicians must realize and be sensitive to the fact that sexuality is an essential part of all of our lives. As clinicians, we need to utilize or develop skills to help guide the patient. The use of different interventions to solve the troublesome problem of ED is helpful. But it is vital that interventions take into account the sophistication of human sexual relationships and the partnerships that are formed. Clinicians have a chance to make a positive impact in patients’ lives including issues related to ED. Health care providers should incorporate a sexual history as a normal part of the nursing/clinical assessment. In this way, we can provide holistic care that addresses the patient’s physical, spiritual, psychological, and emotional needs. This may not be an easy task. But as patient advocates, it is something we should strive to achieve.

**References**


American Cancer Society. (2005). Sexuality and cancer for the man who has cancer and his partner (pp. 56-59). Tampa, FL: Author.


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