# Psychosocial aspects of ejaculatory dysfunction and male reproduction

John P. Wincze, Ph.D.

Men's Health Center, Miriam Hospital, and Warren Alpert Medical School of Brown University, Providence, Rhode Island

This article provides a summary of the biopsychosocial model and the assessment and treatment of male sexual dysfunction as manifested in cases of infertility. In couples trying to get pregnant, a unique set of psychosocial and behavioral changes may evolve that directly interferes with a couple's usual pattern of sexual behavior, resulting in sexual dysfunction. The unique set of changes is discussed and how these changes impact on erectile and ejaculatory function. Strategies for assessing and managing male sexual dysfunction that compromise fertility are reviewed. (Fertil Steril® 2015;104:1089–94. ©2015 by American Society for Reproductive Medicine.)

**Key Words:** Biopsychosocial model, DE, delayed ejaculation, erectile dysfunction, ED, male sexual dysfunction, psychosocial etiology, PE, premature (early) ejaculation

**Discuss:** You can discuss this article with its authors and with other ASRM members at http://fertstertforum.com/winczej-psychosocial-ejaculatory-dysfunction/

Use your smartphone to scan this QR code and connect to the discussion forum for this article now.*

* Download a free QR code scanner by searching for "QR scanner" in your smartphone's app store or app marketplace.

Psychological and social aspects of male sexual dysfunction may present barriers to successful fertility. Men with no known medical reasons for infertility may experience difficulty with conception due to erectile dysfunction (ED), premature (early) ejaculation (PE), or delayed ejaculation (DE). The psychosocial basis for these disorders may be overlooked or may be incompletely assessed during a fertility work up due to a physician's lack of expertise in understanding the psychological and social nuances that are often present in such cases or due to a patient's reluctance or failure to disclose important details of his sexual functioning. This article provides a comprehensive discussion of the assessment and treatment of nonmedical contributions to male sexual dysfunction impacting on fertility.

The biopsychosocial model is today's gold standard for assessing and treating sexual dysfunction in men and women (1). In brief, this model advocates for an integrative look at the medical and nonmedical (psychological and social) factors that contribute to sexual problems as well as an integrative strategy for treatment (2). Medical contributions to sexual dysfunction within this model are the specific diseases or conditions (such as diabetes) that have a direct pathophysiologic effect on sexual functioning as well as the indirect medical factors such as chronic pain or chronic obstructive pulmonary disease, which may also adversely impact on sexual functioning although there are no specific physiologic pathways. The nonmedical factors within the model are individual (personality, sexual history, and comorbid mental health problems), relationship/partnership (quality of partnership as well as partner's sexual and mental health concerns), and environmental (conditions under which sex occurs).

The established psychological diagnosis of a sexual problem is determined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). DSM-5, the most recent edition, has established criteria for all sexual dysfunctions as follows: the problem is present on 75% of occasions, the problem has been present for at least 6 months, and the problem causes stress (3). It should be noted, however, that a large percentage of male patients complaining of sexual problems do not meet DSM-5 criteria. For example, some men may present for treatment after a single occurrence of ED or even in feared anticipation of ED. Sexual problems may present as either acute or chronic or as specific or generalized. In general, sexual problems that are acute after a period of successful sexual relations and problems that are specific to one partner or set of circumstances are more amenable to treatment.

Finally, it should be emphasized that sexual behavior is often imbued with strong feelings influenced by one's family values, culture, or religion. It is important for clinicians to explore such influences when addressing sexual functioning and incorporate treatment approaches that are respectful of these influences. Challenges to treatment arise when family, cultural, or religious influences conflict with "sexual sense." For example, a man struggling with ED

Received June 18, 2015; revised and accepted July 23, 2015; published online August 19, 2015.
Reprint requests: John P. Wincze, Ph.D., The Men's Health Center, Miriam Hospital, 164 Summit Avenue, Providence, Rhode Island 02906 (E-mail: john_wincze@brown.edu).

Fertility and Sterility® Vol. 104, No. 5, November 2015 0015-0282/$36.00

http://dx.doi.org/10.1016/j.fertnstert.2015.07.1155

may be conflicted because "lustful" thoughts about his wife are forbidden by his religion. In such cases, it is usually helpful to work with a religious leader whom the patient respects to navigate around such barriers to treatment.

This discussion points to a conceptual model and areas of concern to be taken into consideration when addressing sexual dysfunction problems, whether the problems are related to a couple's concerns about pregnancy or not. Efforts to become pregnant often add additional unique factors that must be considered.

## CHANGES IN SEXUAL BEHAVIOR WHEN "TRYING TO GET PREGNANT"

When a couple is trying to get pregnant, a unique set of changes may occur in the couple's usual approach to sexual activity that may adversely impact sexual functioning. Sexual activity may take on the single purposeful goal of conception and may no longer include a focus on eroticism and mutual sexual satisfaction. In addition, urgency and pressure may become associated with sexual intercourse rather than relaxation and pleasure; accordingly, sex also may become scheduled rather than spontaneous. All these changes may produce a state of performance anxiety for both partners. Simply stated, performance anxiety is a focus on the outcome of sex, rather than an enjoyment of the process of sex.

Men are more profoundly affected by performance anxiety than women because a man's penis (erect or flaccid) is observable by both him and his partner (4). Focused vigilance on the firmness of an erection contributes significantly to the risk of ED. Performance anxiety is the single most important nonmedical contribution to ED. Once a man and his female partner are worried about ED, it often becomes a vicious circle and a self-fulfilling prophecy. Performance anxiety also may be exacerbated by a female partner's emotional response to ED when it is expressed as doubt of her partner's attraction to her, anger, blame, or belittlement. Unwittingly, the pressure on a couple to perform successfully may also come from their parents and in-laws, who may be expressing their investment in grandchildren or constantly inquiring into the status of pregnancy.

Performance anxiety is not a true anxiety but rather may more accurately be described as cognitive interference or performance worry. In fact, true physiologically expressed anxiety (increased heart rate, increased blood pressure) may actually increase sexual response in a positive direction (5, 6). The more a man focuses on nonerotic and worrisome thoughts, however, the more likely sex is interfered with. Although it is most notably present in ED, performance anxiety may also be present in PE and DE.

There is evidence that the diagnosis of infertility alone contributes to loss of sexual desire and satisfaction in men undergoing fertility assessment (7, 8). The infertility evaluation is associated with an uncontrollable and unpredictable situation that further increases stress (7), which can exacerbate already existing performance anxiety.

## ERECTILE DYSFUNCTION

Erectile dysfunction (ED) is the most widely recognized and studied of all sexual dysfunctions and has been the focus of intensive scientific and public interest and intense commercial activity over the past two decades (4, 9). With the development of phosphodiesterase type 5 (PDE5) inhibitors, more than 100 million men worldwide have received prescriptions; the Internet is replete with Web sites providing descriptive information on ED as well as guidelines for assessment and treatment (4). With DSM-5 (3), changes have occurred that reflect our increased understanding of the disorder and that increase the reliability and validity of the diagnosis (10). As indicated previously, the changes in the DSM diagnosis of ED take into consideration the severity and duration of ED; specifically, the diagnostic criteria must be present for a minimum duration of 6 months and present on at least 75% of occasions (10). In addition, the condition must cause an individual significant stress to fully meet the diagnostic criteria. The individuals who express little or no concern about ED thus would not meet DSM-5 criteria, whereas others who are extremely distressed or even suicidal would. In general, younger men experiencing ED express much greater negative emotions than older men (9).

### Prevalence

Erectile dysfunction is by far the most prevalent sexual dysfunction experienced by men. It must be noted, however, that prevalence rates vary widely not just for ED but for all sexual dysfunctions owing to differences in research methodology, to the criteria used to define the disorder, and to the population under study (4). For ED, it is generally recognized that age is a significant factor affecting prevalence rates, with 10% of men aged 35 years or younger experiencing ED and with 50% of men over 60 experiencing ED (9, 11). The difference in prevalence rates by age is due to the increase in medical conditions that contribute to ED found in an older population.

Patients describe ED in a number of different ways, including an inability to obtain an erection, an inability to maintain an erection, or having a "softer" or less firm erection. For some men, the presence of ED has been a lifelong problem; for others, ED has occurred after a period of normal sexual functioning. The condition may also be situational or generalized. Situational ED occurs only in specific situations or with specific partners whereas generalized ED occurs under all circumstances and with all partners. Younger men in couples who are focused on becoming pregnant generally have fewer medical conditions contributing to ED, and they are more likely to be experiencing acute situational ED precipitated by the performance anxiety associated with the pressure to conceive.

In situational ED, men typically experience ED with their usual partner, but they experience full erections and orgasms during private masturbation or with a different partner. In private masturbation, men do not usually feel the same pressure to perform that may be present in sex with their usual partner; hence, the worry is removed, and the focus is solely on the erotic material and physical sensations. During masturbation men are also more likely to use visual erotic material that may be novel or unusual and intensely stimulating. The combination of a lack of worry about performance, novel