

Self-Esteem and Depression in Men Who Present with Erectile Dysfunction

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A number of authors have commented on the relationship of erectile dysfunction (ED) and depression. Feldman et al. (1994), in the Massachusetts Male Aging Study, found a positive correlation between impotence (ED) and the Center for Epidemiologic Studies Depression Scale. "At the maximum degree of depression, the combined age-adjusted probability of either moderate or complete impotence was nearly 90%, compared with 59% at mid scale and 25% at the least depressed extreme" (Feldman et al., 1994, p. 55). In the Feldman study, the ages ranged from 40 to 70 with a mean of 53.8, somewhat older than the patient group in this study.

Araux-Pacheco (1992) used the Hamilton Rating Scale for Depression to find a positive link between patients needing a vacuum device to treat impotence and general depression. Ackerman et al. (1995) in their study of ED comment: "The psychological consequences of erectile dysfunction are well documented, and frequently include depression, performance anxiety, and relational distress" (p. 32).

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Erectile dysfunction always has a psychologic component in addition to the underlying physical cause. The extent of depression and reduced self-esteem in patients who present with erectile dysfunction are explored in this study. Suggestions are given for how urologic nurses can overcome patients' fears and concerns.

There are few studies in the area of self-esteem as it relates to patients who present with ED. Intili (1997) looked at how stressors and reduced self-esteem affect patients with premature ejaculation (PE). Although PE and ED are both common male sexual dysfunctions, the underlying physiologic mechanisms and the average age of the patients are different.

Intili (1997) found considerable benefit from assessing the degree of depression and low self-esteem prior to initiating a treatment regimen for ED. Many men are reluctant to add an additional treatment "failure" to their present failure to perform sexually and to their concurrent perceived loss of masculinity. Perceived sexual failure always has a psychologic component secondary to the organic dysfunction (Althof, 1996; Intili, 1996). Knowing the patient's stress levels as they relate to depression and low self-esteem could guide the nurse in presenting and explaining various treatment modalities in a way that maximizes positive outcomes.

This small study is a cross-validation study for depression in ED and a pilot study for self-esteem in patients who present with ED.

Methodology

Clinic patients diagnosed with ED during August and September of 1996 were asked to complete two test instruments. A total of 15 men agreed to participate anonymously. ED was defined as an inability to achieve an erection satisfactory for sexual intercourse due to organic factors as determined by two parameters: subjectively by a patient-reported lack of morning erections on first waking; and objectively by low or negligible nocturnal erections as measured by Rigiscan®. Ackerman et al. (1991) demonstrated that there is a significant relationship between self-reports and Rigiscan studies.

Depression was measured using the Center for Epidemiological Studies Depression Scale (CES-D Scale) (Radloff, 1977). Self-esteem was measured with the Rosenberg Self-Esteem Scale (Rosenberg, 1979). These scales were administered by the nurse researcher to the 15 men. They were asked to fill out the scales prior to the initiation of any treatment. Patient ages ranged from 37 to 54 with a median of 46.0 years and a mean of 45.6 years; 86% of the men were married.

The depression scale reported a normative mean of 9.25.

The self-esteem scale reported a normative mean of 1.76. In this study the null hypothesis for both test scales was: "The means of the normative data and the sample will be statistically the same within $\alpha=0.05$, one tailed test."

Results

The results of the CES-D Scale test showed a mean of 19.14 with a standard deviation of 4.29. Using a Z distribution, the critical value for Z is 1.645. The observed value for Z is 4.31. The null hypothesis is rejected with $p < .001$.

The results of the Rosenberg Self-Esteem Scale showed a mean of 8.75 with a standard deviation of 3.82. Using a Z distribution, the critical value of Z is 1.645. The observed value for Z is 1.87. The null hypothesis is rejected with $p < .03$.

The Pearson r value correlation between the two scales was $-.61$, significant at the $.05$ level.

Application to Practice

The study validates earlier work on the link between depression and ED with the subjects showing significant depression as measured on the CES-D Scale. In addition, the study demonstrates these men are lower in self-esteem than the general population. The Pearson r calculation showed a significant negative correlation ($-.61$) between self-esteem and depression. Men reporting low self-esteem also showed high levels of depression as self-esteem and depression increased. The nurse should use this knowledge of depression and low self-esteem as a guide when interviewing a patient with ED. Many treatment modalities for ED involve multiple office visits and continued erectile failure until a satisfactory response is achieved. Understanding the depth of

depression on first presentation can often aid the nurse in preparing the patient for possible additional failure until the adoption of a successful treatment regimen.

We have found that when a man is asked, "What things make you a man in your own eyes?" the answer always includes some reference to the ability to have an erection sufficient for sex. Before baby boys can talk, they have erections. Young men judge themselves on the size, firmness, and "staying power" of their erections.

It is not possible for a man of any age to lose his erectile function and feel that he is a "real" man. The inability to perform is a direct threat to a man's core belief in himself. Loss of vaginal lubrication is an annoyance to a woman; loss of erectile function is a traumatic event to a man. Every man with self-reported sexual dysfunction has a psychologic component to his problem. Successful treatment of the impotent man involves attention to both his physical and psychologic aspects.

On the one hand, nursing as a profession is overwhelmingly female. On the other hand, most men who present with erectile dysfunction are past 50. The greatest problem a female nurse, and especially a young female nurse, faces with her impotent male patients is how to establish a relationship where discussion is open and relatively unembarrassed. Few older men will be comfortable discussing their "failure" as a man with a woman young enough to be their daughter or granddaughter. The comfort ability must originate with the nurse, and many nurses could benefit from some suggestions about how to attain a relaxed, professional atmosphere.

The Introduction

Start the session with a firm handshake. Look the man straight in the eye. Do not look down at your clipboard. Read his written responses to your office questionnaire before you enter the room. Speak in a level business tone. Do not sprinkle your sentences with tentative phrases such as: you know, uh, ah, well. Communicate verbally and nonverbally your confidence and knowledge. Do not laugh or tell jokes. Allow plenty of time for a discussion. Do not look at your watch. Dress conservatively and professionally with minimal makeup and cologne. Avoid any appearance of personal interest.

A conversation that starts with a simple statement of the truth may be helpful: "Thank you for coming to our clinic, Mr. Jones. My name is Mary Jo Brown. I'm a registered nurse with special training in urology. Many men find that talking to a female nurse about their erection problems is embarrassing or uncomfortable. I know that I have some embarrassment every time I talk to my male gynecologist about my problems. So, I guess it works both ways. You need to know that everything we say here is completely confidential. The questions I ask you are important for an accurate diagnosis of your problem. Let's start, if we could, with you giving a general description of your problem. Is that OK?"

Or: "Thank you for coming today, Mr. Jones. My name is Mary Jo Brown. I'm a registered nurse with special training and certification in urology. I want you to know from the start that at our clinic we believe that a problem with erection, also known as impotence, is a medical problem. Many men become depressed when they lose their erectile function, and

we can talk about that. It's like a spiral down into a swamp: You don't perform well, you start to worry; the more you worry, the worse the problem. After a while, you're caught in the swamp of worry and you can't think yourself out of it. Sex becomes a major source of stress and worry rather than a source of pleasure. Our job here is to reverse that spiral.

"Most of the time we are successful treating erectile problems; and we have seen that when your problems reverse, then you feel better about yourself. So our first job is to identify the medical cause of the erectile difficulty. I have to ask you some questions and maybe even do some tests. I know they may be embarrassing. Sometimes I find asking these questions is even uncomfortable for me. But the reason for my questions is to pinpoint the problem. If I ask you something that's too embarrassing, will you let me know? Let's begin, if we could, with you giving a general description of your problem."

Men rarely discuss their sexual difficulties with friends, acquaintances, or even their regular physicians. It is often the case that they are in your office because their partners have pushed them to a urologist after years of declining function. In classic denial, the pain of their loss of manhood is too great to face. We know that most impotence is caused by reversible factors including undiagnosed diabetes, hypertension, medication side-effects, and prostatitis. Our patients do not see their dysfunction clearly; their view is clouded by the inevitable depression and low self-esteem that accompanies the loss of their perceived manhood. As nurses, our primary job is to find a way around those barriers to treatment.

The Questions

The first "real" question in any discussion of impotence can be: "Do you have erections when you wake up in the morning, very first thing?" The question establishes the clinical tone and hopefully projects that my interest is in the man's erectile function and not in a judgment about his performance. Be prepared for the man to resist answering the question if he had low scores on the depression and self-esteem tests. Push the conversation: "It's basic biology that young men have many erections at night when they're asleep. And it's normal for this activity to diminish somewhat with age. Has this been your general pattern, too? Or have your nighttime erections dropped off more than that?"

Followup questions can steer away from performance and focus on function: "Did this loss of full erections come on gradually, like maybe over a year or so, or was the loss real fast, like in a week or two?" Organic impotence due to a chronic condition usually develops gradually. Impotence due to prostatitis or with a psychogenic cause (divorce, bankruptcy) develops quickly.

The Answers

Your patient may only give you short, terse answers. Do not mistake depression and embarrassment for rudeness. Understand that the patient may never overcome his discomfort of discussing with a woman his failures as a man. Hopefully, you will be able to assist the man to conquer the initial fear and embarrassment of a conversation he has probably not had with anyone else. In that case, the interview will be successful.

In addition to interviews, some female urology nurses also do penile blood flow studies or teaching on the use of

injections or vacuum devices. Once again, it is important that the patient sense you are comfortable, knowledgeable, non-judgmental, and competent in your actions. Talk your way through a procedure with full technical explanations for everything you do. Videos are useful, but nothing replaces one-on-one instruction, especially with men who score poorly on either depression or self-esteem tests. They are not focused on learning. Teach slowly with reverse demonstration and with multiple sessions spaced 2 weeks apart.

Conclusion

On a personal note, the nurse co-author of this paper is a male over 50, short, and nearly bald. I make it easy for patients to establish a level of trust with me by acknowledging their emotional fragility at the same time I project competence in our diagnostic procedures and confidence in a positive outcome. Hopefully, some of the suggestions given in this article will assist other nurses who practice in the area of male sexual dysfunction. □

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