The new modes of pharmacologic therapy give health care practitioners an unprecedented opportunity to treat patients with erectile dysfunction (ED), an undiagnosed and underreported condition. Yet even with a portfolio of effective treatment modalities, such as phosphodiesterase type 5 (PDE5) inhibitors, nonpharmacologic interventions should be considered as means to support and augment the effects of these agents. Of equal value—and necessity—is the involvement of the man’s partner in both the assessment and treatment processes. Because men see the primary care physician’s office as a natural and expected place in which to address issues of sexual health, those healthcare professionals who are prepared to initiate discussion of ED can offer patients and their partners the possibility of effective and enduring treatment success and the restoration of a satisfying relationship.

Despite the considerable advances made recently in the pharmacologic treatment of erectile dysfunction (ED), a profound lack of discussion of the condition itself prevents a sizable proportion of affected men from receiving treatment. At present, more than 70% of ED remains undiagnosed. Lack of training, subjective reactions, and misperceptions on the part of medical practitioners are frequent causes of this noncommunication.

Misperceptions include physicians’ belief that they are ill-equipped to treat ED and the concern that treatment, once initiated, will be too time-consuming to be addressed effectively in the typical primary care setting. Compounding this situation is the belief that the man in whom ED has been diagnosed is the only partner in his relationship who should be included in the management of the condition.

Primary care physicians have become well versed in asking questions about patients’ sexual partners and practices, questions that are used routinely in screening for sexually transmitted disease such as hepatitis and HIV. Yet, many practitioners are inexperienced when it comes to investigating sexual satisfaction among patients and their partners. Traditional medical education does not always prepare physicians to discuss sexuality in a clear and candid manner with their patients. Therefore, physicians do not often initiate discussions about the possibility of ED or about couples’ issues of intimacy and overall sexual health.

This failure to discuss such issues may result, in part, from the physicians’ emotional inhibitions regarding the discussion of these subjects. The absence of this discussion has also been attributed to a perceived lack of time in the typical primary care visit and the belief that treating patients with ED is a complex and time-consuming endeavor that cannot be properly managed or contained under the pressures of managed care.

Among one group of primary care physicians (n=90), 53 practitioners (59%) claimed that they would hesitate to actively bring up these subjects because of “lack of time” or “incapacity.” Approximately two thirds (n=57) reported that they often or very often felt a lack of knowledge or skills in dealing with erection problems, and about a half (54%) indicated the need to be brought up to date regarding the management of erection problems.

Initiating Discussion With the Patient

Regardless of the obstacles or impediments to this discussion, primary care physicians are in a unique position to address sexual and relationship issues that exist between patients and their partners, and they can maximize the benefits of being in this position. Discussion of sexual health may uncover underlying comorbid conditions and fosters better patient-physician relations. Other benefits are outlined in Figure 1. The immediate goal should be to initiate an in-office dialogue with the patient. Later, by including the patient’s partner in the treatment plan, the broader goal, that of enhancing or restoring patient-partner intimacy, can become the primary focus.

The first interaction between the physician and the patient is vital in establishing rapport. It is useful to remember that the patient’s anticipation of this meeting is as important an event as the meeting itself. Thus, introducing the patient to the topic of ED before the first face-to-face interview may help create a more comfortable atmosphere. Brochures or posters in the waiting room, for example, can reassure the patient that sex is a discussable topic. If the physician knows that ED is going to be the subject of the consultation, he or she can mail educational material to the patient before the office visit to assure him that many men experience ED and that treatment options are available.
Another helpful strategy is to send patients standardized questionnaires on ED, such as the Brief Male Sexual Function Inventory for Urology; the International Index of Erectile Function (IIEF) and its short form, the Sexual Health Inventory for Men (SHIM) (Figure 2); and the Erectile Dysfunction Inventory of Treatment Satisfaction (EDITs), though this last instrument is more useful in evaluating sexual satisfaction posttreatment. Reviewing these materials before having to discuss the topic face to face gives patients time to become used to the subject and to familiarize themselves with the vocabulary of ED and treatment.

Once the patient is in the office, it is that patient’s assessment of the physician’s level of comfort in discussing the upcoming topic that will be a large determinant of his own comfort. The initial meeting should take place in a quiet environment that is free from interruptions, and the physician needs to avoid conveying any sense of haste. Physicians must remember that they do not need to be expert sexologists, have perfect sexual relationships with their own partners, or share the values and attitudes of their patients to make them more comfortable discussing sexual matters; they need to be good interviewers, which requires a different skill set entirely.

Patients will invariably look to the physicians’ reactions to see if it is safe to continue revealing their sexual history and experiences. If physicians listen well, are not judgmental when the patients’ responses are perceived as either dull or unconventional, and do not project their own anxiety and insecurity surrounding the topic onto their patients, patients will feel free to disclose information that the physicians can use to make a diagnosis and get treatment under way.

The discussion that ensues can reveal emotional problems that compound the absence of physical intimacy, for despite the growing recognition that most ED is organic, a relational aspect almost always accompanies it. Data from the National Health and Social Life Survey (NHSLS)1,2, a 1992 study of adult sexual behavior in the United States, indicate that emotional and stress-related problems generate elevated risk for having sexual difficulties in all phases of the sexual response cycle.3,4 Problems with human sexuality, regardless of etiology, are inevitably associated with relationship issues, issues of self-esteem and gender, and deeply ingrained moral values that must be added to the usual anxieties patients have about bodily processes.5

Men’s Use of Health Care Services

Men may not readily volunteer information about sexual dysfunction, but it may in fact be the motive behind their visit with a physician. And because men often avoid routine visits and are known to underuse primary health care services, it may be suspected that a man who voices vague somatic complaints might actually be in the office because of problems with sex.6,7 This scenario is consistent with men’s patterns of seeking support for health care issues in general. Focus groups revealed that men tend to get most of their support for health concerns from female partners instead of from other men, and that their support-seeking pattern tends to be indirect.8,9 This research also uncovered the fact that when men do use personal barriers to bringing health care concerns to a physician: a sense of immunity or immortality, difficulty in relinquishing control, and a belief that seeking help is unacceptable.9 The existence of these factors further highlights the value that can be added by including the man’s partner in the diagnosis and treatment process.

The Role of Anxiety

According to NHSLS data (n=1247), demographic variables contribute to the experience of sexual anxiety. Unmarried men report higher rates for most symptoms of sexual dysfunction, including anxiety about sexual performance, than married men. And male college graduates are only half as likely to report sexual anxiety as men who did not graduate from high school.7 An understanding of the role of anxiety in ED is an important component in assessment and treatment. It may also be useful if the patient can be helped to understand, in lay terms, how anxiety and worry about performance may reduce sex drive and response to stimulation.

Although studies have demonstrated that anxiety, per se, does not necessarily impair erections and may even in some situations enhance them, anxiety does play a role in many cases of ED: through direct effects, through disruption of cognitive processes related to sexual arousal, through inhibiting sexual responses to avoid anxiety, and as a reaction to sexual failure. Erectile pathophysiology can be related to baseline adrenergic activity, such that in some cases, corporal smooth muscle relaxation is inadequate to allow sufficient blood flow for erection; variations in baseline adrenergic activity may be related to transient or chronic fluctuations in affective tone (eg, anxiety).5

Figure 1. Rationale for discussing sexual health with patients.

Figure 2. Sexual Health Inventory for Men (SHIM), five-item questionnaire derived from International Index of Erectile Function based on five domains.
Involving the Partner
To paraphrase human sexuality research of pioneers Masters and Johnson (1970), if some form of sexual inadequacy is present, the couple is the patient. In other words, there is no such thing as an uninvolved partner; the clinical literature terms a person with normal sexual function who is involved in a relationship with a partner with sexual dysfunction an invested partner. When a couple may be about to resume an intimate, romantic relationship after a prolonged absence from sexual activity, having the participation of both partners is invaluable.

Clinical psychology guidebooks advocate both individual and conjoint interviews for sexual history taking, even when a partner is reluctant to participate. This process gives the clinician not only an opportunity to gather data from a second source, but also provides the clinician with the chance to model for the partner ways to engage, with the patient, in conversations about sexual and relationship issues that are compassionate, nonblaming, and nonjudgmental.

A way to prepare the couple for the partner’s participation is for the staff member scheduling the appointment to inform the patient that “the doctor would like to speak with your wife/partner, as well as with you.” If the patient does not bring the partner to the first appointment, that staff member should encourage him to do so for the follow-up visit.

Routine, independent interviews of patients’ primary sex partners (usually, but not always, their wives) provide supplementary, and sometimes contradictory information that is relevant to diagnosis and treatment recommendation. Most notably, researchers have observed that male patients tend to minimize or deny the role of psychologic or relationship issues in their sexual difficulties, preferring to attribute erectile failure to medical, pharmacologic, or stress-related conditions. Interviewing the patient’s primary sexual partner helps to obtain information of relational and psychologic significance that may have been omitted by the patient. It also allows for the independent assessment of what may be the partner’s contribution to the sexual difficulty, and of the partner’s interest in or capacity for supporting the recommended method of treatment. Such independent interviews have been shown to alter the patient’s diagnosis or treatment recommendation in as many as 58% of cases.

When primary care physicians and psychologists deal with ED, self-report is the cornerstone of the assessment process. Yet, discrepancies often exist between patients’ responses to interview questions about ED and those of their partners. These discrepancies tend to cluster around several categories.

In a study by Tiefer and Melman, at least one such discrepancy was noted in 31 (78%) of the 40 cases, with each couple having an average of 1.7 (of a possible total of 5) categories of information with some discrepancy. The most common type of disparity was in the report of marital satisfaction, in which the partner often reported more discord than the patient had indicated. Almost as common were discrepancies in the reported duration of the problem. Here again, it was the partner who was more likely to report a bleaker perception, ie, that the situation had been going on longer than the patient reported.

Because many men hesitate to bring sexual problems to their physician’s attention, it is sometimes the partner who is the initial source of information about a man’s ED. This fact underscores the importance of interviewing both the patient and his partner (Figure 3). The origin of ED is often multifactorial, with organic, psychological, and behavioral factors interacting to either cause the initial problem or maintain it once it has occurred. It is difficult, if not impossible, to identify and address all the etiologic and maintaining factors by speaking with only one of the partners. In obtaining a history from the respective partners, it is useful to identify the three types of factors that contribute to ED:

- predisposing factors (eg, restrictive upbringing, disturbed family relationships, traumatic early sexual experiences), which may make a man more susceptible to ED;
- precipitating factors (eg, dysfunction in the partner, discord in the relationship, depression, or anxiety), which may have triggered the onset of the problem; and
- maintaining factors (eg, performance anxiety, discord in the relationship, fear of intimacy, impaired self-image, or poor communication), which maintain the problem.

Impact of Erectile Dysfunction on Relationships
Often, erection difficulties will lead to cessation of all sexual activity. This withdrawal of affection may lead to diminished sexual desire on the part of both partners and add to whatever distance or conflict already existed in the relationship. Physicians can help couples explore those misunderstandings that may have played a role in the genesis and maintenance of ED and which, if left unresolved, can compromise the success of whatever therapy is prescribed. For some couples, ED maintains an unspoken, but mutually preferred, “sexual equilibrium.” That is, it serves a function within the relationship, such as regulating intimacy.
or allowing blame for marital failure to be shared. It also allows the couple to avoid facing issues of one or both partners’ dissatisfaction with their sexual relations, such as when the intercourse has become mechanical or boring.

When such dynamics are in play, correcting the man’s ED will not result in sexual or relationship satisfaction. If anything, the couple will find some way to sabotage the treatment or minimize the success of the therapy. Even when pharmacologic treatment of ED results in resumption of firm erections, relationship issues can thwart a successful outcome.

Therefore, it is important that physicians take into account the significance and the complexity of the couple’s dynamics in the development of a treatment plan. Not only must physicians determine the onset and duration of ED, the events surrounding it, the frequency of attempted and successful intercourse, and the complete inventory of sexual partners, but physicians also must do so within the context of a couple’s relationship.

**Strategies for Restoring Intimacy**

Once the patient and his partner have been interviewed and the chosen treatment program is under way, the physician can encourage the couple to begin renewing intimacy and sensuality in their relationship. It may help if the physician suggests to the patient that the inclusion of romance, time spent together outside the bedroom, foreplay (in one study, 60% of female partners of men with ED cited foreplay as their favorite part of sexual behavior), and mutual caressing are important to restoring satisfying sexual activity. Other ways that a patient with ED can include his partner includes speaking positively and constructively about improving their sexual relationship and explaining more effectively how treatment modalities work (eg, provide patient education brochures).

Indeed, involvement of the partner in the treatment process appears to improve compliance with treatment. Women often express the desire to be involved in the initiation of their partners’ erections; if the patient and his partner are encouraged to talk more openly about sexual issues, if the partner is asked what would make their sex life better, and if she is informed about how the treatment works, physicians can expect more favorable outcomes.

**Managing Erectile Dysfunction, A Multidisciplinary Approach**

Data support a multidisciplinary approach to the treatment of ED. Psychological counseling has been shown to have a positive effect on barriers to treatment and on compliance. Primary care physicians need to determine not only their own comfort level with discussions about sexuality and sexual dysfunction, but also whether the patient’s major issues are psychogenic, relational, or organic (in most cases, they will find all), and whether to refer to a psychologist, a marriage counselor, or sex therapist. Even though about 75% of patients complaining of ED have an organic cause (resulting from vascular, neuronal, or endocrine factors), eight empirical studies have demonstrated the significance that psychosocial, cognitive, and interpersonal variables play a role in exacerbating or maintaining even those cases of ED that originate in illness or disease.

**Educational Materials**

Although physicians may be able to provide sex coaching and relationship counseling (or referral, when appropriate), more partner education materials and communication training for couples are needed so that physicians have more tools to assist them in overcoming the patient’s and partner’s emotional barriers to sexual success in a time-efficient manner. There are excellent self-help books and videos that physicians can recommend.

The importance of effective communication cannot be overemphasized: in one early study, couples’ ratings of their ability to communicate effectively with each other were the single best predictors of outcome for psychogenic ED. Having adequate training tools, including a partner interview, may not only help address some of the reporting discrepancies mentioned earlier, but also help to adequately prepare the couple to follow through on treatment recommendations.

**Anxiety Reduction and Desensitization**

Anxiety reduction techniques have been featured prominently among psychologic treatment approaches for ED. These techniques (some of the more traditional of which forbid intercourse and direct the man and his partner to techniques of nondemand body caressing) emphasize the importance of systematic desensitization in overcoming performance anxiety and inhibitions typically associated with ED. Physicians can contribute to the alleviation of anxiety by encouraging sensuality, extended foreplay, and a focus on pleasure rather than arousal. They can also lessen the patient’s anxiety by explaining that treatment often takes time to be fully effective and that most couples need time to comfortably integrate a new mode of treatment into their sex lives.

**Cognitive Behavioral Intervention on Sexual Stimulation Techniques**

Cognitive restructuring techniques are used to overcome sexual ignorance and to challenge the unrealistic sexual expectations that typically accompany ED. For couples with limited sexual repertoires and few alternatives to intercourse, ED can be debilitating and anxiety provoking, frequently leading to the cessation of all sexual activity. Couples in this situation need to be coached in giving and receiving pleasure from manual and oral stimulation, so that the patient, knowing that his partner’s pleasure does...
not depend on his having an erection, experiences a reduction in performance anxiety. Increased genital stimulation may in fact be necessary for the male partner to achieve an adequate erection and may augment the effects of pharmacologic therapy.19

**Using a PDE5 Inhibitor**
As noted earlier, even with the availability of PDE5 inhibitors for the treatment of ED, not all couples perform predictably because psychological resistance interferes with the effectiveness of the intervention. Before institution of a formal treatment regimen, a PDE5 inhibitor can be used as a therapeutic probe to flesh out unrecognized issues, such as underlying anger or resentment. Once identified, the issues that led to treatment resistance are amenable to psychotherapeutic intervention.16

**Comment**
Health care practitioners, especially those in a primary care setting, are uniquely positioned to assist patients and their partners with sexual and relationship matters. Patients with sexual concerns, including ED, report feeling most comfortable discussing these issues with their family physicians and expect to receive advice and treatment from them.4

In meeting the challenge of treating patients with ED, physicians should recognize the crucial role that partners have in the etiology and management of this disorder and be prepared to treat not only the patient, but also the partner for problems that might affect the couple’s sexual relationship.13 The inclusion of the partner in the treatment process provides not only invaluable diagnostic information, but also a more accurate prognosis of treatment outcome than does treating the patient alone.

Physicians have at their disposal an impressive array of treatment tools. A custom-tailored yet inclusive, multidisciplinary approach that views the couple as the patient offers the best opportunity for restoration of sexual function and the intimacy that contributes to enduring treatment success.

**References**