Chapter 55
What is the place of psychosocial issues in andrology?

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Andrological problems can take many forms and include a range of problems such as the impact of environmental toxins on reproduction, impaired erectile function, and testicular cancers. While it is essential to consider the specific systems affected and how to treat those impacts, it is equally important to remember that each of those problems is taking place within a man whose life includes relationships with others. These relationships will vary on their level of intimacy, both psychologically and physically. As a result, attention to how his diagnosis and treatment could affect those relationships is critical when comprehensive care is the goal.

As a rule of thumb, most men know less about their health in general than women. And men have less sexual and reproductive health information, primarily because they typically seek care for these issues when there are problems as compared to women who generally receive at a minimum reproductive health care from the onset of puberty. While there is great variability in how sexual and reproductive health information is delivered in educational settings, it is safe to say that it frequently focuses on how not to create a pregnancy or contract a disease, limiting knowledge about fertility as well as the broader aspects of sexual health that include pleasure. Men are also less likely to ask for help in general and the notion of psychological "help" can be a deterrent to men actually participating in psychotherapeutic activities. Finally, the stigma attached to reproductive and sexual health issues can prevent men from discussing them with their partners.

Psychosocial issues resulting from andrological problems can be wide ranging. Most commonly, they present as increased anxiety, stress, depression, and a sense of loss of control. Guilt and shame can also be associated with them. Some men will turn to activities they think will reduce these uncomfortable feelings such as substance abuse, gambling or increased risk taking in other forms. The focus here will be on the former, but a competent practitioner will

consider maladaptive behavior as a potential consequence of an andrological diagnosis and have referral sources available for patients in need of them.

Sexual problems and their treatment

Erectile difficulties and ejaculatory control are very common presenting problems in the andrologist's office. To a lesser degree patients with low sexual desire may request help. A first line intervention is often information about normal sexual functioning that many men may not have.

Recent epidemiological studies suggest that erectile dysfunction (ED) for all age groups internationally ranges between 32% and 80%, with higher numbers occurring with increased age. Other health conditions can be at play, including diabetes, cardiovascular disease and substance or alcohol abuse. In addition, many pharmaceutical interventions for these disorders can impact erectile function. For example, SSRIs (selective serotonin reuptake inhibitors), diuretics, and beta-blockers all have known adverse impact on erections.

It is important for men to know that erections normally wax and wane in any one sexual encounter and are never as described in literature or as seen in pornographic representations, always rigid and long lasting. All too frequently, a man experiences a brief loss of erection and internally translates it into chronic ED. This performance anxiety associated with his internal dialogue can contribute to persistence of the problem. Typically, the man will worry about what will happen the next time he attempts sexual activity rather than focus on arousal and pleasure during the encounter. Psychotherapeutic interventions for ED predate the use of PDE5 inhibitors and can be most useful when the problem is clearly psychogenic in origin and are useful even when there is a physiological component. A sex therapist will collaborate with the man and eventually bring his partner into the treatment, if he has a regular one. Therapy generally consists of both education about what is normal, substitution of more helpful thoughts, and specific exercises to help the man become more confident about his erection capacity. For an older man with medical complications or the normal impact of aging on erections, helping shift from intercourse as his primary sexual activity to other forms of pleasure may be the goal.

Premature/rapid ejaculation (PR/RE) has an estimated incidence rate of 20-30% across all age groups and is a frequent presenting

problem among younger, less sexually experienced men. It is a complicated disorder because there is no universally accepted definition. Premature or too rapid for what? One man's "rapid" is more than acceptable to another man or his partner. Ejaculatory latency time, control over ejaculation and satisfaction with sexual intercourse have all been utilized as descriptors for the disorder. PE/RE can cause distress, anxiety, depression, shame, reduced libido, impaired interpersonal relationships, anxiety about intercourse and the avoidance of sexual relationships. It may be useful to conceptualize the issue, particularly with younger men, as a learning process. That is, with experience a man learns more about his sexual response to various forms of stimulation and learns to moderate his activity to receive and provide increased pleasure to himself and a partner.

As with ED, PE/RE may occur in conjunction with other medical conditions such as diabetes, hypertension, hyperthyroidism, alcoholism, or the use of recreational drugs. Depression stress, or anxiety about sexual performance can also function as triggers.

The concept of "ejaculatory inevitability" or that point in the sexual response cycle when there is no preventing an ejaculation can be useful for talking with men. Behavioral interventions help him appreciate when he is reaching that point, reduce anxiety about the problem, and help him communicate better with a partner during sexual activity. The "stop-start" technique, extended foreplay and alternate positions for intercourse are other interventions employed for the disorder. More recently the use of topical medications and SSRIs (e.g. dapoxetine) for their adverse side effects of delaying ejaculation have been recommended. Psychotherapy combined with the use of medical treatment is often recommended due to the impact of the disorder on the man's emotional response and the corresponding impact on his relationship with his partner.

For both ED and PE/RE, Cognitive Behavior Therapy (CBT) is a treatment of choice. As noted earlier, helping the patient change his cognitions about the problem as well as his behavior can be essential for long term success. The presumption is that anxious or distorted thoughts will help maintain the sexual problem. Common distortions include "if I was unable to get erect last night, I won't tonight," "I know she thinks I'm inept sexually and a failure as a man," "I'm not a real man because I can't control my orgasm," "If I can't get this right, she'll leave me for someone else." Prior research confirms that counseling in conjunction with medical interventions helps maintain improvements in sexual function as well as relationship quality.

Infertility

Infertility affects an estimated 15% of the population, in close to equal amounts for men and women, considering instances where combined male and female factor coexist. Men do have emotional reactions to infertility, both when the primary diagnosis is with their partner and when a male factor is diagnosed. And community concepts of masculinity often include paternity. Thus, a man who is unable to produce children can view himself as "less than a man." Traditionally, men learn to cope with sadness by hiding feelings. Stereotypes for maleness include toughness and a lack of emotionality. Denial and avoidance of the topic are common coping strategies for men with a male factor diagnosis. This can put them in conflict with their female partners who may interpret this response as not caring. At the same time, men receive messages about being strong for partners which often translates into not disclosing how they themselves feel about the fertility challenge. As a result, she may think he does not care. The disruption that can occur to a relationship is obvious.

Sometimes infertility and sexual prowess are inappropriately conflated. Or a provider may refer to his infertility as "shooting blanks" or some other emasculating phrase, increasing a sense of stigmatization. This has the potential to cause significant personal and interpersonal distress for the infertile man and his partner.

An infertility diagnosis may also lead to sexual problems that include ED or a lack of desire. Conversely, sexual difficulties can also have an impact on fertility. ED that prevents penetration, PE/RE that leads to extravaginal ejaculation and male orgasmic disorder in which intravaginal ejaculation does not take place can all be causes of infertility.

Counseling for the emotional impact of infertility is often recommended to couples in medical treatment. Since the focus of much fertility treatment occurs within OB/GYN and reproductive endocrinology offices with women as the focal point of treatment, men are often an afterthought with regard to their psychological reaction. Men are less likely to seek counseling services in general unless they know someone who has previously had a positive experience with it. Not surprisingly, men tend to focus more on discussion of activities than emotions. As a result, referrals for counseling may go unheeded because the man presumes he will have to engage in stereotypic female behavior. That is, he will be required to talk about emotions, particularly negative emotions like sadness and grief.

The availability of a male counselor and the use of language that is masculine in making the referral ("this may help you tackle the problem" vs. "it will help you cope with your grief") have been shown to increase men's usage of these resources. Label counseling sessions as meetings, conversations, or consultations as opposed to counseling or therapy. Another promising development in this area is the increasing availability of online support networks for men only. Men are notoriously unlikely to attend infertility focused in-person support groups but have reported satisfaction with a system that allows them to be anonymous and discuss emotional issues at the same time with other individuals like themselves who are experiencing similar situations. This can be particularly helpful for men who may be considering the use of donor sperm for azoospermia and are concerned about bonding with a child who is not from their genetic line. A trained infertility counselor can offer good advice on what constitutes parenting and how donor conceived children bond with parents. A group may provide him with an additional outlet for his concerns and could include men who have successfully made the decision to go forward with using donor sperm.

Other problems

Andrological related cancers present a unique set of problems for the treating physician. Most men will be concerned about the impact of treatment on their sexual and reproductive functions but may be reluctant to ask or be overwhelmed by the impact of a diagnosis. A thoughtful explanation of how the cancer and its treatment will likely affect both sexual and reproductive function is advisable. The physician should initiate this conversation and not wait for the patient to bring it up. Addressing their concerns about aging and a discussion on reasonable expectations for how sexual function normally changes are also useful interventions.

Additional thoughts

Men are comfortable with statements such as ''many men experience concerns about their low sperm count and what it means about their ability to have a family. Have you experienced similar thoughts or feelings?'' Similar normalizing statements about sexual problems are also helpful. This type of statement-question technique is an effective way to initiate a dialogue on a sensitive topic, normalizing it at the

same time. With men, who typically do not seek support but clearly benefit from it, normalizing the idea of supportive consultation seems to be critical to improve its utilization.

Medical problems that compromise sexual and reproductive function can be difficult to discuss for most people. Men are at a decided disadvantage in this arena and careful attention to the psychosocial impact of andrological problems can reduce the stress induced by them. To repeat, it is important to remember that each of those problems is taking place within a man whose life includes relationships with others. Taking the entire system into account and offering appropriate resources is crucial to your patient's overall health.

Suggested reading

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