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Erectile Dysfunction

Shannon L. Karl, Nova Southeastern University

DESCRIPTION OF ERECTILE DYSFUNCTION

Erectile dysfunction (ED) occurs when a man is repeatedly unable to achieve and maintain an erection firm enough for sexual intercourse (Miller, 2000; Rhoden, Teloken, Sogari, & Vargas Souto, 2002; U.S. Department of Health and Human Services, 2009). In the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition), the essential features of ED are listed as the repeated inability to develop or maintain an erection during sexual stimulation or activity. More specifically defined than ED, erectile disorder includes the inability to achieve or maintain an erection, occurring at least 75% of the time over the course of at least 6 months [American Psychiatric Association (APA), 2013].

- Erectile disorder has two specifiers: lifelong type and acquired type. Each of these types can be generalized (occurring in all or almost all circumstances) or situational (APA, 2013).
- Erectile disorder that occurs prior to the age of 40 is more likely to result from psychological etiology with onset of erectile disorder after age 40 predominantly stemming from physiological causes (APA, 2013; Crooks & Baur, 2013; Halkitis, Moeller, & DeRaleau, 2008; Miller, 2000).
- Severity levels of erectile disorder are mild, moderate, and severe depending upon the individual's subjective level of distress (APA, 2013).
- ED can cause significant emotional disturbance in men, including low self-esteem, anxious symptoms, depressive symptoms, feelings of shame, and a decreased sense of masculinity which affects interpersonal relationships (Crooks & Baur, 2013; Hyde & DeLamater, 2013).

Prevalence

- Between 10 and 20 million men in the United States suffer some degree of ED (Miller, 2000; Simons & Carey, 2001; Thompson & Barnes, 2013).
- The prevalence of ED is highly age-correlated with 40%–50% of men over 70 experiencing difficulty and 13%–21% of men ages 40 to 70 undergoing problems with erectile functioning (APA, 2013; Inman et al., 2009).

Resources:
American Psychiatric Association: http://www.psychiatry.org
American Urological Association: http://www.auanet.org
Mayo Clinic: http://www.mayoclinic.org/diseases-conditions/erectile-dysfunction/basics/definition/con-20034244
National Institute of Health: http://www.nlm.nih.gov/medlineplus/erectiledysfunction.html

IDENTIFICATION/ASSESMENT STRATEGIES

ED is associated with organic illness, such as vascular disease and diabetes mellitus, so comprehensive medical assessment and care is necessary (Miller, 2000; Rhoden et al., 2002; Strassberg, Perelman, & Watter, 2014). Due to the physiological and psychogenic etiology of ED, all clients should be assessed for relationship difficulty, individual vulnerability, psychiatric comorbidity, sexual history, and cultural/religious factors (APA, 2013; Thompson & Barnes, 2013).

ED can result from the effects of multiple substances (e.g., alcohol, cocaine, barbiturates, anxiolytics) as well as medication classifications (e.g., antidepressants, antipsychotics, antihypertensives, antihistamines). As literally hundreds of medications and substances negatively impact sexuality, it is important for all counselors to screen for licit and illicit substance use (Finger, Lund, & Slagle 1997; George et al., 2009; Miller, 2000; Sadock & Sadock, 2007).

Age represents a primary contributing factor for ED. The majority of adults 65 and older report a continued interest in sexual activity although ED affects approximately half of men in that age range (APA, 2013; Inman et al., 2009; Hilman, 2008). It is important for counselors to gather careful and thorough assessment information for all clients, especially when working with older adults. Specific measures for overall erectile function can be used to assist in the evaluation of ED.

International Index of Erectile Function (IIEF)

The IIEF is a 15-item, self-administered assessment of erectile functioning that possesses solid psychometrics, has been validated in 32 languages, and is commonly used across clinical settings for the assessment of ED (Forbes, Baillie, & Schneiring, 2014; Miller, 2000; Rosen, Cappelleri, & Gendrano, 2002; Rosen et al., 1997). The IIEF is comprised of five domains: erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. Erectile function is represented by Q1, 2, 3, 4, 5,15; orgasmic function by Q9,10; sexual desire by Q11,12; intercourse satisfaction is Q 6, 7, 8; and, overall satisfaction is Q13,14. Considered the international gold standard, the test holds utility across clinical and research settings with the ability to indicate even slight changes in functioning (Rosen et al., 1997). The IIEF is based upon functioning over the past six months and is best suited for clients who engage in and/or desire sexual activity (Forbes et al., 2014; Rosen et al., 2002; Yule, Davison, & Brotto, 2011).

International Index of Erectile Function-5 (IIEF-5)

The IIEF-5 questionnaire is an abbreviated five-item version of the IIEF that also assesses for erectile functioning occurring over the past six months. Also referred to as the Sexual Health Inventory for Men (SHIM), the instrument is easy and quick for counselor use in many professional settings (Yule et al., 2011). The IIEF-5 is an effective screening measure for clients and helps counselors monitor progress and measure treatment outcomes (Rosen, Capelleri, Smith, Lipsky, & Pena, 1999; Rosen et al., 1997; Yule et al., 2011). The IIEF-5 includes one question representing each of the five domains and provides a summative overall score. Questions are presented on a 1 to 5 Likert scale with 1 being "very low" and 5 "very high." The scoring ranges are: "5–7 severe erectile dysfunction," "8-11 moderate erectile dysfunction," "12-16 mild to moderate erectile dysfunction," "17–21 mild erectile dysfunction," and "22–25 no erectile dysfunction." There is the option to select no sexual activity for zero points on four of the five items. The IIEF-5 is widely-used and known for its clinical utility and objectivity (Rosen et al., 1999; Yule et al., 2011).

Resources:

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): A multidimensional scale for assessment of erectile dysfunction. *Urology*, *49*(6), 822-830. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9187685

Rosen R. C., Cappelleri J. C., Smith M. D., Lipsky, J., & Pena, B. M. (1999). Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction. *International Journal of Impotence Research*, *11,* 319-26. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10637462

International Index of Erectile Function (IIEF): http://www.baus.org.uk/Resources/BAUS/Documents/PDF%20Documents/Patient%20information/iief.pdf

International Index of Erectile Function-5 (IIEF-5): http://www.hiv.va.gov/provider/manual-primary-care/urology-tool2.asp

INTERVENTION STRATEGIES

ED often results from a combination of organic and psychogenic etiology (Laumann, Paik, & Rosen, 1999; Miller, 2000). Detailed medical and psychosocial history is the first step in treating all people who have this disorder. With the diagnosis of erectile disorder, it is important to rule out differential diagnoses such as major depressive disorder (MDD), post-traumatic stress disorder (PTSD), substance use disorder, and erectile disorder due to another medical condition. Erectile disorder is frequently comorbid with premature (early) ejaculation and male hypoactive sexual desire disorder (APA, 2013). ED is common in men diagnosed with MDD or PTSD. Combat

veterans may be specifically susceptible resultant from exposure to severe stress, trauma, and physical injuries (Letourneau, Schewe, & Freuh, 1997).

Cultural and geographic norms should be taken into consideration when assessing and treating ED. Religious influences related to sexual expression determine how sexuality is conceptualized and impacts motivation to seek treatment. In western culture, it is normative for couples to value open communication, emotional intimacy, and mutual pleasure; however, outside of western culture, this is not always the case (Crooks & Baur, 2013; Dailey, Gill, Karl, & Barrio Minton, 2014).

Medical Interventions

As vascular disease represents the most common etiology of ED, it is necessary that all men experiencing ED symptoms receive a complete medical evaluation (Moore et al., 2014). Risk factors for the acquired type of ED encompass age (over 40), smoking, poor physical fitness, diabetes mellitus, and decreased sexual desire. Acquired ED is likely to persist due to the likelihood of causal or contributing biological factors (APA, 2013).

Pharmacotherapy is efficacious in treating ED. Two commonly prescribed medications are sildenafil (Viagra) and tadalafil (Cialis). Essentially, sildenafil and tadalafil extend the vasodilator effects of nitrous oxide in the body and thus enhance blood flow to the penis (Crooks & Baur, 2013; Duterte, Seagraves, & Althof, 2007). They are contra-indicated in men with heart disease and other health problems and should only be used under appropriate medical supervision. These medications carry the risk of priapism, which is a persistent erection that can cause damage to penile tissue (Crooks & Baur, 2013; Kress & Paylo, 2015). Used less frequently, testosterone replacement therapy can be effective in some men as it counteracts the loss of libido which can occur secondary to taking some psychotropic medications (Preston, O'Neal, & Talaga, 2013; Roberson & Kosko, 2013).

Vacuum extraction devices (VEDs) represent a non-surgical method urologists prescribe to enhance erectile functioning. VEDs pull blood into the penis to induce tumescence, which is then maintained by placing a plastic band around the base of the penis. Other less-frequently administered treatment examples are intracoproreal injection therapy with alpostradil and intraurethral semisolid pellets of prostaglandin E1 (Hatzimouratidis et al., 2010; Kress & Paylo, 2015). Each of these interventions should be closely monitored by a medical professional.

The most invasive medical intervention is the surgical implantation of a penis prosthesis. Although a penile implant cannot restore the ability to ejaculate or return lost sensation, 85% of men who have undergone the surgery report increased sexual functioning and satisfaction (Cortes-Gonzales & Glina, 2009; Crooks & Baur, 2013; Richter, Leibovitch, & Alkalay, 2006). This type of surgical procedure is performed only for men who are not helped by medication or less invasive treatment methods. Radical prostatectomy is the most common reason for undergoing penile implantation surgery (Crooks & Baur, 2013).

Resources:
National Institute of Health: http://www.nlm.nih.gov/medlineplus/erectiledysfunction.html
Sexual Medicine Society of North America: www.sexhealthmatters.org
Urology Care Foundation: http://www.UrologyHealth.org

Sex Therapy

Sex therapy enables men with ED (and their partners) to focus psychotherapeutic treatment on sex; this is inclusive of sexual functioning, behaviors, feelings, and physical or emotional intimacy and never involves sexual activity with a client. ED is a frequent reason men participate in sex therapy (Saigal, Wessels, Pace, & Schonlau, 2006). One goal of sex therapy is to directly assist in reducing performance anxiety, which can be problematic for men with ED (McCabe & Connaughton, 2014).

Sensate focus is a common sex therapy technique (Crooks & Baur, 2013), which uses partner sensual exploration in a soothing, gentle way that targets reduction of sexual performance anxiety. Sensate focus helps couples concentrate exclusively on the excitement phase without pressure to complete the sexual response cycle (APA,

2013; Masters & Johnson, 1966). It is also helpful for sex therapists to provide information and assign homework, such as reading or viewing psychoeducational materials or engaging in new sexual activities (Althof, 2006).

Sex therapy often leads to improved communication skills and enhances the general quality of the relationship (Crooks & Baur, 2013). Certification in sex therapy is imperative for counselors specializing in ED and other sexual concerns. Sex therapy certification is granted by the Association of Sexuality Educators, Counselors, and Therapists and requires a minimum of an earned master's degree in counseling or a related field, state licensure or certification, coursework, and additional supervised clinical training (Crooks & Baur, 2013; Kaplan, 1981).

Resources:
American Association of Sexuality Educators, Counselors, and Therapists: www.aasect.org
International Society for Sexual Medicine: http://www.issm.info/
Mayo Clinic: http://www.mayoclinic.org/tests-procedures/sex-therapy/basics/definition/prc-20020669

Cognitive Behavioral Therapies (CBT)

CBT interventions address the cognitive and behavioral components of ED. Psychological factors have long been accepted as a major contributor to erectile difficulty (Kaplan, 1981; Masters & Johnson, 1966). Clients often find discussing ED uncomfortable and shameful and thus delay seeking therapy until the difficulty is well manifested (Crooks & Baur, 2013; Kress & Paylo, 2015). Traumatic experiences of a sexual nature often negatively impact sexual functioning; resultant from this, sexual activity can be associated with negative thoughts and feelings (Hall & Hall, 2011).

In working with clients experiencing ED, effective CBT techniques can include restructuring of negative cognitive schemas and the introduction of thought-stopping techniques. These techniques directly address ruminative negative thoughts and self-defeating statements. Quinta, Luisa, and Pedro (2012) found that men with sexual dysfunction possessed maladaptive schemas pertaining to sexual competence, which are important to address in treatment. Clients also benefit from therapeutic focus on countering negative self-statements and developing newly formulated, adaptive schemas (Crooks & Baur, 2013).

Resources:
Beck Institute for Cognitive Behavior Therapy: http://www.beckinstitute.org/
National Association of Cognitive-Behavioral Therapists: http://www.nacbt.org/whatiscbt.htm

Couples Therapy

Couples therapy is helpful in addressing any underlying communication or relationship issues that contribute to ED. Both members of the couple may have feelings inclusive of low self-esteem, anxiety, avoidance, and impaired communication patterns (Crooks & Baur, 2013). As sexual orientation and masculinity are often defined in terms of sexual functioning (Halkitis et al., 2008), providing psychoeducation to help both members of the couple understand the causes, etiology, and treatment of ED is beneficial (Hartman et al., 2014; Roberson & Kosko, 2013).

ED produces individual and interpersonal distress that is damaging to relationships. A decreased desire for sex is common in partners of men with ED. Couples counseling can help both members adjust to changes in sexual expression, and typical treatment topics include general unresolved relationship issues, lack of trust, impact on fertility for heterosexual couples, and lack of attraction or sexual interest in one's partner. It should be noted that some men with ED and their partners do not experience distress; these couples enjoy alternative methods to sexual activity and nonsexual expressions of closeness (Miller, 2000).

Resources:
American Association of Marriage and Family Therapy: http://www.aamft.org
Mayo Clinic: http://www.mayoclinic.org/tests-procedures/marriage-counseling/basics/definition/prc-20012741

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