

## March 1997 - Pipeline

### The Other Side of the Story

In treating male sexual dysfunction, it has become invaluable to evaluate the patient and his partner. We may be doing a less than adequate job in sexual dysfunction if we don't see both partners. For couples to be satisfied with treatment, it is critical that both partners have a thorough understanding of the problem and realistic expectation of the possible solutions. The urologist and nurse in the clinical team play a critical role in helping the patient and partner in these areas. Like other health issues that require a multidisciplinary approach, addressing the physical, psychological and social aspects of the erection problem are often essential for comprehensive care and ultimate patient satisfaction.

Many men experience impotence as a real challenge to their self esteem, their ego, and self confidence but not many of us think seriously about how the female partner is feeling or handling the disruption to their marital relationship.

To further understand these difficulties, we need to first look at the physiological changes associated with aging in both men and women which is shown in Figure 1. Both parties have a decrease in hormones; estrogen in women, testosterone in men. The size of the cervix, uterus and ovaries is changing constantly, and the thickness and elasticity of the vagina coupled with lack of lubrication can make things extremely difficult and possibly painful. On the male side, sometimes the testicular size does decrease, as does the production of sperm. A change in viscosity and volume of ejaculate can often cause men some concern. When a man has an erection problem, the couple has a sexual problem. In that simple truth lies the rationale for including both partners in diagnosis and treatment. Both are suffering.

Figure 1: Physiological Changes Associated with Aging

<u>Women</u>	<u>Men</u>
<i>Estrogen decreased</i>	<i>Testosterone decreased</i>
<i>Size of Cervix, Uterus and Ovaries</i>	<i>Production of sperm</i>
<i>Thickness and Elasticity of Vagina</i>	<i>Size of testes</i>
<i>Lubrication</i>	<i>Viscosity and volume of ejaculate</i>

We should also look at the effects of aging on sexual responsiveness as seen in Figure 2. As you can see, both male and female response and excitement levels tend to slow down, both require more stimulating and to gain the same effect and both have orgasms of shorter duration. The big difference is the clitoral response which stays intact, as well as, the multi-orgasmic capacity of the female being retained. On the other hand, men's erections are less firm and their ability to have more than one erection is decreased. We need to encourage men and women to ask questions, and to use frank, non-medical terms when answering these questions. We also need to acknowledge that sexual problems for women may develop along with or after a partner's problem, and offer advice and treatment for her at the same time. Women may feel very hurt and angry because her partner has withdrawn from her physically and emotionally. She should be given permission to express her feelings in private with clinical staff which may help better communication pathways.

Figure 2: The Effects of Aging on Sexual Responsiveness

<u>Women</u>	<u>Men</u>
<i>Slowed response/excitement</i>	<i>Slowed response/excitement</i>
<i>More stimulation required</i>	<i>More stimulation required</i>
<i>Clitoral Response Intact</i>	<i>Erection less firm</i>
<i>Orgasms of shorter duration</i>	<i>Orgasms of shorter duration</i>

*Multi-orgasmic capacity retained*

*Multi-orgasmic capacity impaired*

In Figure 3, we notice that in many cases both the males and females are experiencing similar feelings, particularly feelings of frustration, embarrassment, anger, guilt, self-blame, depression and even grief and loss. I find in my practice women in the relationship have as many or more questions, doubts, resentments and insecurities. They need information, understanding and reassurance more than the male 'patient'. Very few of us will develop a sense of sexual security and that tends to make the rejected partner withdrawn and resentful, and interferes with communication in the relationship.

We should stress that men and women have different views of the relative impotence of sexual intercourse, with the overall relationship being the key for the woman, and the sex most important to the man. There are patients that feel if they could only get an erection routinely, all problems in their relationship would be solved. Of course, this is rarely the case. Sometimes we are able to advise on a repertoire of mutual satisfying activities that do not depend on an erect penis. This advice tends to lessen the patients' performance anxieties regarding sex, and many help them recover sexual function despite their underlying disease. It can often be helpful to emphasize to the couple that almost everyone has a psychological reaction to an erection problem, even if its cause is primarily physical.

**Figure 3: The Feelings Experienced**

<i><u>Women</u></i>	<i><u>Men</u></i>
<i>Disappointment</i>	<i>Despair</i>
<i>Frustration</i>	<i>Frustration</i>
<i>Embarrassment</i>	<i>Embarrassment</i>
<i>Fear of rejection</i>	<i>Anger</i>
<i>Anger</i>	<i>Guilt and Shame</i>
<i>Guilt and Betrayal</i>	<i>Fear of rejection</i>
<i>Self-Blame</i>	<i>Self-Blame</i>
<i>Depression</i>	<i>Depression</i>
<i>Grief and Loss</i>	<i>Grief and Loss</i>

I would like to focus for a minute on the symptoms of the female who is having difficulty with intercourse which is often not considered adequately in dealing with male sexuality. Women who are contemplating resumption of intercourse after a long period of abstinence have physical, psychological and health needs to consider. She may often have vaginal dryness, loss of vaginal muscle tone, possibly hormonal imbalances that have not been dealt with either post hysterectomy or post menopausal. A visit to her gynecologist might help this situation quite dramatically. She can also develop symptoms which are painful and cause difficulty such as cystitis or non-specific vaginitis. The couple should be warned about these kinds of things and it should be suggested that they both be treated if vaginitis symptoms occur. Painful intercourse due to both vaginal dryness or loss of vaginal muscle tone is often felt and not understood by either partner. Discussing these difficulties with a female partner is one of the areas that a well trained nurse can be helpful.

Sometimes the female partner as well as the male partner feel more comfortable sharing some of their concerns with the nurse as opposed to the urologist. The nurse would then be in a unique position to advise the urologist when a procedure or a concern of this nature requires more explanation and possibly relieve some doubt. We discussed briefly earlier some of the reactions that females get. Some of them feel guilty that possibly they have not worked hard enough at their sexual relationship. They have been somewhat reluctant on some occasions to accommodate the male partner's sexual desires, and that this is now creating difficulty for him. The woman might secretly wonder if the husband is having an affair, or might even worry that he is

severely ill. It may also be a case where the husband starts arguments to actually avoid sexual encounters, and this of course increases her feelings of rejection, neglect and self-doubt. She may question her own attractiveness. She may withdraw. She may often be afraid

to bring up the subject with her husband because of the painful nature of the subject. Each partner becomes very isolated and miserable. I even had one couple who when told that the problem seemed to be primarily psychological, the female partner actually accused her husband of being homosexual!! This created further concern and disruption in their relationship. Because she feels an erection expresses feelings for her, she may find that the underlying problem is that he no longer loves her, and occasionally this creates a resistance in participating in other types of treatment as well as feeling that ultimately her husband will leave her anyway. Her concerns and beliefs need to be carefully considered.

Eventual reactions to this condition are usually of a far more serious nature. The literature quotes several cases of severe clinical depression on the part of the female, as well as the male. More alarmingly you start to get compensation with other things in their relationship. Possibly in some females they will actually use making fun of the partner in front of family and friends which of course only further increases his performance anxiety. You ultimately end up with decreased communication between the couple and substance and alcohol abuse on the part of both men and women. Physical abuse has also occurred, and this does not necessarily mean the man attacking the woman. At least in one case, I had a male complaining about his wife beating him with a frying pan! Women have often made comments such as I feel like the loneliest person in the whole world. She finds the loss of other sexual needs such as kissing, caressing and manual stimulation creates a different kind of emotional pain and sense of loss. Many females find these other sexual activities actually more important than the actual act of vaginal intercourse. Sexual symptoms are not life-threatening but may be severely disruptive or destructive to the individuals or to marital adjustments. Other coping mechanisms that females often use are: they become more focused on family needs, possibly friends, and maybe even working harder at their own careers to avoid further contact with their male partner.

Decreased sexual desire and decreased affection and closeness become common coping mechanisms. Most couples become more physically distant because of one or the other is afraid of getting something started that can't be finished. Sometimes it is more the difficulty that if she approaches him for sex, she will be labeled as demanding, domineering and castrating. On the other hand if she does not approach him, she can be labeled infantile, passive, masochistic, non-sexual or maternal. Masters and Johnson's studies pointed to sexual ignorance, religious orthodoxy, sexual inhibitions and performance anxiety as high on the list for causes of impotence. The couple must be reassured that they continue to enjoy sexual pleasure without intercourse and it should be emphasized to the male that the female does need these other close physical contacts such as hugging and kissing regardless whether sexual activity takes place. Women often comment they would like him to be affectionate either in words or deeds without always having to have it end up in sex. Men need to be given permission to express affectionate feelings outside sexual motivation even though society has considered this sometimes too feminine, i.e. "non-macho".

A great deal of confusion is grounded in the socialization process that women experience growing up in our society. Many couples have difficulties learning how to negotiate compromise and separate the sexual dimensions of their relationship. Affection is an emotional feeling or response and can be expressed verbally or non-verbally. The clients attaches a flower, a stroke, a hug, a kiss, and an "I love you" with sexual interaction. All can express one's sexual feelings towards one another. When no affection is expressed in a relationship, it is easy to assume there are no positive feelings which may or may not be the case. If expression of affection and sexual desire are confused, which is common, then all expressions of affections can be taken as invitations for sexual interaction. Couples often get caught in this confusion and have been trading sex to gain affection, and affection to get sex with neither one being happy with the outcome of the interchange. Eventually each one begins to feel angry over the situation, and begins to withdraw. As the frustration builds so do anger and resentment leading to an inhibition of sexual desire. In some couples it can be valuable to help them learn what affection is necessary in the expression of sexual feelings but sexual expression is not necessary in the expression of affection. This is an important principle for couples to remember but more importantly if affection and sexuality become confused, communication and negotiation become essential if problems are to be avoided.

When it comes to treatment, for couples to be satisfied, it is crucial if partners have a thorough understanding of the problem and have a realistic expectation of the solutions. The urologist and clinical team play a critical

role in helping the patient and partners in this area. Unsuccessful cases are often due to one or more of the following elements:

- unrealistic expectations on the part of patient or partner
- unclear communication between the doctor and patient
- misunderstandings on the part of the partner
- unresolved conflicts in the relationship which restoration of potency does not resolve

As one astute doctor put it, addressing patient's sexual problems would be simpler if patient's genitals came to the office on their own. They are however attached to a person and that person's family, community and world. Couples have extremely varied reactions to the differential diagnosis depending on the current quality of their relationship and the amount of time the sexual problem has been present. Other factors are the motivation of both partners and the level of interest and desire by both partners to reinstate sexual activity. Sometimes couples have their own beliefs about why the problem occurred in the first place, and it is hard to convince them in spite of testing that their conclusions are not the problem. They also may not necessarily like the treatment options that are available and prefer status quo. Occasionally first attempts to discuss treatments can be clumsy and result in an overall negative experience. This may lead to an unsatisfactory treatment. Couples will need time to adjust to the change that the restoration of potency has made in their lives. Couples need to also know that failure of one treatment does not mean they need to give up. The longer sex has been a problem, the more often a couple will speculate about its cause and meaning. Sometimes it has created a situation where they do not want sexual affection from each other anymore, and there is often a hidden agenda of "help us but don't change us". One must be careful because sometimes no treatment and just the knowledge of what is happening in the partner's body is enough information for the couple's resolution. When it comes to individual treatments, I find filtering information and questions from the husband to the wife can lead to misunderstandings. To create happiness, the wife's own concerns must be addressed.

In summary, as was mentioned earlier, for couples to be satisfied with treatment both have to be happy with the solution and be realistic in their expectations of what is going to happen with these treatment options. Males should also be reminded that they are not 25 anymore and that their sexual prowess will not remain at that level. I think that we do not emphasize enough to patients that they do not necessarily have to have any treatment. If they are happy with the situation then sometimes they are better to maintain status quo. They have usually figured out other ways to make love satisfactorily and no one is dissatisfied with the present situation. Often what happens is that we as health care professionals tend to influence the patient to head towards one treatment or another. I often tell my couples that I can give them the options, I can give them the pro's and con's, but I am not in their relationship (at home). The two of them need to make a decision together, hopefully to the satisfaction of both partners. Of course for this to happen easily, communication must be the key. Communication in marital relationships is one of the least used tools of a good relationship, and I am constantly encouraging them to talk to each other. They have to ask each other how they are feeling. They have to possibly help each other do things differently to make their sexual satisfaction better. The lack of communication tends to cause more difficulties before treatment, and definitely after treatment has been instituted. This often becomes a major problem. As long as the option of no treatment is a couple's decision, then it should not create a loss of emotional and sexual closeness. Hopefully they have not drifted apart due to the silence in their relationship during this difficult time.

I hope you have realized during this summary that involving the partner wherever possible is the key to success of treatment modalities, and I feel that this is an area that is not being looked at as well as it should be and is causing major difficulties in treatment outcomes. Communication is the key!

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\*\*Figures 1, 2, and 3 taken from the Geddings Osbon Foundation brochure "Male Impotence, A Woman's Perspective"

## References

1. Daily, D. *Affection and Sexuality*. The Renal Family 26-28.

2. Renshaw, CR. *Coping with an impotent husband*. Illinois Medical Journal, January 1981:29-33.
3. Clark, MM. *Treatment of erectile dysfunction should include counseling for both partners* . The Chronicle of Urology and Sexual Medicine, August 1996, 4.
4. Berger, RE, Berger, DM. *Couples: The Art of Solving impotence problems. A Guide to Sexual Success*. 1987: 154-159.
5. Milne, C. When "Not Tonight Honey" is no joke. March 1996;12-13.
6. Chernick, B. Stress can play out as sexual dysfunction. Family Practice. August 19,1996;33.