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This activity is designed for urologists who treat patients with sexual desire and arousal disorders, particularly erectile dysfunction. After participating in this activity, the participant should be able to:

- Recognize the complex psychosocial issues involved in erectile dysfunction.
- Perform a psychosocial, as well as the physical, evaluation of patients with sexual dysfunction.
- List professional and community resources used to meet the full range of patient needs.

CME Information

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Length of Time to Complete the Activity: 1 hour

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The Link Between Sexual Dysfunction (Desire & Arousal Disorders) and Hypogonadism: Focus on Psychosocial Aspects

Sexual health is a fundamental human right, and patient complaints about sexual function deserve the same attention and respect as other medical complaints. Addressing sexual dysfunction necessarily means considering all contributing factors, including both physiologic and psychosocial factors. Thus, sexual medicine is more complex than merely addressing the physiologic aspects by writing a prescription to treat erectile dysfunction. Unfortunately, inadequate appreciation for the role played by psychosocial issues, time constraints on office visits, and patient reticence to talk about erectile dysfunction and other sexual difficulties often limit the extent to which psychosocial issues are addressed. Additional office visits may need to be scheduled specifically to address these concerns.



Interrelationship of Psychosocial and Biological Factors

How do I know if the problem is psychological or biological? In almost all cases it is both. In the 1970s we used to try to distinguish which one was primary, but sexual medicine today has moved away from this dichotomy in favor of considering all contributing factors and treating the whole patient. It is now recognized that sexuality is a function of mind, body, and relationships. A history of psychiatric or psychological problems, such as depression, poor coping skills, and low self-esteem; relationship difficulties; and sexual abuse or trauma should be addressed along with low testosterone levels, altered blood flow, and high cholesterol. In many ways, urologists should consider themselves as

overall men's health doctors in the same way gynecologists often act as primary care physicians for women.

What should I include in a thorough evaluation of a male patient with sexual complaints? The evaluation should include three important components: sexual history, medical history/examination, and psychosocial evaluation.¹ Sexual history includes the frequency and quality (rigidity, sustainability) of erections during both sexual and nonsexual circumstances, orgasmic/ejaculatory difficulties, degree of sexual desire, and pain. In particular, a sexual history should be taken following surgery or hospitalization, a new diagnosis of medical illness, medication initiation or adjustment, or major life changes (eg, divorce, childbirth).²

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During the medical history, you should ask about hypertension, diabetes, cigarette smoking, bike riding, and pelvic fractures. This should be accompanied by a physical examination of the testicles and penis, during which you should evaluate for Peyronie's disease, pulse, neurologic changes, and any obvious endocrine abnormalities, such as might be evidenced by hair growth pattern. Please refer to Part 2 of this *Expert Insights* series, Focus on Clinical Evaluation, for a more in-depth discussion.

The psychosocial evaluation includes assessment of four key elements: the patient's general psychological state, and presence of psychiatric conditions that can affect sexual function (eg, depression, anxiety, psychosis, paranoia, and obsessions); relationship factors; degree of coping and self-esteem; history of sexual trauma or abuse.

What evidence is there of a connection between psychological illness and erectile dysfunction? Findings from the Massachusetts Male Aging Study showed a "robust" association between depressive symptoms and erectile dysfunction, independent of age and other confounders.³ Moreover, there is an interrelated triad of cardiovascular disease, depression, and erectile dysfunction. All three conditions share many of the same risk factors and etiologies, including age, heart disease, diabetes, hypertension, sedentary behavior, related medications, cigarette smoking, and abnormal lipid levels. Diagnosis of any one of these conditions is associated with a higher risk of the other two conditions compared with the general population.⁴

Effective treatments, such as antidepressants and cognitive-behavioral therapy, are available for the management of depression; however, the extent to which control of depression results in improved sexual function has not been evaluated. Moreover, many antidepressants, particularly selective serotonin reuptake inhibitors, cause sexual side effects. Patients with well-controlled depression who want to address erectile dysfunction should receive a standard history, physical examination, and laboratory (including hormone) evaluation. In a cross-sectional, population-based study of community-dwelling, older men, Beck Depression Inventory scores were significantly and inversely associated with bioavailable testosterone levels, independent of age, weight change, and physical activity. Similar results were found for dihydrotestosterone. Moreover, men with categorically defined depression had levels of bioavailable testosterone that were 17% lower than in all other men.⁵ These findings suggest that

testosterone supplementation may be beneficial in a proportion of depressed men with erectile dysfunction.

Given the high prevalence of depression, particularly among patients with sexual dysfunction, how can I quickly, but effectively, screen for depression? Standardized depression scales, such as Center for Epidemiological Studies-Depression (CES-D) scale or Beck Depression Inventory, may be helpful, but asking a few simple questions can also help identify depressed patients: Are you sad, tired, or irritable? How are you coping with stress? Are you anxious? Do you have difficulty concentrating? Are you having trouble sleeping or staying awake? Have you had a significant change in appetite? Do you find enjoyment in life? During the evaluation, the patient's expression, demeanor, and voice may also provide clues to the presence of depression.

Issues to Address

What relationship issues should be addressed when managing sexual dysfunction? Psychosocial evaluation should include assessment of the patient's past and present relationships. Relationship issues can affect sexual dysfunction in complex ways. Rather than seek treatment, many patients with sexual dysfunction begin avoiding interpersonal relationships by turning to excessive drinking, drug use, or working in order to avoid the embarrassment of divulging the problem to a partner. They may even leave loved ones just to prevent exposure of their lack of sexual capability. Conversely, emotional and psychological effects of other, nonsexual, relationship problems can also inhibit sexual function. Thus, the relationship with the partner must be addressed, through couples counseling if necessary, before resolution of sexual dysfunction can occur.

Some important questions to ask include: Are you in a relationship? Are you emotionally satisfied with your relationship with your partner? Do you find your partner sexy and attractive? How is the communication and level of intimacy? How is your partner reacting to the sexual problem? Are there changes in your partner's behavior or in the relationship that are contributing to the problem?

It is important to include the partner in the discussion and to address the partner's concerns. Women may assume that their partner's erectile dysfunction is indicative of his having an affair or of finding her unattractive. Communicating that erectile dysfunction commonly has a biological component that can be treated can help relieve some of the stress and tension on the relationship.

How should I address the issues of coping, self-esteem, and sexual trauma/abuse? These factors can greatly affect sexual function. Patients who feel good about themselves tend to function better sexually. Those who have less self-confidence and do not cope well have more sexual problems and lose relationships quickly. It is a good idea to ask patients how well they are coping with the problem and in what ways they are having difficulty coping. I also ask whether the problem has affected the patient's self-esteem. Patients who are having difficulty coping with sexual problems may require the attention of a psychologist.

There is a very high prevalence of sexual trauma/abuse in our society, and men, as well as women, can be victims. Sexual abuse or trauma has profound and long-lasting effects, often secretly raging inside the person for years. Part of the recovery process is to give patients permission to discuss the abuse and get it into the open. Sexual dysfunction rarely is resolvable until this occurs. Sexual trauma or abuse is almost always an indication for psychological therapy.

How do I address other psychosocial issues, such as ethical, cultural, and religious issues, that may arise during the management of sexual dysfunction? It is important to take into account cultural and religious differences in the way you approach discussions about sexuality. For example, masturbation and premarital sex may not be permissible in many societies. It is also necessary to respect patient confidentiality, since sexual issues, in particular, may be sensitive ones for the patient. When a patient presents as a referral, I do not supply the referring physician with detailed information about the patient's evaluation or management without patient consent. In fact, I usually give my report to the patient to return to the referring physician.

Effective Communication

Many of my patients seem reluctant to even raise the issue of sexual complaints. How do I make sure they are getting the care they need? Patients with sexual dysfunction may be too embarrassed or uncomfortable to raise the issue—or they may hesitate because they do not know how you feel about discussing such concerns. In one survey, about two-thirds of patients said they do not bring up sexual complaints because they are afraid such discussions will embarrass the physician!⁶ In a survey of 62 men and their expectations of primary care physicians regarding sexual health concerns, 97% of men reported having sexual concerns, but only 19% had discussed them with their physician, though most said they wanted to address these

problems.⁷ Participants indicated that they preferred having the physician initiate the discussion.⁷ This is particularly noteworthy since barely one-quarter of physicians actually do ask about sexual problems.

Care should be taken to approach the issue in a sensitive, professional way that is least likely to cause embarrassment. For example, rather than asking, "John, do you have an erection problem?" you might say, "John, you have chest pain/lower urinary tract symptoms/obesity/high cholesterol/diabetes, and you are 65 years of age. Did you know there's a high prevalence of erection problems in men who have increased age and chronic illness? If you are experiencing this problem, we have new treatments that can help you. Why don't you schedule another appointment, and we can address this." To help put patients at ease, hold such discussions in quiet settings where there are few interruptions and without the presence of family members and friends (except the partner, if his/her presence is desired). Have the patient remain dressed and sit at eye level. Ask clear, direct, unambiguous questions in as sensitive and nonjudgmental a manner as possible.

I also recommend watching for what I call "the ED shuffle"—that is, the patient who seems reluctant to end an office visit and is shuffling around without saying what is on his mind. In this way, erectile dysfunction often comes to your attention at the last minute of a visit, when there is insufficient time to address it.

Asking about sexual dysfunction often gives patients permission to reveal painful, hidden problems. Just being asked provides validation and permission for them to express something that may have been pent up for years. As a result, crying is a common reaction. I always keep a box of tissues readily available. The ability to quickly grab a tissue, without having to search for one, also reduces the embarrassment of shedding tears in front of a doctor.

Keep in mind that over half of the male population between the ages of 40 and 70 years experiences some form of erectile dysfunction, so if you see 10 male patients in that age range in an hour, five have erection problems. If you are not detecting these concerns, then you have not fulfilled all of the needs of those patients for optimum medical care.

What role do other healthcare professionals play in treating sexual dysfunction? The ideal management model in a urologic practice calls for a triad of physician, patient, and nurse or physician assistant (PA). The role of the nurse or PA is analogous to that of a diabetic educator or a cardiac rehabilitation nurse/staff. These clinicians can provide important patient education, spend time discussing psychosocial issues and providing appropriate referrals to professional and community resources, and perform follow-up calls.

The extent to which you and your staff become involved in handling psychological and other psychosocial issues depends on your comfort level. You may also choose to refer patients to other professionals, such as psychologists, psychiatrists, social workers, marital counselors, and sex therapists. One excellent resource is the American Society for Sex Educators, Counselors, and Therapists (ASSET), which has members throughout the United States. I also recommend keeping on hand referral numbers for community-based resources, such as Alcoholics Anonymous, Weight Watchers, smoking cessation programs, etc, so that you can easily address psychosocial issues when they arise.

When you make referrals, point out that confronting the problem is likely to improve the patient's well being and reassure the patient that you will continue to be involved in his care. Follow-up should always be performed to determine whether there is any improvement and to offer alternatives if needed.

References

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Tips & Resources

Staff Development

Society of Urologic Nurses and Associates (SUNA): National, nonprofit, professional membership association that supports and promotes the certification of urologic nurses and associates by providing educational preparation for the certification examinations offered. Web site: www.suna.org/cgi-bin/WebObjects/SUNAMain.woa/1/wa/viewSection?s_id=1073743838&wosid=nEcXvVUe5G0X3e4SutVEtGaY2RT

For a continuing education article on erectile dysfunction go to: www.suna.org/cgi-bin/WebObjects/SUNAMain.woa/1/wa/viewSection?wosid=7Hfb2Kyd4g4b3sWSfhtAXQjvyt&tName=article08217231&cs_id=1073743836&ss_id=536872985

University of Medicine and Dentistry of New Jersey-Center for Continuing and Outreach Education: Program designed primarily for healthcare clinicians in managing erectile dysfunction (ED). Physicians and pharmacists who would like a more comprehensive understanding of ED might also find value in this learning experience. For more information, contact CCOE Enrollment Services: phone (in NJ): 973-972-4267; phone (outside NJ): 800-227-4852; fax: 973-972-7128; website: <http://ccoe.umdnj.edu/online/em3/03IC03/index.htm>

Patient Education

American Association of Sex Educators, Counselors, and Therapists (AASECT): Map directory of sex educators, counselors and therapists. Find an area therapist, counselor, or educator by clicking on a state. Web site: www.aasect.org/directory.cfm

News and Notes

International Society for Sexual and Impotence Research Biennial Meeting, Oct. 17-21, 2004, Buenos Aires, Argentina. For information, www.issir2004.org/

International Society for the Study of Women's Sexual Health Annual Meeting, Oct. 28-31, 2004, Atlanta, Ga. For information, www.isswsh.org

Sexual Medicine Society Annual Scientific Meeting at the 2004 AUA Annual Meeting, Sunday, May 9, 2004, 10:00 AM-5:00 PM, San Francisco, Calif, Metropolitan I & II at the Argent Hotel. For information, www.smsna.org/meetings/2004aua_meeting.asp or call 847-517-7225.

Society for the Scientific Study of Sexuality, 46th Annual Meeting, Sexual Science and Politics: Mutual Interactions, Nov. 4-7, 2004, Orlando, Fla. For information, www.sexscience.org/



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Case Vignettes

Psychosocial issues can take a long time to manage. I have a limited amount of time and many other physical problems to address. How can I make sure these concerns are handled properly?

Nurses and PAs can be invaluable in providing support and education. Take, for example, the case of a 58-year-old patient, slightly overweight, with high cholesterol, diabetes, and hypertension, who presented to his urologist with complaints of urinary urgency and frequency. He was treated for lower urinary tract symptoms, but, at the end of the visit, he seemed reluctant to leave. When questioned whether he had any other concerns, he acknowledged that he had lost interest in sex and had been having difficulty sustaining an erection, despite loving his wife. He said he no longer woke with morning erections, either. His physician reassured him that erectile dysfunction is a common and treatable condition. The physician asked him to schedule another appointment for further discussion. In the meantime, the patient was provided with a prescription for a PDE5 inhibitor and an order for laboratory/hormonal evaluation.

One month later, the patient returned with his wife, who believed he was having an affair. He said he felt “really low.” Although the PDE5 inhibitor had helped, the wife was uncomfortable with his wanting to have sex immediately after administration. A review of his blood test results revealed hypogonadism. The patient and his wife then spent time with the nurse who explained testosterone supplementation and also how best to use the PDE5 inhibitor, including having some sexual stimulation before pill administration. The nurse also addressed the patient’s depression and the wife’s concerns and referred them to the local ASSECT-certified therapist and to a weight loss and exercise program.

After 5 follow-up visits with the nurse and sex therapist, the patient had begun to lose weight and was on a regular exercise program. His androgen levels

normalized with testosterone supplementation, and he had more energy. He and his wife just returned from a vacation in Puerto Rico and are now satisfied with their sex life. They continue follow-up appointments with the nurse and therapist.

This is a very common occurrence—patients get into a rut, where they are doing the same job and living a mostly sedentary life. They gain too much weight and drink too much, and communication and shared interests with their partners diminish. Erectile dysfunction can be a crisis that provokes change, especially if there is fear of losing the partner. Nurses can help promote positive changes in such cases by educating patients, providing empathy and support, and taking the time to make weekly follow-up calls to check on the patient and the relationship.

If a patient comes in complaining of erectile dysfunction, and the problem is corrected with pharmacologic therapy, what kind of follow-up is necessary?

Treating erectile dysfunction with a prescription for pharmacologic therapy is only a partial answer, because sexual dysfunction includes psychosocial and relationship components as well as biologic dysfunctions. For example, I received a phone call from the partner of a patient I had treated with a PDE5 inhibitor. She was upset because he was now seeing another woman and using Internet pornography sites. She was afraid of losing him after 35 years of marriage. This couple was referred for sex therapy and marriage counseling during which it became clear that he had only a nonsexual relationship with the other woman and was willing to quit using Internet pornography. Through therapy, the wife also realized that she had overreacted because his impotence had caused her to lose some of her self-esteem and feelings of attractiveness. Thus, it is important to be available to “patients beyond just writing a prescription. The psychosocial and relationship issues are equally important and should be addressed as well.

Put It Into Practice

- Patients have the right, and generally desire, to have their physician raise and address issues pertaining to sexual functioning. These issues should be raised in a professional, nonjudgmental, and straightforward manner.
- Correct management for sexual dysfunction includes evaluation of mind, body, and relationships. Psychosocial evaluation should always accompany physical and laboratory/hormonal evaluations.
- The ideal care team in a urologic practice model includes a triad of doctor, patient, and nurse/PA. When needed, referrals should be provided to other professionals, including sex therapists, psychologists, other mental health professionals with interest/training in sexual medicine, or another healthcare clinician (eg, nurse) certified in sexual medicine. Community resources should also be used as needed.
- Psychosocial evaluation should include consideration of psychological condition, self-esteem, coping mechanisms, state of the partner relationship, and a history of sexual trauma and abuse.

Issues In This Series

Issue 1: Focus on Epidemiology and Etiology

Issue 2: Focus on Clinical Evaluation

Issue 3: Focus on Treatment

Issue 4: Focus on Special Populations

Issue 5: Focus on Psychosocial Aspects

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