An investigation of factors that determine when men with erectile disorder present for treatment

This study by Sangan Sookdeb explored the factors that determine the time interval between men suffering the onset of erectile disorder and their presentation for treatment. As prognosis is considered to be related negatively to the length of time a man suffers erectile disorder, understanding factors that delay presentation may identify changes in practice methods that will encourage earlier presentation.

Introduction

Erectile dysfunction is a common problem among men in the general population and in medical settings because of ill health and medication side effects. It is also the most frequent difficulty with which men present at sexual dysfunction clinics (Bancroft and Coles 1976). Over 50 years ago, Kinsey et al (1948, 1953) reported that erectile failure affected 0.1 per cent of men aged 20 but up to 25 per cent of those aged 65, with one in nine marriages ending in separation due to sexual difficulties. More recent data from the Massachusetts male ageing study (McKinlay and Feldman 1994) revealed that 51 per cent of men aged 40 to 70 had some degree of erectile problems.

In recent years, there have, however, been significant advances in our
understanding of the mechanisms of erection and in clinicians’ ability to treat impotence. For example, the treatment of erectile failure now includes physical therapy, such as intercavernosal injections of vaso-active agents, vacuum pump devices, surgical interventions (penile implants), oral medications, creams and gels applied to the penis and additional drug combinations – such as Invicorp, a combination of phentolamine and vaso-active intestinal polypeptide for intracavernosal injection and transurethral administration (Riley 1998).

The latest drug to revolutionise the treatment of erectile disorder is sildenafil (Viagra). Although this drug is approved for use in the UK market under medical guidance, there have been controversies surrounding its misuse reported. For example, Wheldon (2005), writing in the Daily Mail, reported that a small number of Viagra users ‘have been blinded due to side effects of the medication’. In The Guardian, McCartney (2005) reported that ‘billboards proclaimed that erectile dysfunction could be ‘‘sorted’’ in 10 minutes’. Other media reports have suggested that Viagra is being misused by people who mix it with cocaine and ecstasy.

These reports have had a negative impact on the medical use of sildenafil, especially for those who are in genuine need. Most drugs have some side effects and Viagra is no exception.

Besides, drugs may solve one part of a couple’s problem but neglect other physical and psychological aspects that may be causing the erectile disorder. Treatment outcome can also depend on the interval between the onset of problems and when the individual or couple present for therapy.

**Definition**

There are many definitions of erectile failure, also known as impotence. Diedrich et al (1992) define impotence as ‘the recurrent and persistent inhibition of sexual excitement during sexual activity manifested in males by complete and partial failure to attain or maintain erection until completion of the sexual activity’. Eardley et al (1999) characterise erectile dysfunction as ‘the inability to achieve an erection that is adequate for intercourse to the mutual satisfaction of both partners’.

Others say that the chief clinical feature of impotence ‘is the failure to
attain or maintain an erection firm enough for vaginal intercourse’ (Kaplan 1974).

The American Psychiatric Association’s diagnostic manual (DSM IV) (1994) defines male erectile disorder as follows:

- ‘persistent or recurrent inability to attain or maintain until completion of the sexual activity, an adequate erection’
- ‘the disturbance causes marked distress or interpersonal difficulty’
- ‘the erectile dysfunction is not better accounted for by another Axis 1 disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (eg a drug abuse, a medication) or a general medical condition’.

The World Health Organization’s ICD-10 (1992) definition of erectile dysfunction is as follows: ‘Failure of genital response. In men the principal problem is erectile dysfunction, that is, difficulty in developing or maintaining an erection suitable for satisfactory intercourse. If erection occurs normally in certain situations, eg during masturbation or sleep or with different partners, the causation is likely to be psychogenic. Otherwise, the correct diagnosis of non-organic erectile dysfunction may depend on special investigation (eg measurement of nocturnal penile tumescence) or the response to psychological treatment.’

Factors affecting prognosis
Various factors may affect the prognosis of erectile failure. Authors have contrasting opinions on how outcome and prognosis are affected. For example, Hawton (1983) and Hawton et al (1992) proposed that prognosis is dependent on the way in which the patient presents the problem. They also suggested that prognosis depended on the male’s willingness to solve the problem. Kaplan (1974), on the other hand, suggested that duration of the symptoms in secondary impotence has better prognosis than primary erectile complaints. She also stressed that emotional and physical distress, such as fear of failure and the presence of sexual demands, could precipitate impotence.

Other authors, such as O’Connor (1976), Whitehead and Matthews (1977) and Snyder and Berg (1983), put more emphasis on the quality of
the couple’s relationship. For example, if the patient has many negative feelings towards his partner and sex with her is a tense experience or he feels guilty having sex with her, then he will continue to experience erectile difficulty in those situations.

Besides, many men withdraw from their partners after such erectile failures because of the incorrect but deeply held belief that sex demands a ‘firm erection’. The real problem lies not in the man’s functioning but in his ideas about how he should function.

Therefore this conflict in the relationship acts as an operant reinforcement on the sexual functioning for erectile failure to continue to occur. This view is supported by Leiblum and Rosen (1989) and is consistent with the views of Cooper (1969), Whitehead and Matthews (1977) and Fordney-Settlage (1975) who state that prognosis and outcome are dependent on the couple’s motivation to change.

However, many men continue to think that all they need is some procedure or device to help them achieve an erection. Unfortunately, these individuals continue to experience psychological difficulties post-treatment (Melman and Holland 1978, Mohr and Beutler 1990).

**Therapists and therapeutic interventions**

In the UK, the main professionals who treat erectile failure are general practitioners (GPs), psychologists, psychiatrists, hypnotherapists, urologists, endocrinologists, sexual therapists and marital therapists. However, many people feel comfortable seeking counselling from their own religious healers including priests from churches, hakims (Muslim leaders), witch doctors, or others. Many individuals also self-refer having seen media advertisements and newspaper articles or having heard and seen items on the radio and television. In addition, many family planning and well-man clinics provide basic advice and counselling as a treatment protocol.

However, GPs remain the ‘gatekeepers’ and are the first medical professionals the majority of patients contact. Here, initial treatment can include oral medications and intercavernosal injections methods, although Schover and von Eschenbach (1985) argue that these treatments do not include psychological interventions.
issues in research

The study
This article is based on original research that I carried out as part of my master’s degree in human sexuality at St George’s Hospital Medical School, London. It explores the factors that determine the time interval between a man suffering the onset of erectile disorder and his presentation for treatment. My interest developed from my clinical practice in mental health in primary care (a GP surgery). I observed that a significant number of patients referred by their GPs for the management of depression were in fact presenting with sexual and relationship difficulties and, in particular, ‘erectile failure’ as a primary diagnosis. I undertook the research during clinic sessions over a three-month period in 1996.

Methods
Data were collected by postal questionnaires, face-to-face interviews and telephone interviews. All subjects \((n=37)\) selected had a diagnosis of erectile failure and were attending a sexual dysfunction clinic. A few data were extracted from the case notes of patients who had already completed treatment. Strict confidentiality was maintained and observed at all times. All professional staff who participated were selected at random from general and psychosexual clinics from various parts of the UK. Stamped-addressed envelopes were enclosed with the return date specified and a brief explanatory letter about the aims and objectives of the study.

Ethical consideration
The relevant ethics committees approved the study, and professional and legal boundaries were observed throughout the duration of the study and beyond. Willing participants were given the opportunity to opt out at any time. Particular attention was paid to ensuring that criticism was not directed at any group of respondents.
Results

Age range
The age range of patients is shown in Table 1.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Number of patients</th>
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<td>25-34</td>
<td>10</td>
<td>27%</td>
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<tr>
<td>35-44</td>
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<td>45-54</td>
<td>10</td>
<td>27%</td>
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<td>55-64</td>
<td>9</td>
<td>24%</td>
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<td>65-74</td>
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<td>8%</td>
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<td>75-84</td>
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Marital status
Of the 37 men, 25 (68 per cent) were married, six (16 per cent) were cohabiting and six (16 per cent) were single.

Sexual orientation
Thirty-four men (92 per cent) were heterosexual and three (8 per cent) did not identify their sexual orientation.

Factors that encouraged patients to seek help
These are outlined in Table 2.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number of patients</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>To regain potency</td>
<td>31</td>
<td>84%</td>
</tr>
<tr>
<td>Partner pressure</td>
<td>16</td>
<td>43%</td>
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<tr>
<td>Support/encouragement</td>
<td>16</td>
<td>43%</td>
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<td>Wanted to start a family</td>
<td>3</td>
<td>8%</td>
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</table>
Appointment with GP

Table 3 shows the length of time patients took between the onset of their problem and their appointment to discuss it with their GP.

Table 4 shows how long patients waited for appointments with specialists after being referred by their GP. Of the 37 patients, 25 men (68 per cent) said they felt they had waited too long to see a specialist; 27 men (73 per cent) thought that help should have been more readily available.

Twelve men (32 per cent) gave two reasons: to regain potency and partner pressure.

Results from GPs

Fifty four GPs participated in the research. Eighteen (33 per cent) treated their patients themselves with brief counselling; four (7 per cent) with intracavernous injections; and two (4 per cent) with vacuum pumps. Thirty six GPs (66 per cent) referred their patients to psychosexual therapists; 44 (81 per cent) to urologists; eight (14 per cent) to psychiatrists; eight (14 per cent) to

<table>
<thead>
<tr>
<th>Years</th>
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<tbody>
<tr>
<td>0</td>
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<td>7</td>
<td>19%</td>
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<tr>
<td>0</td>
<td>2</td>
<td>5</td>
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psychologists; two (4 per cent) to physicians; and two (4 per cent) to genito-
urinary clinics. Twenty-one GPs (39 per cent) referred their patients to more
than one agency: that is, to urologists and psychosexual therapists.

The time interval between GPs consulting with patients and patients’
appointments with specialists varied from two weeks to two years.

**Data from urologists (n=14)**
The waiting times for the first consultation with a urologist varied from two
to 12 weeks. The frequency with which urologists saw their patients for fol-
low-up appointments varied from weekly initially to every three months, and
then to ‘as required’.

**Prioritising referrals and back-up services**
Eleven (78 per cent) urologists prioritised their patients, but five (45 per cent)
saw patients on a ‘first come, first served’ basis. Three (27 per cent) used age

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**Table 4. Waiting time to see a specialist after initial interview (n=37)**

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<tr>
<th>Years</th>
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<th>Weeks</th>
<th>Number of patients</th>
<th>Percentage</th>
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as priority; four (36 per cent) used clinical presentation as priority. In addition, five (36 per cent) urologists worked in a multidisciplinary team while nine (64 per cent) did not. Eleven (79 per cent) had back-up services such as a urology clinic, intracavernous injection clinics, psychological screening, and nurse practitioner or psychiatric services.

**Data from psychosexual therapists: (n=6)**
The waiting time for first consultation with a psychosexual therapist varied from six to 12 weeks and the frequency with which they saw patients also varied – from weekly to every two months. Psychosexual therapists prioritised patients in a similar way to urologists. Furthermore, four (67 per cent) worked in a multidisciplinary setting and also had back-up from psychological, urological, and hormonal clinic services.

**Data from physicians (n=2)**
The waiting time for first consultation varied from six to 12 weeks and the frequency of sessions varied from weekly to monthly. One physician used clinical presentation to determine priority; the other did not but worked in a multidisciplinary setting with back-up services similar to the urologists’ and psychosexual therapists’.

**Factors influencing return rates**
The postal survey is one of the cheapest methods to collect data. Barriball *et al* (1996) reported that it is respected as a legitimate means of data collection throughout much of the literature. The postal survey is easy to manage and is suitable for many, though not all, health topics. It is a popular choice and the fastest technique of all for data collection, but it can be correspondingly imprecise (Reid 1992). The return rate tends to be low (French 1993).

In this study, 73 per cent of the GPs responded, although a few required telephone calls as reminders. The initial plan was to collect data from 100 patients, which proved extremely difficult because of the limited time available for the duration of the study. Therefore, 40 per cent of the data were collected from the case notes of patients who had been treated very recently.
Discussion

There have been relatively few studies carried out regarding the onset of erectile problems and the time interval before presenting to GPs, urologists, physicians and psychosexual therapists. Many patients present indirectly with symptoms of depression, stress, insomnia, panic attacks and marital disharmony, and many couples present with sexual problems at infertility clinics (Hawton 1991). Other sources of referral are dependent on the setting and the links that it has with other healthcare organisations (Hawton 1991, Bancroft 1989, Phanjoo et al 1996, Duddle 1975).

In this study, the patients’ data showed a bimodal age distribution. The age range of those presenting for treatment peaked at 25 to 34 years (27 per cent), with a second peak occurring at 45 to 54 years (27 per cent). There was a slight drop at 55 to 64 years (24 per cent), which is consistent with the findings of Hirst et al (1996). In the 65 to 74 age range, the average waiting time prior to presenting at a GP was between three and four years.

Moreover, the study found that female partners play a major role in determining when men seek help: 43 per cent of the men seeking help from their GPs did so because of partner pressure. At first, the female partner is baffled by the anguish her partner goes through when he fails to get an erection. It appears almost impossible for the female partner to realise the intensity of the anxiety the man is experiencing because of his ‘sexual inadequacy’. His self image, self-confidence and self-respect dwindle. Although many women reassure their partners that an erection is not important, most men do not believe them. Many women reported that their partners believed that things would improve given time, while a significant number of women felt that the absence of sexual activity meant that there was something wrong with them instead; they were not desirable, not loved, not attractive and not found ‘sexy’ by their partners. They also felt excluded and inadequate, and many believed that they were the cause of their partner’s problems.

There were many other women who believed that sexual intercourse was the only act that could prove that their men still loved them. As a consequence many men withdrew in shame and distanced themselves from their partners, experiencing anger and frustration at failing to ‘perform’, thus exacerbating their difficulties. A few men reported that their entire sexual
experience was limited to intercourse only. They lacked sexual education, and said that they were ‘used up sexually’. They therefore refrained from seeking treatment, having concluded that it could not do themselves or their partner any good, and stopped initiating sex altogether.

There were others who believed the myth that men were not supposed to have any sexual problems and that any personal problems should be resolved quickly and without complaint. Their inability to do this suggested weakness and dependency. Many were reluctant to acknowledge that they had a sexual problem until they were threatened with separation and divorce, although there were reports of sexual difficulties among female partners of men experiencing erectile disorder (Speckens et al 1995).

Conclusion
In my clinical practice, patients have used various terms, such as ‘useless’, ‘hopeless’, ‘fraud’, ‘unmanly’, ‘loss of manhood’, ‘non-man’, ‘wimp’ and so forth, to describe their feelings about erectile failure. This is because erectile problems evoke horror in men and hit their masculinity (Milsten and Slowinski 1999). They perceive the problem as a weakness and it takes a long time, with considerable ‘self-talk’ and courage, before they seek professional help because of the stigma attached to personal sexual matters (Zilbergeld 1979).

Furthermore, the problem is magnified because it is not only the patient who is uncertain about how to address these issues; many family physicians and primary healthcare workers lack teaching and training in sexual health. In many cases, men did not present, or took a long time to present, for treatment because they were unaware that the condition is now treatable in the vast majority of the cases (Riley 1998). Cultural myths that men are not supposed to have any personal problems, and certainly not sexual ones, play a major role in avoidance-seeking behaviours.

However, despite all these difficulties and complexities, a significant number of men do seek help for their sexual problems. Practising sexual therapists should keep an open mind and should explore and discuss various treatment options without prejudice before letting patients decide for themselves which options are best for them.
Men can change. They can learn to talk about their sexual feelings with their partners and adopt new and creative ideas about their sexual activities. In conclusion, the words of Garner and Garfinkel (1985) should be borne in mind: ‘As clinicians we are attending to what our patients are telling us and are adapting our procedures to address these recurring themes.’

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Acknowledgement
My thanks to Professor Alan J Riley, professor of sexual medicine at the University of Central Lancaster for his continuous support and encouragement during the entire project, and to Professor Chris Brannigan, director of research, nursing and counselling psychotherapy and module director of the professional doctorate programme in cognitive behaviour therapy at the University of Derby, who provided support, guidance and very helpful comments in restructuring and updating information.

This article has been subject to double-blind review

**References**


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